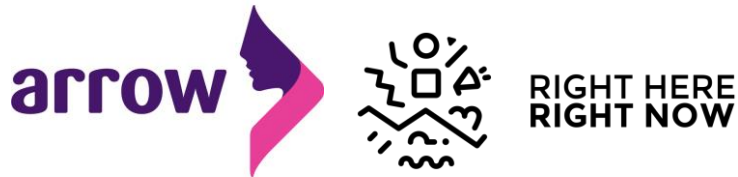


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Report submitted by:
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On behalf of Right Here Right Now



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Right Here, Right Now global partnership envisions a world where young people, in all their diversity, acquire full and uninterrupted access to life skills based education and youth-friendly sexual and reproductive health services, including safe abortion. The Asian Pacific Resource & Research Centre for Women (ARROW) is the regional coordinator and one of the members of the *Right Here Right Now* global partnership.

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The Sexual Rights Initiative is a coalition of six organizations from all regions of the world that work together to advance human rights related to gender, sexuality and reproduction.

This submission is endorsed by: Bandhu Social Welfare Society; Bangladesh Mahila Parishad (BMP); BRAC; Family Planning Association of Bangladesh (FPAB); James P. Grant School of Public Health - BRAC University; Naripokkho; RHStep; SERAC-Bangladesh; Unite for Bodily Rights (UBR) Alliance, Bangladesh.

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Executive Summary

1. This submission, prepared ahead of the 3rd Cycle of the Universal Periodic Review (UPR) for Bangladesh, looks at the challenges faced by the adolescent and youth population in Bangladesh in relation to their sexual and reproductive health and rights (SRHR). It considers three key SRHR issues, in particular, that affect the country’s young people- i) the absence of comprehensive sexuality education (CSE) in their schooling; ii) the lack of access to sexual and reproductive health (SRH) services including safe menstrual regulation (MR) that cater specifically to young people; and iii) the lack of inclusive national policies on SRHR for people with diverse sexual orientations and gender identities. It also provides recommendations to the state of Bangladesh with respect to these issues.
2. The existing CSE curriculum in the public Bangladeshi schools following the National Curriculum and Textbook Board (NCTB) is woefully inadequate, with the content generally presented in a manner that perpetuates gender stereotypes and stigma related to sexuality. It leaves adolescents with very little conceptual understanding of issues such as reproduction, sexuality, sexual behaviour, gender, and sexual and gender diversity. The implementation of this curriculum is also very limited; teacher training on CSE has not been effectively institutionalised and therefore teachers are often unable to approach teaching the module in an effective manner.
3. Public healthcare providers offering SRH information and services can hardly make up for this dearth of CSE as far as young people are concerned, since existing reproductive healthcare services do not cater to the SRH needs of unmarried adolescents due to stigmatisation and structural barriersⁱ, and therefore, in the absence of proper access to SRH knowledge, information and services, they remain vulnerable to serious health risks. Adolescent fertility rate in Bangladesh is among the highest in the worldⁱⁱ, and those aged 15-19 years contribute up to one-fourth of the country’s total fertilityⁱⁱⁱ, a result of the practice of child marriage, which leads to early and unwanted pregnancies. The criminalisation of abortion in Bangladesh, the stigma around the use of contraception and the advent of the problematic ***Child Marriage Restraint Act 2017*** make it increasingly challenging for young people, especially girls and young women, to make informed and healthy choices regarding SRHR.
4. The SRHR situation is even bleaker for people with diverse sexual orientations and gender identities. Bangladesh gave official recognition to “the third gender” in 2014^{iv} but neglected to define this gender category, thereby effectively failing to protect the rights of all transgender populations and other gender-diverse groups. Section 377 of the Bangladesh Penal Code 1860 criminalises ‘unnatural offences’ which results in gender-diverse and sexually diverse communities, among others, being subjected to stigma, discrimination and violence, and creates

significant barriers to their access to many fundamental services, including sexual and reproductive healthcare and legal redress. The criminalisation also potentially affects the security of human rights defenders and activists who work for the rights of these diverse communities.

General Context

5. There are 29.5 million adolescents in Bangladesh, including 14.4 million girls and 15.1 million boys, together representing nearly one-fifth of the country's total population of 144 million.^v Adolescents often lack relevant SRH information and are thus unable to make healthy choices, including about how to negotiate sexual relationships. About 85% of girls in rural areas are married by the age of 16.^{vi} While the overall contraceptive use rate is 52%, it is only 42% among adolescents aged 15-19.^{vii} According to the latest Bangladesh Demographic Health Survey (BDHS), adolescents aged 15-19 contribute up to one-fourth of total fertility rate.^{viii} Information and awareness about HIV is also severely lacking among adolescents and young people in Bangladesh, especially young women.^{ix}
6. Conservative attitudes and traditions, combined with social stigma, affect the SRHR of adolescents, especially girls. Adolescents and youth lack adequate information about sexual and reproductive issues, and lack access to quality youth friendly SRH services. While there are multiple initiatives undertaken by both public and private entities to provide SRH services, the majority of them cater to men and women of reproductive age (15-49 years).^x There are very few interventions in place that specially cater to adolescents' SRH needs.^{xi} In addition, the coverage of SRH service providers remain limited in areas such as urban slums despite the fact that these areas have more dense adolescent population.^{xii} There is also a critical gap in SRH services and information for unmarried youth and adolescents, especially girls.^{xiii}
7. Persons with diverse sexual orientations and gender identities generally face discrimination, stigma, harassment and violence from family members, schoolmates, police, and at the workplace, healthcare facilities, and government offices.^{xiv}

Lack of Comprehensive Sexuality Education

8. The Adolescent Reproductive Health Strategy (2006) recommends the inclusion of comprehensive sexuality education in school curriculum, with special services for out-of-school and married adolescent girls.^{xv} However, the implementation remains hindered by stigma and reluctance of teachers to discuss SRH issues. Bangladesh issued textbooks with a sexuality education curriculum for grade 6 and above in a culturally-sensitive and age-specific language in 2013.^{xvi} The textbooks were revised by Bangladesh Madrasah Education Board in 2014 and new curriculum was issued in 2015. The curriculum covers a range of issues including puberty and menstruation, but the undertone of the content remains stigmatising and fails to address the SRH needs of adolescents and young people. For example, the chapter on menstruation and puberty has connotations of purity and perpetuates the concept of menstrual blood being dirty. It also prohibits premarital sexual intercourse and discourages open discussions about

HIV/AIDS.^{xvii} Discussions around sexual harassment, for instance, do not address the root causes and instead promote the ideas that girls need to act and dress in way that does not attract unwanted attention from men and boys.^{xviii}

9. Furthermore, the implementation of the existing CSE curriculum is limited by the delivery mechanism. The curriculum is implemented for grade 6 and above, and hence important opportunity is lost in terms of reaching out to adolescents before their ideas and perceptions around these issues are formed. The curriculum is also not uniform and consistent. For example, the curricula being taught in Madrassa is different from the curriculum of Bangla and English medium public schools. Teachers do not use a rights-based approach and often stigmatise issues around sexuality and reproductive health. The transfer of information is influenced by teacher judgements and perceptions.^{xix} The teachers' training system does not include CSE as part of their training material.

Lack of Access to Youth-Friendly Sexual and Reproductive Healthcare Services

10. Unmarried adolescents fall outside the existing sexual and reproductive health care services system, due to systemic barriers. A recent analysis of the effectiveness and gaps of existing adolescent SRH interventions and programs revealed SRH clinical service delivery remains primarily limited to married women and girls, as they are designed to provide antenatal check-ups, delivery, and family planning services. Limited targeted clinical services are available to unmarried adolescents, which makes them vulnerable to health risks and discriminatory treatment. The Government has attempted to address these challenges by initiating Adolescent Friendly Health Centers (AFHC), however, the reach of these initiatives remain limited due to several factors including quality of the services and capacities of the staff at these facilities.^{xx} Unmarried youth and adolescent also hesitate to access these services due to the issues of privacy, confidentiality, and significant stigma associated with unmarried adolescent seeking SRH services.^{xxi}
11. In Bangladesh, abortion can only be legally performed if it is necessary to save the life of the pregnant woman. Under the Bangladesh Penal Code 1860, induced abortion is illegal unless the woman's life is in danger. However, menstrual regulation (MR)^{xxii} is part of the family planning programme since 1970s. In spite of availability of legal and safe MR services, unsafe abortion is still prevalent in the country. An estimated 1,194,000 induced abortions were performed in Bangladesh in 2014^{xxiii}, and it is highly likely that many of these were done in unsafe conditions or by untrained persons.^{xxiv} Lack of awareness, trained staff and adequate equipment remain significant barriers in provision of MR services.^{xxv} Many women are unaware of the existence of MR services. Those who know about the service, often do not go to the service providers because a third party authorisation by a guardian or spouse is required in practice as a function of social and cultural norms, even though it is not required in policy. Furthermore, it is almost impossible for young unmarried girls to access MR services due to stigmatisation.
12. According to the latest BDHS, adolescents aged 15-19 contribute up to one-fourth of total fertility.^{xxvi} While use of modern contraception by women of reproductive age (15-49 years old)

is 52% overall, it is only 42% among 15-19 year old adolescents.^{xxvii} Rates of contraceptive use are even lower among those who have not yet had children. In 2011,^{xxviii} it was found that 20% of married adolescents without children were using contraception, compared to 42% among all adolescents. Adolescent girls begin their married lives without proper knowledge of contraception and with limited ability to exercise their reproductive rights, including decisions related to family planning, childbearing and maternal and child health services, and usually begin childbearing soon after marriage.^{xxix, xxx} The burden of using contraception is always higher on women/girls and the promotion and awareness generation on contraceptive methods is more focused on women/girls than men. Further, unmarried young women and men face difficulty in accessing contraceptives as a result of social stigma.

13. The National Parliament of Bangladesh passed the Child Marriage Restraint Act 2017, which allows a boy or a girl to get married before reaching the statutory age limit (currently set at 18 years for women and 21 for men) under *special circumstances*.^{xxxi} There is no minimum age for when these special considerations can apply, but there are grave concerns that the law could lead to rape victims or impregnated adolescent girls being married to their abusers/rapists to protect the honour of the unborn child,^{xxxii, xxxiii} or the honour of the girl.^{xxxiv} Furthermore, the harmful impact of early age marriage on the mental, physical and economic well-being of girls^{xxxv} is being completely overlooked. Bangladesh has one of the highest early age marriage rates in the world, with 52% of the women being married by the time they are 18.^{xxxvi}

Lack of Inclusive SRHR Policies for People with Diverse Sexual Orientations and Gender Identities

14. The government of Bangladesh gave legal recognition to the long-marginalised *Hijra* population by officially acknowledging the community as the '*Hijra sex*' in 2014^{xxxvii}, but did not provide a definition of transgendered persons. The absence of a legal definition has led to abuses in the implementation of the legal change regarding recognition of *Hijras*.^{xxxviii} Since the recognition builds on the sole interpellation of the *Hijra* as a special group of 'disabled' people with genital defects, or missing or ambiguous genitals^{xxxix} (a misconception that is further evident in the draft Anti-discrimination law that is currently under consideration^{xl}). As a result, transgendered candidates under the government employment programme were denied employment on account of *not* qualifying as *Hijra* when, after being subjected to humiliating medical examinations^{xli}, it was found that they had male genitalia. Instead, they were accused of "impersonating" *Hijras*. In the absence of a rights-based procedure for the legal recognition of the *Hijra* community, and other transgendered persons, they remain vulnerable to violations of their human rights.^{xlii}
15. Currently, there is no legal or social recognition of the rights of persons of diverse sexual orientations and gender identities in Bangladesh. While the Constitution guarantees the right to freedom from discrimination and equal access to services for every citizen^{xliii}, there is no practical application of such fundamental principles when it comes to the rights of persons of diverse sexual orientations and gender identities. In the absence of legal and social recognition, their access to justice and ability to seek legal protection remains restricted.

16. The lack of inclusion and recognition of persons with diverse sexual orientations and gender identities in national laws and policies is a major barrier in their access to basic health services, including sexual and reproductive health care. For example, the HIV/AIDS Intervention Services, offered under the National AIDS/STD Programme (NASP) by the Ministry of Health and Welfare until 2011, which aimed to prevent HIV transmission and protect the rights of high risk groups and People Living with HIV, targeted only MSM (men who have sex with men), sex workers and the *Hijra* community^{xliv}, effectively excluding all other gender diverse and sexually diverse groups of people - who are equally vulnerable - from the scope and support of the Programme.
17. Section 377 of the Penal Code criminalises all sexual interactions that do not result in reproduction and are considered 'against the order of nature'.^{xlv} The criminalisation further perpetuates the social stigmatisation of persons with diverse sexual orientations and gender identities and makes them ever more vulnerable to discrimination, harassment and violence. Furthermore, recent killings of human rights defenders, who were working with persons of diverse sexual orientations and gender identities, have created a climate of fear.

Implementation of previous UPR recommendations in relation to SRHR of young people

18. Young people's issues, especially their sexual and reproductive health needs, received very little attention during first and second cycles of Bangladesh's UPR.
19. During its first and second reviews, the Bangladesh Government accepted recommendations to work towards protection of human rights defenders (HRDs) (A/HRC/11/18, Cycle 1, Para 94, recommendation 28, Australia, Netherlands; A/HRC/24/12, Cycle 2, Para 129, recommendation 104, Norway), however, in the past year, reprisals against HRDs, including killings, have continued.
20. In relation to recommendations regarding Bangladesh's reservations on Articles 2 & 16 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) (A/HRC/11/18, Cycle 1, Para 94, recommendation 3, Slovenia, France, Norway; A/HRC/24/12, Cycle 2, Para 130, recommendations 8, 9, 14, Sweden, Germany, Finland, Austria, Denmark, Australia), the reservations remain^{xlvi}, which results in persisting inequality for women in families, affecting their sexual rights.
21. Bangladesh has categorically refused to repeal article 377 of the Penal Code (A/HRC/24/12, Cycle 2, Para 131, recommendation 2, Chile), stating that, "activities subject to the concerned Article are not a generally accepted norm in the country".

Recommendations for action

Youth-friendly Health Services

22. The Government should ensure that menstrual regulation (MR) policies are revised to explicitly mention that third party authorisation, including of a guardian or spouse, is not required for receiving menstrual regulation services. Government should implement programmes to increase

awareness about MR among the community and services provides and increase the facilities with adequate equipment.

23. The National Adolescent Health Strategy needs to be revised and effectively implemented to ensure a range of SRH services, including contraceptives, which are of good quality and are affordable and accessible for both unmarried young men and women. The Government should also promote the use of contraceptives by men.
24. The Government should ensure that knowledge, information and counselling on contraceptive methods is universally accessible to young married and unmarried men and women, and that policies regarding contraceptive methods are being effectively implemented and monitored.
25. The National Adolescent Health Strategy needs to be revised in terms of providing access to SRH services regardless of gender identity or sexual orientation.
26. The Child Marriage Restraint Act 2017 is a huge step backwards and should be revised to remove exceptions and legal loopholes.
27. Expand the grounds on which abortion is permitted to include women's physical and mental health status, in case of rape and incest, and in cases of foetal impairment.
28. Laws regarding sexual violence need to be revised and promoted and there must be sufficient budgetary allocations for programmes and interventions.

Comprehensive Sexuality Education (CSE)

29. Comprehensive sexuality education (CSE) should start from the primary level and it should be age appropriate to meet the needs of the adolescents. Evidence-based, scientific and non-judgmental information needs to be incorporated into the National Curriculum and Textbook Board (NCTB) by the Ministry of Education.
30. The curriculum contents need to be synchronized irrespective of different systems including general education, Bangla medium schools, English medium schools, and religious schools, including Madrasas.
31. Home science and physical education content by NCTB should be rights-based rather than perpetuating gender stereotypes and stigmatisation. Furthermore, skills-building needs to be commenced that helps understanding of young girls' and boys' biological changes and making informed decisions and choices. NCTB should take measures to ensure content on sexual and reproductive health rights (SRHR), support service, sexual harassment, gender based violence (GBV), cyber-crime, child marriage, critical reasoning, and negotiation skill are included in the curricula.
32. The development of the curriculum by NCTB should be done through a consultative process engaging women, girls, young people, parents, teachers, and CSOs to ensure that the CSE curricula covers SRHR issues comprehensively and to ensure progressive content.
33. NCTB should engage SRHR academics and practitioners to sensitise and build capacities of CSE curricula developers.
34. Government should introduce programmes to ensure teachers and educators are sensitised and trained to effectively implement CSE in educational institutes.

35. Government should ensure provision of comprehensive SRHR information and life skills to out-of-school youth, young married girls, sexually-and gender-diverse persons, and disabled young people.

Recognition for People with Diverse Sexual Orientation and Gender Identities

36. Provide a clear, inclusive and dignified definition in the law of what constitutes the ‘third gender’ and also clarify the distinction between ‘intersex’ and ‘transgender’ and other gender identities, by enacting legislation that protects and promotes the fundamental rights of individuals with diverse gender identities, through consultations with the *Hijra* community, the transgender population, intersex persons, SRHR experts, human rights activists and NGOs, and by taking their recommendations into account.
37. Ensure that the procedures for third gender recognition allow individuals the freedom to identify themselves, and are not contingent on the fulfilment of medical check-ups and verifications.
38. We urge the government to reform Section 377 of the Penal Code 1860 to decriminalise non-normative consensual sexual acts, to put an end to stigma, discrimination, harassment and violence against persons with diverse sexual orientations and gender identities.
39. Ensure SRH services for everyone, irrespective of their sexual orientation and/or gender identity, and widen the ambit of national health policies and the National AIDS/STD Programme (NASP) and other healthy policies and programmes to include all gender diverse and sexually diverse groups, to ensure their equitable access to sexual and reproductive health services.
40. Enhance the protection and security of human rights defenders and activists, irrespective of the groups or communities whose rights they seek to ensure and promote, by ensuring their access to legal support, and assistance from law enforcement agencies, in the event of any kind of threat or attack, and take into consideration the gravity of the threat to human rights defenders, activists, journalists and bloggers working for the rights of people with diverse sexual orientations and gender identities.

ⁱ http://evidenceproject.popcouncil.org/wp-content/uploads/2017/02/Bangladesh-ASRH-Report_January-2017.pdf

ⁱⁱ Ibid.

ⁱⁱⁱ Ibid.

^{iv} http://www.csbronline.org/wp-content/uploads/2016/08/ShaleAhmed_HjiraRights_CSBR-ILGAAAsia2015.pdf

^v http://evidenceproject.popcouncil.org/wp-content/uploads/2017/02/Bangladesh-ASRH-Report_January-2017.pdf

^{vi} <https://www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf>

^{vii} http://evidenceproject.popcouncil.org/wp-content/uploads/2017/02/Bangladesh-ASRH-Report_January-2017.pdf

^{viii} Ibid

^{ix} Ibid

^x Ibid

^{xi} Ibid

^{xii} Ibid

^{xiii} Ibid

^{xiv} https://www.wewillspeakout.org/wp-content/uploads/2013/11/GBV-Study-report_Final-FHI_PNG-and-Bangladesh.pdf

^{xv} <http://arrow.org.my/wp-content/uploads/2017/04/Bangladesh-Country-Profile-on-SRR.pdf>

^{xvi} Sabina, Nazme. *Religious Extremism and Comprehensive Sexual and Reproductive Health and Rights in Secondary and Higher Secondary Education in Bangladesh. National Report*. Dhaka: Naripokkho and Asian-Pacific Resource and Research Centre for Women (ARROW). 2016.

^{xvii} Ibid

