

C o u n t r y
P r o f i l e
on
Reproductive Health
in
Bangladesh

Sponsored by : **World Health Organization**
Drafted by : **John Snow Inc., Bangladesh**

Preface

Thepress

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This is a series of country profile of Bangladesh

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ACRONYMS

AFLE	Adolescent Family Life Education
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BBS	Bangladesh Bureau of Statistics
BCC	Behavioural Change Communication
BDHS	Bangladesh Demographic and Health Survey
BFS	Bangladesh Fertility Survey
BINP	Bangladesh Integrated Nutrition Project
BIRPERHT	Bangladesh Institute of Research for Promotion of Essential & Reproductive Health and Technologies
BIRDEM	Bangladesh Institute of Research on Diseases of Endocrine and Metabolism
BMI	Body Mass Index
BRAC	Bangladesh Rural Advancement Committee
BSMMU	Bangabandhu Sheikh Mujib Medical University
BWHC	Bangladesh Women's Health Coalition
CCs	Community Clinics
CBD	Community Based Distribution
CBO	Community Based Organization
CBR	Crude Birth Rate
CDR	Crude Death Rate
CEDAW	Convention on the elimination of all forms of Discrimination against women
CPR	Contraceptive Prevalence Rate
CSWs	Commercial Sex Workers
CWFD	Concerned Women for Family Development
D&C	Dilatation and Curettage
DFID	Department for International Development
DH	District Hospital
DGHS	Directorate General of Health Services

DHS	Directorate of Health Services
EC	Emergency Contraception
EFA	Education for All
ELISA	Enzyme-Linked Immuno-Sorbent Assay
EmOC	Emergency Obstetric Care
ENC	Essential Newborn Care
EPI	Expanded Programme of Immunization
ERD	Economic Relations Division
ESP	Essential Services Package
FDSR	Family Development Services and Research
FFYP	Fifth Five-Year Plan
FHI	Family Health International
FP	Family Planning
FPAB	Family Planning Association of Bangladesh
FWAs	Family Welfare Assistants
FWCW	Fourth World Conference on Women
FWVs	Family Welfare Visitors
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIS	Geographical Information System
GK	Ganoshastha Kendra
GPs	General Practitioners
GPA	Global Prevention of AIDS
GoB	Government of Bangladesh
HA	Health Assistant
HbsAg	Hepatitis B Virus Antibody
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
H&FWC	Health and Family Welfare Centre
HIV	Human Immuno-deficiency Virus
HLC	High Level Committee
HNP	Health and Nutrition Program
HNPSP	Health, Nutrition and Population Sector Program
HPSP	Health and Population Sector Programme

HPSS	Health and Population Sector Strategy
HRD	Human Resource Development
HRM	Human Resource Management
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh.
ICPD	International Conference on Population and Development
IDA	International Development Association
IDD	Iodine Deficiency Disorder
IDU	Injecting Drug Users
IEC	Information Education and Communication
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPGMR	Institute of Post-Graduate Medicine and Research
I-PRSP	Interim Poverty Reduction Strategy Paper
IUI	Intrauterine Insemination
IVF	Invitro Fertilization
KAP	Knowledge, Attitude and Practice
KMC	Kangaroo Mother Care
LTFP	Long Term Family Planning
LBW	Low birth weight
MAP	Monitoring the AIDS Pandemic
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Centre
MDG	Millennium Development Goals
MHS	Maternal Health Service
MIS	Management Information System
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare
MO	Medical Officer
MR	Menstrual Regulation
MRTSP	Menstrual Regulation Training and Services Programme
MSCS	Marie Stopes Clinic Society

MSM	Men having sex with men
MVA	Manual Vacuum Aspiration
NAP	National AIDS Programme .
NGOs	Non-Government Organizations
NMR	Neonatal Mortality Rate
NIPHP	National Integrated Population and Health Program
NIPORT	National Institute of Population Research and Training
NPC	National Population Council
NRR	Net Reproductive Rate
NSDP	NGO Service Delivery Program
OGSB	Obstetric and Gynaecological Society of Bangladesh
PAC	Post Abortion Care
PBD	Professional Blood Donors
PDAP	Participatory Development Action Programme
PIP	Programme Implementation Plan
PLWHA	People living with HIV/AIDS
PMED	Primary and Mass Education Development
PMM	Prevention of Maternal Mortality
PoA	Program of Action
PPNG	Penicillinase Producing N. Gonorrhoeae
PRB	Population Reference Bureau
PSTC	Population Services and Training Centre
RH	Reproductive Health
RH-FP	Reproductive Health-Family Panning
RPR	Rapid Plasma Reagin
RTIs	Reproductive Tract Infections
SCs	Satellite Clinics
SDPs	Service Delivery Points
SIDA	Swedish International Development Agency
SNL	Saving Newborn Life
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STIs.	Sexually Transmitted Infections

TBAs	Traditional Birth Attendants
TTBAs	Trained Traditional Birth Attendants
TFR	Total Fertility Rate
TOT	Training of the Trainers
TPHA	Treponema Pallidum Hemagglutination
TT	Tetanus Toxoid
U5MR	Under 5 Mortality Rate
UFHP	Urban Family Health Partnership
UH&FWC	Union Health and Family Welfare Centre
UHC	Upazilla Health Complexes
UMIS	Unified Management Information System
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UTPS	Unity Through Population Service
VAC	Vitamin-A capsule
VAW	Violence against Women
VCT	Voluntary Counseling and Testing
VIDA	Village Integrated Development Association
WHO	World Health Organization

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Executive Summary

1. Introduction

The term 'reproductive health' emerged from 1994 United Nations International Conference of Population and Development (ICPD) held in Cairo, Egypt. ICPD was a watershed event that significantly altered the policies and programs related to women's health around the world by broadening the more traditional women's health agenda of family planning and MCH to include issues like safe motherhood, STDs/HIV/AIDS, post-abortion care, adolescent health, violence against women and sexual and reproductive rights.

Bangladesh as a signatory to the ICPD declaration, has taken on the obligation of eliminating discrimination against women in the enjoyment of all civil, political, economic and cultural rights. An essential framework is provided for promoting and protecting the rights of girls and women throughout the life cycle, and for attempting to eliminate inequality, discrimination and gender-based disparities.

The Government of Bangladesh seeks to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. MOHFW adopted in 1998 the Health and Population Sector Strategy (HPSS) to provide a package of essential health care services for the people of Bangladesh and to slow down population growth. The main sectoral objectives of the HPSS are: maintenance of the momentum of efforts in Bangladesh to lower fertility and reduce mortality, reduction of maternal mortality and morbidity and reduction in the burden of communicable diseases. The essential services package identified in the HPSS consists of basic reproductive and child health services, including family planning, maternal care and immunization as well as control of selected communicable diseases, limited curative care and behavior change communication. The Health and Population Sector Program (HPSP) was formulated in 1998 on the basis of HPSS. In order to encompass all the activities of the health sector, the Government has revised the HPSP and formulated the new 'Health, Nutrition and Population Sector Program (HNPSPP) (2003-2006). The vision and targets outlined in the Interim Poverty Reduction Strategy Paper (i-PRSP) of the government have been adopted as overarching long-term policy framework for HNPSPP.

2. Fertility, population growth and family planning

The population of Bangladesh has grown from about 42 million in 1942 to 130 million in 2001. The crude birth rate is currently 30.2 per 1000 live births while the crude death rate has fallen from 19 in 1975 to 8 in 1995. The total fertility rate has decreased from 6.3 in the late 70s to a present rate of 3.3. However, TFR has remained almost constant for the last 10 years despite some marginal increase in contraceptive use (44.6 percent in 1993-94 to 53.8 percent in 1999-2000). The plateauing of TFR inspite of rising CPR has been one of the biggest concerns for the policy makers. Available data show that in Bangladesh heavy reliance is placed on the traditional and temporary methods. The government aims to improve the situation through emphasizing appropriate method-mix with increasing proportion of clinical and terminal methods.

The Government's family planning program has adopted broad implementation strategies calling for greater integration of family planning with health, involvement of stakeholders in design and monitoring, a focus on users of services rather than demographic targets,

improved quality of care and a wider range of reproductive health services, with increased attention of maternal and adolescent health care provided as part of an essential service package. Plans have been developed to create community clinics where contraceptive services and information would be available along with other selected primary health care services included in the ESP. The key areas which need attention are : arresting the trend of early marriage, delaying birth especially, the first birth, encouraging wider birth intervals, improvements in child survival, immunization and nutrition, encouraging adoption of long-term family planning methods and involvement of NGOs and other stakeholders in the country's family planning efforts.

3. Safe Motherhood

The state of maternal health in Bangladesh is dismal. Bangladesh has one of the highest maternal mortality rates in the world – at 3 per 1000 live births. The tragic consequences of these deaths is that about 75 percent of the children born to these women also die within the first week of their life. The major causes of maternal death are post partum haemorrhage, eclampsia, complications of unsafe abortion, obstructed labor, post-partum sepsis and violence/injuries. Close to 87 percent of pregnant women do not receive assistance from a skilled attendant. A recent study shows that 63 percent of pregnant women do not receive any ante-natal care. Around 15 percent of all pregnant women develop potentially life threatening complications. Women with obstetric complications face a variety of barriers in obtaining care. There are three delays which a pregnant mother needs to overcome to receive timely services. These delays concern taking decisions to seek medical care, reaching a medical facility and in receiving care at the facility.

Interlinked with maternal health is the neonatal health. Of the 3.8 million babies born every year in the country 150,000 babies are stillborn. The current neonatal mortality rate is 42 per 1000 (1995-1999) which has fallen from 63 per 1000 in 1985-89. Three leading causes have been identified which lead to such high newborn death. These are : infection, complications during delivery and complications of pre-maturity.

Safe motherhood and neonatal care have been accepted as sub-areas under reproductive health care element of essential services package under HPSP. The Government's maternal health strategy include reductions in maternal mortality and morbidity, social mobilization, caring practices, decision-making at home level and service delivery through provision of emergency obstetric care services, promotion of women's access to resources and ensuring quality of services. Maternal health services are provided at community and facility levels through a network of domiciliary field workers, satellite clinics, health clinics and hospitals.

4. Unwanted pregnancy/unsafe abortion

In Bangladesh, about a third of all births can be considered as unplanned. These include mistimed (desired at a later date) and unwanted. If all unwanted births were avoided the fertility rate would fall from 3.3 to 2.2 children per woman. Low contraceptive continuation rates, method failure and high unmet need for contraceptives are some of the leading causes of unwanted pregnancies and abortions.

A large number of women resort to either menstrual regulation or clandestine abortion to terminate unwanted pregnancies. Unsafe abortion may be induced by the woman herself, by non-medical persons or by health workers in unhygienic conditions. Although induced

abortion is illegal in Bangladesh except when done to save a woman's life, the practice is believed to be common. Every year 2.8 percent of all pregnant women undergo MR and 1.5 percent induced abortion. The annual number of induced abortion is about 730,000 of which MR is 430,000. The overall rate of hospitalization for abortion is 2.4 per 1000 live births.

Consistent and correct use of modern methods of contraception can prevent many unwanted pregnancies and in turn, save lives. Government, NGOs and private sector can intensify their efforts to improve access for men, women, unmarried individuals and adolescents to high quality, client-centered information and services.

5. Adolescent and sexual reproductive health

According to 2001 census report as many as 36.3 million Bangladeshis are adolescents (10-19 years of age) constituting 23% of the population. In general, knowledge of reproductive health among adolescents is low. The majority have no idea about the changes associated with puberty until they experience them. A large proportion of the married female adolescents are unaware of the need for antenatal checkup during pregnancy, post-natal care services, the number of TT doses required for first pregnancy and for the life time, emergency obstetric care, emergency preparedness for delivery and the danger of abortion performed by untrained person.

There is an increasing number of anecdotal reports of adolescents accessing commercial sex workers and a growing body of knowledge that indicates a high level of premarital sexual activity among adolescent boys in Bangladesh. As they mature and become sexually active, adolescents become vulnerable to contracting STDs/ RTIs/HIV/AIDS. Adolescents' nutrition is also an important issue to be considered. Among the adolescent girls aged 11-16 years 43 percent suffer from anaemia.

The Government made adolescent health care a pivotal subcomponent of the essential services package. Under the HNPSP the adolescent health problems will be addressed with the involvement of the NGOs and the adolescents themselves. The interventions will include school health, adolescent sexual and reproductive health services, education programs, peer education, programs on pregnancy and unsafe abortion, STI/HIV/AIDS prevention program, nutrition program, TT program and protection against violence.

6. Addressing STIs / HIV / AIDS

The actual incidence and prevalence of reproductive tract infection/sexually transmitted disease in Bangladesh are difficult to gauge as many patients suffering from RTIs/STDs conceal their diseases. However, several studies point to the fact that the prevalence is high. The reported use of condom in sex acts with commercial sex workers was found to be very low. It ranged from 1.0 percent to 10.9 percent among various at risk groups.

The exact number of people currently living with HIV/AIDS in Bangladesh is not known but is variously estimated to be approximately 30,000. The prevalence rate is highest among intravenous drug users (2.6 percent) followed by 0.6 percent among commercial sex workers and 0.4 percent among STD patients. All the known HIV-risk behavior and factors – CSWs, men who have sex with men (MSM), intravenous drug users (IDUs) and high rates of STI –

are acknowledged to be present in Bangladesh. As a result there is an increasing concern that a marked epidemic of HIV might occur in a manner similar to that documented in the neighboring countries. At an average of 18.8 clients a week, sex workers in Bangladesh brothels report among the highest turnover of partners anywhere in Asia. Among the hotel-based sex workers it is still higher, averaging 44 clients a week. It means that once a woman does contract HIV from a client, she can pass it on to large number of people very quickly especially when the rate of condom use is low. Men rarely use condoms and virtually all sex workers report some sex without condom with their clients.

Sharing of needles and syringes with an infected person is one of the surest ways of spreading HIV. In Bangladesh, needle sharing is common. A study found that 93.4 percent of the drug injectors had shared needles with others.

Realizing the gravity of the HIV/AIDS situation in Bangladesh, the Government undertook a project on 'prevention and control of sexually transmitted diseases' in 1996. Later in 1997 the government approved the National Policy on HIV/AIDS and STD related issues. The National AIDS Policy outlined various aspects of HIV/AIDS prevention and care covering public health aspects like surveillance, HIV/AIDS counseling and testing diagnosis and treatment of sexually transmitted diseases. The government also developed in May 1997 a strategic plan for the National AIDS Program (1997-2002) for HIV/AIDS prevention and care. The program is implementing separate packages for preventing HIV/AIDS among at-risk populations.

7. Approaches in reproductive health

The rights-based approach to sexual and reproductive health is concerned with gender equity and equality, sexual and reproductive rights and client oriented sexual and reproductive health care. In terms of gender equity and equality, the women in Bangladesh are not in a favorable position. Age-old tradition, social norms and values, economic dependence, illiteracy and prevalence of rigorous family laws create and legitimize discrimination and inequality against women. Violence against women is very common. Rapes and acid attacks are on the rise. The government through its ESP tries to ensure the reproductive health rights of the women. Both the government and the NGOs are committed to the delivery of ESP components.

The life cycle approach to women's health anticipates and aims to meet women's health needs throughout her life cycle, from infancy to old age. This approach emphasises the importance of health seeking behavior throughout the life and need for appropriate services to meet women's health needs to respond to the life-cycle needs of women. The government formulated the National Reproductive Health Strategy (1997) based on the principles of ICPD. The strategy prioritizes four services areas in reproductive health: safe motherhood, family planning, MR and care for post-abortion complications and management of RTI/STD. Reproductive Health issues in Bangladesh are mostly focused on needs and problems of women, which overlook the requirement and involvement of men to a large extent. Men in Bangladesh despite having positive attitude towards family planning are unable to adopt it because of lack of method choice and male providers. In matters of reproductive health decision-making they are mostly ignorant about protection of themselves and their wives. Again despite good intentions most husbands are not able to arrange the ANC and the

assistance during delivery in the right health centre by the right medical professional because of their ignorance. Involvement, motivation and education of men in reproductive health matters can greatly contribute in improving the RH situation in Bangladesh.

8. Challenges and future direction

Reproductive health agenda is a multi sectoral issue. Reducing maternal mortality, morbidity and violence against women cannot be achieved through the health sector alone.

The major challenges currently faced by the Bangladesh in the field of RH are related to problems in the areas of programmes, policies and resources. The plateauing of TFR is a big concern for Bangladesh and the long-term policy and strategy of HNPSP will emphasise a method mix with greater proportion of clinical and terminal methods. The priority action areas in the field of RH are to improve: (i) EOC, EmOC and Safe motherhood; (ii) improving family planning services, (iii) meeting needs of adolescent RH, (iv) prevention and treatment of STI/RTI/HIV/AIDS; v) minimising the need and improving PAC; (vi) increase male involvement in reproductive Health; (vii) improving newborn care and (viii) Reduce violence against women.

The Government envisions fulfillment of every woman's right to safe motherhood with a mission to nurture a socio-cultural movement that leads to reduction in mortality and morbidity and enhancement of women's status. However, strategies and interventions will require to focus on efforts to enhance women's status and self-esteem if effective results are to be obtained.

CHAPTER ONE

Introduction

Bangladesh has adopted the ICPD (International Conference on Population and Development) global policy. The country has modified its approach to fertility reduction not only through family planning but also through inclusion of a broad based reproductive health approach. Efforts are increasingly being made to incorporate important reproductive rights and women's empowerment in the Population Policy, which is under review, to improve the quality of life of the people of the country. The proposed policy is based on the principles of the ICPD, which mainly deal with improvement of quality of life through improved health care, equity and empowerment of women, human rights and cultural interest.

Background

The state of reproductive health in Bangladesh is gradually improving. The country has been able to achieve considerable progress in fertility regulation and in increasing contraceptive prevalence rate (CPR). By the early nineties the total fertility rate (TFR) had come down to 3.3 from the level of 6.3 in the mid seventies. During the same period CPR increased to 54 percent from the level of 8.5 percent while life expectancy at birth had increased to 61 years by the late nineties from the level of 48 years in the mid-seventies. During the same period, development of physical infrastructure, institutional facilities and health and family planning services was also remarkable (MOHFW, May 2003).



Photo: Amin/JSI Bangladesh

The International Conference on Population and Development (ICPD)

The International Conference on Population and Development (ICPD), held in Cairo from the 5th to 13th September 1994, established a close link between population policies and reproductive health including women's rights. The ICPD advocated that there is a need to expand the horizon of a country's population policy beyond the confines of achieving stabilization of population through reduction in its fertility. Stabilization of population is to be achieved by providing the opportunity and option to decide, not by coercion and control. The major objectives and goals of the ICPD Program of Action are:

- sustained economic growth in the context of sustainable development;
- education, especially for girls;
- gender equity and equality; and
- infant, child and maternal mortality reduction and provision of universal access to reproductive health services, including family planning and sexual health.

ICPD has recommended a rights-based approach for sexual and reproductive health. This approach was reaffirmed and extended at the Fourth World Conference on Women (FWCW) in Beijing in 1995 and again at the ICPD+5 review in 1999.

Even before the ICPD was held Bangladesh had been trying to implement the proposals and actions relevant to those in the ICPD document. During the three decades preceding the conference, the Government of Bangladesh (GoB) had launched countless interventions for socio-economic development for the alleviation of poverty, spatial and income equity of the population and improvement in family planning and maternal and child health care services. Prior to the ICPD, the Bangladesh family planning program was revamped with emphasis on quality and access to health services and sustainability of the health system. Women's empowerment had already become a national issue of concern and attention.

The ICPD was held at a time when Bangladesh had already begun making some fundamental changes in its health system, and therefore the event has reinforced its commitment to continue with the changed process. The ICPD has helped to create a strong integration of the existing programs and has facilitated a holistic approach for women's development. Involvement in the ICPD of NGOs, advocacy groups and technical assistance agencies as well as the GoB has facilitated the process of program redefinition.

The Bangladesh Population Policy, which is on the anvil, advocates for the stabilization of a population that is sensitive to national tradition and culture, while upholding human rights and adhering to commitments made at various international conferences on issues such as education (Jomtien, 1993), population and development (Cairo, 1994), women and children (Beijing, 1995), and other relevant international fora, as well as adhering to the agreements reached at the Millennium Summit (New York, 2001).

The outline of the first Population Policy was prepared in 1976, to comply with the articles 15-18 in Part 11 of the Bangladesh Constitution, which states "the State has the responsibility to ensure to its citizens certain basic needs such as health, education, food and security". In the Population Policy Outline, high population growth rate was identified as the nation's "number one problem." This policy has been reflected in all successive plans and programs.

The National Population Policy of Bangladesh, which is under review, "aims at improving the overall standard of living of the people of Bangladesh through improved reproductive health status and contributing to a more desirable balance between population and development".

The major policy objectives of the proposed policy are:

- Provide quality reproductive health and family welfare services to people at all levels of the society, and especially the under-served rural and urban population.
- Support and provide quality antenatal delivery and post-natal services, emergency obstetrics care; manage complications arising from unsafe abortions; ensure delivery by skilled staff.
- Ensure universal child immunization, supply of vitamin 'A' and other micronutrients; ensure prevention of malnutrition among children and pregnant women.
- Ensure coordination among relevant Ministries
- Ensure adequate availability and access to sexual and reproductive health counseling and services to adolescents
- Develop the human resource capacity of planners, managers and service providers
- Ensure gender equity and empowerment of women
- Increase social security for the elderly and food security and shelter for the destitute
- Reduce rural to urban migration
- Ensure a conducive environment for improved quality of life and better living conditions
- Adopt poverty alleviation strategies and ensure shelter for all.

Post-ICPD developments in Bangladesh

The Ministry of Health and Family Welfare seeks to create conditions for the people of Bangladesh to have the opportunity to reach and maintain the highest attainable level of health. It is a vision that recognizes health as a fundamental human right and, therefore, the need to promote health and to alleviate ill health and suffering in the spirit of social justice. This vision derives from a framework that is based on the core values of access, equity, gender equality and ethical conduct (MOHFW, May 2003).

Following the ICPD, many activities have been undertaken and many relevant formal bodies have been set up in Bangladesh (Barkat A and U Rob, 1999). A National Plan of Action was developed, disseminated and approved by the GoB. The plan covered the themes of poverty reduction, women's equity, equality and empowerment, reproductive rights and reproductive health.

Some of the major events that have taken place after the ICPD are:

- Formation of a National Committee for the Implementation of the Program of Action (PoA) of ICPD
- Development of a National Plan of Action
- Preparation of document entitled "Strategic Directions for the Bangladesh National Family Planning Program: 1995-2005"
- Development of a Health and Population Sector Strategy (HPSS) and Health and Population Sector Program (HPSP)
- Development of a National Integrated Population and Health Program (NIPHP)
- Development of a National Policy on HIV/AIDS and STD related issues
- Establishment of a National Council for Women's Development
- Formation of a National Population Council
- Formation of a National Population Policy Committee
- Formation of a National Health Policy Committee
- Formation of a High Level Committee
- Formulation and approval of a National Food and Nutrition Policy
- Formulation of a National Reproductive Health Strategy
- Formation of a government-NGO Consultative Council
- Formulation of a National Women Development Policy.
- Establishment of Partners in Population and Development, and the South-South Centre.

Post-ICPD global developments

According to an assessment by UNFPA of the ICPD's impact on population policies and program around the world, many countries have taken steps to broaden existing family planning and related policies and programs (maternal and child health, birth spacing, safe motherhood, etc.) to include other reproductive health information and services. They are giving increased attention to the quality of care in reproductive health and family planning programs. Several governments have taken steps to decentralize the management of public health programs to promote community participation in reproductive health care. Several countries have reported that most aspects of the reproductive health concept were available for middle and higher income groups in urban areas and were unavailable or inadequately available to most of the rural and urban poor. Initiatives have been undertaken in many countries to address the reproductive health and rights of adolescents and to put their needs on the political agenda. Gender issues have been incorporated in the design and implementation of reproductive health programs and women are now involved in decision-making positions to advance efforts to meet their reproductive health needs. Many countries now recognize the need to involve men in reproductive health programs and some have taken up innovative programs. Following the ICPD, steps have been taken to increase the collaboration of governments with NGOs and the private sector in delivering reproductive health information and services.

In 1998, the sector wide approach (SWAp) i.e. the program approach was adopted in the health and population sector. When the idea of the sector wide approach was shared with the government, its operational advantages appeared to be attractive. The GoB developed the Health and Population Sector Strategy (HPSS) on the basis of consensus between and development partners. Subsequently, the Health and Population Sector Program (HPSP) was formulated based on HPSS (MOHFW, May 2003).

Implementation Plan (PIP) of HPSP was also put in place from July 1998. The major component-wise outcomes of the program were:

- Essential Service Package defined, funded, promoted and implemented
- Services delivery mechanism unified, restructured and decentralized
- Integrated support systems strengthened
- Hospital-level services focused and improved
- Policy and regulatory framework strengthened
- Other important public health services strengthened

The Fifth Five Year Plan (FFYP) (1997-2002) of the GoB was formulated in 1998 to create a greater degree of public awareness of the population problem through a social movement in order to reach the replacement level of fertility by the year 2005. The focus of the FFYP was on a reproductive health subprogram which aims at extending the coverage of reproductive health services, including efforts to improve safe motherhood, quality obstetric care, clinical methods of contraception and the management of RTIs and STIs. Issues of gender equity and equality and reproductive rights were introduced in the programs of education, law enforcement, religious affairs, the garments and tea plantation industries and other sectors. The FFYP also completed a phased program to upgrade a network of 64 Maternal and Child Welfare Centers (MCWCs) with proper equipment and training of staff in EmOC so that these can offer a package of comprehensive maternal health services.

Present situation

The HPSP came to an end on 30th June 2003. In order to encompass all the activities of the health sector, the GoB has revised the HPSP and formulated the new "Health, Nutrition and Population Sector Program (HNPSPP) (2003-2006). The vision and targets outlined in the Interim Poverty Reduction Strategy Paper (i-PRSP) of the GoB have been taken as an overarching long-term policy framework and political commitment of the Government upon which the

The broad strategies of the HNPSPP are:

- Reduction of morbidity, mortality, fertility and malnutrition;
- Increasing access (to the poor) and improved service delivery by providing essential services through close-to-client facility, public health services, as well as secondary and tertiary hospitals, and access to essential drugs and indigenous & traditional medicine by improving quality laboratory services and through improved Management Information System;
- Disease prevention, control and reduction;
- Health promotion and behavior changes;
- Addressing health of specific target groups such as the urban poor, school children, adolescents and young people;
- Ensuring adequate human resources for health needs through updating HRD and management strategies, ensuring high quality medical education, training of nurses, laboratory technicians and pharmacists, continuing education and developing a National Center of Excellence;
- Health Sector reform such as autonomy to institutions, decentralization or unification, promoting partnership with private and NGO sectors and involving community and stakeholders in planning, implementation and monitoring;
- Organization and management of health services through sector wide management & procurement of goods and services.

Note:

The strategy for the provision of ESP is to provide health and family planning services and nutrition interventions through a mix service structure at the peripheral level coupled with appropriate domiciliary services and a functional referral system. Services will be near and user-centered, culturally sensitive, need-based, effective, efficient and well utilized and will be planned and managed with active community involvement.

The vision is outlined in IPRSP as:

“With the constitutional obligation of developing and sustaining a society in which the basic needs of all people are met and every person can prosper in freedom and cherish the ideas and values of a free society, the vision of Bangladesh’s poverty reduction strategy is to substantially reduce poverty within the next generation”.

HNPSP will be developed and will contribute to poverty reduction in the country.

The goal of the HNPSP is sustainable improvement of health, nutrition and family welfare status of the country’s population, especially the vulnerable, e.g., the poor, the women, the children and the elderly.



Photo: Amin/JSI Bangladesh

The purpose will be to increase the availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality services for a defined Essential Services Package plus other selected services.

The priority objectives are to achieve the targets set in the Millennium Development Goals. These are (1) reducing maternal mortality ratio (MMR); (2) reducing total fertility rate (TFR); (3) reducing malnutrition; (4) reducing infant and under-five mortality; (5) reducing the burden of TB; (6) ensuring essential services through close-to-client (CTC) facilities; (7) improving access to and quality of care of secondary and tertiary hospitals; (8) control of communicable diseases including kala-azar, dengue, leprosy, STD and HIV/AIDS; (9) control of non-communicable disease like cancer, cardiovascular diseases, diabetes, thyroid disorder etc; (10) control and prevention of public health issues like arsenicosis, environmental and occupation hazards and food safety; (11)

National Plan of Action

Areas of Action

- **Poverty Alleviation and Sustainable Development**
 - Rural poverty alleviation in order to minimize the problem at source
 - Agriculture
 - Industrialization
 - Urbanization, migration and environment
- **Health and family Planning**
 - Health Goals
 - Safe Motherhood
 - Family Planning
 - Male Involvement
 - Adolescent and Child Welfare
 - RTI/STD/HIV/AIDS, Infertility and other Reproductive Health Services
 - Child/Infants/Neonate
- **Research, Training and Information**
 - Generation, analyze, dissemination of newer information through research
- **Education**
 - Education is for sustainable development and the improvement in the quality of life
- Greater public knowledge, understanding and commitment necessary to respond positively to population concerns

preventing injuries due to violence (especially against women and children) and accidents and injuries (MOHFW, May 2003).

HNPSP will continue to focus on areas of reproductive health and population such as safe motherhood, reduction in total fertility and advocacy for vulnerable groups. Efforts in detecting, preventing and treating RTIs/STDs/HIV/AIDS will also continue.

Strengths and challenges

Bangladesh has been successful in reducing the population growth rate from 3% in the mid-seventies to 1.4% by the year 2000. Over the past three decades, the country has achieved impressive reductions in fertility and infant and child mortality. The 1994 Cairo Conference hailed Bangladesh as a family planning success story. In spite of this achievement, population growth has been a continuous impediment to the government's efforts to improve the standard of living of the people. High population density (2,403 persons per square mile, one of the highest in the world), deforestation and reduction of cultivable land, air and water pollution, scarcity of drinking water, inadequate shelter, unemployment, malnutrition and slow pace of progress in health and education sectors are some of the problems faced by the country today.

Continued emphasis on reproductive health services is required to attain replacement level fertility. The quality of basic health services must also be improved simultaneously.

The Millennium Development Goals (MDG) and targets set in the i-PRSP imply achieving the following targets for IMR, U5MR, MMR, life expectancy, population growth and underweight children by the end of the HNPSP period:

Table 1.1

Indicators in light of MDGs:	Major Goal Post Poverty Targets				
	Current (2000)	2004	2006	2010	2015
Income-Poverty (percent)	50	45	43	35	25
Infant Mortality Rate (/1,000 live births)	66	56	48	37	22
Under-Five Mortality Rate (/1,000 LB)	94	80	70	52	31
Maternal Mortality Ratio (MMR/1,000 LB)	32	29.5	27.5	24	14.7
Life Expectancy (Years)	61	64	66	69	73
Population Growth (percent p.a)	1.6	1.5	1.5	1.4	1.3
Percent Child under Five Underweight	51	48	42	34	26

Source: I-PRSP, ERD, 25 March 2003 (www.erdbd.org/iprsp)

A new set of benchmarks adopted at the ICPD+5 Review

(a) The 1990 illiteracy rate for women and girls should be halved by 2005; and by 2010, the net primary school enrolment ratio for children of both sexes should be at least 90 per cent;

(b) By 2005, sixty per cent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods to prevent infection; 80% of facilities should offer such services by 2010, and all should do so by 2015;

(c) At least 40% of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80% globally by 2005; these figures should be 50% and 85%, respectively, by 2010; and 60% 90% by 2015;

(d) The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75% by 2010, and by 100% by 2015.

Recruitment targets or quotas should not be used in attempting to reach this goal;

(e) To reduce vulnerability to HIV/AIDS infection, at least 90% of young men and women between ages 15-24, should have access by 2005 to preventive methods – such as female and male condoms, voluntary testing, counselling, and follow up, and at least 95% by 2010. HIV infection rates in persons 15-24 years of age should be reduced by 25% in the most affected countries by 2005 and by 25% globally by 2010.

The Ministry of Health and Family Welfare will contribute to achieving the long-term vision and the targets set in the i-PRSP programs and activities in a phased way. Each individual program will have its own strategic vision (for the program period) to realize part of the targets set in the i-PRSP in a manner which will enable all targets to be achieved in full by the end of 2015. Investment in health will contribute to improvement in health outcomes and will enable to achieve sustainable human development and poverty eradication goals (MOHFW, May 2003).

It is estimated that by 2025, almost a half of the population of Bangladesh will be urban. Inhospitable urban environment, lack of employment opportunities, congestion and the high rate of the growth of urbanization are contributing to increased poverty. With the majority of the population being under 25 years of age, combined with large-scale internal and external migration and the serious threat of HIV/AIDS spreading rapidly in the region, the need to address adolescent reproductive health issues has also acquired significant urgency.

The relatively young age structure of the population indicates continued rapid population growth in the future. According to the 2002 World Population Data Sheet of the Population Reference Bureau (PRB), 40% of the population is under 15 years of age and 3% are of the age 65 or above. This young age structure constitutes a built-in “population momentum” which will continue to generate population increases well into the future, even in the face of rapid fertility decline. An additional two million people gets added to the population each year. With this trend, the population is likely to grow to 172 million by 2020 and might stabilize at or below 210 million by the year 2060 even if replacement level fertility (i.e., $NRR=1$) is achieved by the year 2010. However, if it is delayed by another 10 years i.e., until 2020, the population will stabilize 25 years later (i.e., 2085) at 250 million. This will inevitably put a tremendous constraint on national resources and will negatively affect all efforts to improve the quality of life and living standards of the people.

Multi-disciplinary and multi-sectoral efforts are needed for influencing population stabilization efforts. This involves active participation of ministries and sector corporations like that of Health, Education, Labour, Employment, Social Welfare, Women and Children’s Affairs, Youths, Sports and Cultural Affairs, Rural Development and Cooperatives, and Planning and Information.

A new set of benchmarks adopted at ICPD+5 Review

(a) The 1990 illiteracy rate for women and girls should be halved by 2005; and by 2010, the net primary school enrolment ratio for children of both sexes should be at least 90%;

(b) By 2005, 60% of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods to prevent infection; 80% of facilities should offer such services by 2010, and all should do so by 2015;

(c) At least 40% of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80% globally by 2005; these figures should be 50 and 85%, respectively, by 2010; and 60 and 90% by 2015;

(d) The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75% by 2010, and by 100% by 2015. Recruitment targets or quotas should not be used in attempting to reach this goal;

(e) To reduce vulnerability to HIV/AIDS infection, at least 90% of young men and women, of the age of 15-24, should have access by 2005 to preventive methods – such as female and male condoms, voluntary testing, counselling, and follow up, and at least 95% by 2010. HIV infection rates in persons 15-24 years of age should be reduced by 25% in the most affected countries by 2005 and by 25% globally by 2010.

CHAPTER TWO

Fertility, Population Growth And Family Planning

The estimated population of Bangladesh is 130 million. The density of population per sq. km. is 876, with male-female sex ratio at 103.8:100. The percentage of urban population is about 23.4 and rural population is 76.6%. The crude birth rate in the country is currently 30.2 per 1000 live births. There is a considerable urban – rural difference in crude birth rate: 25.3 in the urban areas and 31.3 in the rural areas. The crude death rate has fallen considerably over the last few decades, from 19 in 1975 to 8 in 1995. The growth rate has come down to 1.48% at the end of Fifth Five Year Plan through decline in the CBR and CDR.

Fertility changes and population growth

Bangladesh has been passing through a critical phase of demographic transition. The fertility trends show a decline since the mid-seventies, which can be observed from the estimates of the series of demographic surveys over the last two and a half decades, beginning with the Bangladesh Fertility Survey (BFS) in 1975. The rapid rate of fertility decline during the period of 1971-1975 (6.3 children per woman) to 1991-1993 (3.4) has become stagnant at the present rate of 3.3 since 1994. Three successive BDH surveys have shown total fertility rates (TFR) as 3.4 in 1993-1994, 3.3 in 1996-1997 and 3.3 in 1999-2000 (NIPORT, Mitra and Associates, and ORC Macro, 2001).

Over the last 25 years, there has been a decline of 48% in TFR – i.e., a decline of 1.9% per year (Table 2.1). The pace of decline was steeper during the late 1980s to the early 1990s, and after that it has remained almost constant. For example, within a period of five years, starting from 1989 to 1993/94, fertility declined by 33% or 6.6% per year, while for the next six year period (1993/94 to 1999-00), it was only 3.8% or less than 1% (0.63%) per year.

In this country, fertility control tends to be practised later in marriage and newly married couples continue to have children at more or less the same rate as before (ibid.). It has been observed that delayed marriage can play an important role in reducing the level of fertility through reduction of the childbearing span. However, the level of fertility appears to be a function of not only age at marriage, and hence of age at first birth, but of birth spacing as well. Birth intervals play a major role in determining the total fertility rate.

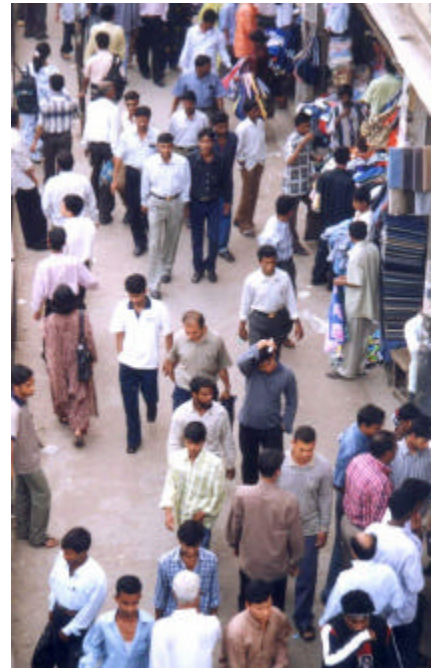


Table 2.1: Trends in current fertility rates

Age-specific and total fertility rates among women of the age 15-49, selected sources, Bangladesh 1975 to 1999-2000						
Survey and approximate time period						
	1975			1993-1994	1996-1997	1999-2000
	BFS	1989 BFS	1991 CPS	BDHS	BDHS	BDHS
Age group	1971-1975	1984-1988	1989-1991	1991-1993	1994-1996	1997-1999
15-19	109	182	179	140	147	144
20-24	289	260	230	196	192	188
25-29	291	225	188	158	150	165
30-34	250	169	129	105	96	99
35-39	185	114	78	56	44	44
40-44	107	56	36	19	18	18
45-49	35	18	13	14	6	3
TFR 15-49	6.3	5.1	4.3	3.4	3.3	3.3

Note: For the 1975 and 1989 BFS surveys, the rates refer to the 5-yr period preceding the survey; for the other surveys, the rates refer to the 3-yr period preceding the survey. The BFS and BDHS surveys utilized full birth histories, while the 1991 CPS used an 8-yr truncated birth history.

Source: 1975 BFS (MHPC 1978:73); 1989 BFS (Huq and Cleland, 1990:103); 1991 CPS (Mitra et al, 1993:34); 1993-94 BDHS (Mitra et al, 1994:24); 1996-97 BDHS (Mitra et al.,:30)

In the high performing regions of Bangladesh, where high performance is defined in terms of achievements in family planning and fertility, the total fertility rate is low mainly due to long birth intervals. However, in the low performing regions although the age at marriage is substantially higher as compared to that of the high performing regions, the total fertility rate is high mainly due to the shorter birth intervals. The BDH survey reveals that women in Rajshahi and Khulna divisions marry early while those in Sylhet and Chittagong divisions marry later (ibid.). There have been some notable findings (Islam M A et al., 2001.), which indicate that:

- a. Infant deaths are causing higher levels of fertility at an increasing speed than in the past. This might be attributable to the slow pace of decline in the level of infant mortality over the recent past.
- b. Sex preference does not show any remarkable impact on birth intervals. The sex of the previous child seems to have little influence on the birth interval.

The past decline in the level of fertility was mainly attributable to the strong family planning program (Cleland et al, 1994). An analysis of the reasons for the unchanged level of fertility during the period between 1993-94 to 1996-97 and 1996-97 to 1999-2000 based on Table 2.2 reveals that the positive achievements of some indicators in reducing the TFR is offset

TFR is defined as the number of children a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the current observed age-specific rates. The general fertility rate represents the annual number of birth in a population per 1000 women of the ages 15-44.

A birth interval, defined as the length of time between two successive live births, indicates the pace of childbearing. Information on birth intervals provides insight into birth-spacing patterns, which have far-reaching impact on both fertility and child mortality levels. Research has shown that children born too soon after a previous birth are at increased risk of dying at an early age.

by the negative impact of others. The same indicators (like age at marriage and birth) having a negative impact during the period 1993-94 to 1996-97 have changed to having a positive impact in the later period of observation (between 1996-97 to 1999-2000). The impact of increased birth interval and continuation of two major contraceptives (oral pill and injectables) in decreasing the level of TFR was essentially offset by decreases in age at marriage, age at first birth and duration of breastfeeding which favored an unchanged TFR during the period 1993-94 to 1996-97. Moreover, increased continuation of injectables, increase in age at marriage, age at first birth and birth intervals contributed to a decrease in the level of TFR while a decrease in the duration of breast-feeding, continuation of oral pills and condom had contributed to an increase in the level of TFR.

Table 2.2: Selected indicators of fertility and population growth

Indicator	1993-1994	1996-1997	1999-2000
Median age at first marriage (years)	14.4	14.2	15.0
Median age at first birth (years)	17.7	17.4	18.0
Median birth interval (months)	34.7	36.6	38.8
Median duration of breastfeeding (months)	>36	32.8	30.5
Continuation of contraceptives at 36 months			
Oral pill	0.274	0.290	0.269
Condom	0.140	0.150	0.131
Injectables	0.197	0.279	0.291

Source: Plateauing of fertility level in Bangladesh: Exploring the reality by the Centre for Policy Dialogue. November 2001

Also, it can be seen in the table that increased continuation of injectables, increase in age at marriage, age at first birth and birth intervals contributed to a decrease in the level of TFR while decrease in the duration of breast-feeding, continuation of oral pills and condom contributed to an increase in the level of TFR. In Bangladesh, heavy reliance is placed on the natural and temporary methods of family planning compared to other countries, which have attained low TFR. Those countries have attained low TFR by using an appropriate contraceptive methods mix with temporary, and clinical methods, and less reliance on natural methods. Use of the terminal methods has been drastically reduced in Bangladesh since many years.

It is estimated that 65% of the growth in population during 2000-2025 will be attributable to the current young age structure of the population (Islam M A et al., 2001). The high level of fertility will be the major contributor to the growth of population around 2005. Since then, population momentum will cause growth at an increasingly rapid pace. The three most feasible approaches to reduce the impact of population momentum are: delayed age at marriage, delayed age at first

Regions in Bangladesh that are lagging behind in achieving the replacement level fertility are characterized by the positive factor of higher age at marriage. However, regions with low levels of TFR have longer birth intervals than regions with high levels of TFR. In other words, delayed age at marriage does not contribute apparently to the decline in the level of fertility. But from the multivariate analysis, it is observed that lower age at marriage can be linked with increased progression to next birth at short intervals.

The age at which childbearing begins has important demographic consequences for society as a whole as well as for the health and welfare of the mother and child. In many countries, postponement of first births – reflecting an increase in the age at marriage – has contributed greatly to overall fertility decline. Early initiation into childbearing is generally a major determinant of large family size and rapid population growth, particularly in countries where family planning is not widely practised. Moreover, bearing children at a young age involves substantial risks to the health of both the mother and child. Early childbearing also tends to restrict educational as well as economic opportunities for women.

birth, and wider spacing of successive births. The last point is the most successful proven approach for Bangladesh, which has been observed in the Khulna and Rajshahi divisions. The remaining two factors need long-term change in the socio-economic and demographic behavior and practice, while wider birth spacing can be attained through improving the service delivery system of the prevailing family planning programs.

Family Planning

The Bangladesh Family Planning (FP) Program evolved in the context of a very strong worldwide population stabilization effort supported by international donors. The program had specialized staff, facilities, equipment and other resources. Women who elected to use contraception were referred to as “acceptors.” The program adopted a door-to-door service delivery approach and had method specific targets, and in some cases recruitment of clients was remunerated on a per capita basis.

In order to achieve the major program objectives, the MOHFW (Ministry of Health and Family Welfare) envisages to adopt broad implementation strategies including provision of quality RH-FP (Reproductive Health – Family Planning) services that will respond to client needs, strengthening population and development linkages; reducing gender disparities to access to RH services; eliminating gender discriminatory practices and giving priority to the needs of poorer sections of the population, especially destitute women and children.

The Bangladesh Government’s Health and Population Sector Strategy of 1997 reflects many of the policies outlined in the ICPD Program of Action. The strategy calls for greater integration of family planning with health, involvement of stakeholders in design and monitoring, a focus on users of services rather than demographic targets, improved quality of care, and a wider range of RH services with increased attention to maternal and adolescent health care provided as part of an “essential services package – ESP” (MOHFW, 1997). Plans have been developed to create “community clinics” where contraceptive services and information would be available along with other selected primary health care services that had been included in the ESP. The community family planning workers who went from door-to-door would receive additional training and would be based in the community clinics.

Many of the NGOs adopting the Government’s ESP approach have also discontinued door-to-door contraceptive distribution; instead, the services are being offered through static clinics and satellite clinics. The higher quality and broader range of

TFR in Bangladesh has longer birth intervals, which is just the reverse for regions with high levels of TFR. In other words, delayed age at marriage does not contribute, apparently, to decline in the level of fertility, but as noted from multivariate analyses, lower age at marriage can be linked with increased progression to next birth at short intervals.

This implies that although delayed marriage is not directly associated with reduction in the level of fertility, it can act through increasing birth intervals to reduce the level of fertility. Thus, in lagging regions like Sylhet and Chittagong, the level of fertility would be even higher in the absence of delayed marriage. On the other hand, in leading regions like Khulna and Rajshahi, if the age at marriage could be delayed the decline in the level of fertility would be much faster.

services available in these two types of clinics with the opportunity of “one stop shopping” are intended to attract clients and also increase the impact of the services on health.

For more than two decades, agencies in the health and population sector of Bangladesh have provided information and education on selected health issues and on FP as a key intervention. These programs of communication activities have resulted in increases in awareness and have contributed to a greater use of key health and FP services in the country. IEC activities have also contributed to the increase in the utilization of the services and development of a favorable environment towards family planning including a sustained and strong political support for program activities.

Knowledge of FP methods among ever-married, including currently married men and women, was assessed by the BDH-Survey 1999-2000. It was found that knowledge of FP methods is high among Bangladeshi couples. Virtually all respondents know at least one modern FP method, and eight out of ten (79-82%) know at least one traditional method. The pill is universally known among currently married men and women. Knowledge of at least one method reached universal proportions among ever-married women of reproductive age in Bangladesh in 1983. Thereafter, knowledge of specific methods has become more widespread, growing continuously with time to reach more than nine out of every ten women by 1996-1997 for almost every modern method.

There has been little change in the knowledge of family planning methods over time, which has remained as high as found in the BDH Survey 1999-2000 as in the earlier survey of 1996-1997. With family planning methods widely known, knowledge of at least one modern method is universal both among women and men in all age groups in both urban and rural areas and across all categories of educational level. These findings are an indication of the success of program efforts in providing contraceptive information to all eligible couples across the country. Trends in the knowledge of family planning methods are shown in the Table-2.3.

Among ever-married women 75% have ever used a method and about 68% have used a modern method (NIPORT, Mitra and Associates, and ORC Macro, 2001). The pill is by far the most commonly used method; more than 55% of ever-married women have used this method. The other commonly used methods are injectables (20%), condoms (19%), periodic abstinence (19%), withdrawal (14%), female sterilization (7%) and IUD (7%). Men report higher ever use of contraception than women. Eighty seven percent of currently married men, compared to 78% of currently married women report having ever used a family planning method. Ever use of

The Behavioral Change Communication (BCC) component of ESP is designed to contribute to:

- Changes in attitudes and behavior of people to improve their health status
- Build effective community support for health seeking behavior
- Change attitudes and behavior of service providers in favor of more client-centered services.

Table 2.3 Trends in knowledge of family planning methods

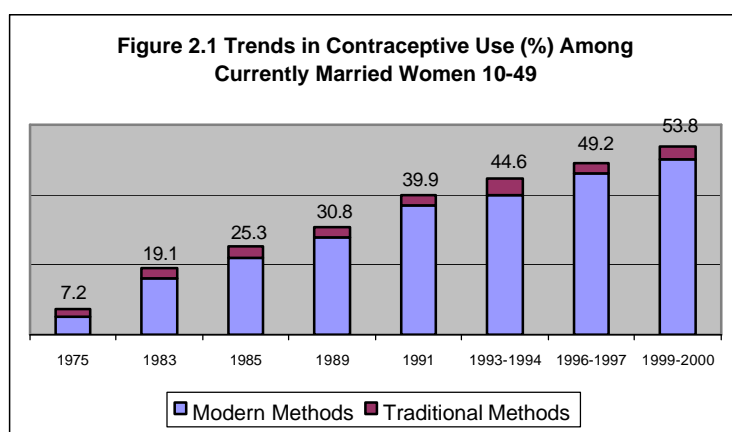
Percentage of ever-married women age 10-49 who know specific family planning methods, selected courses, Bangladesh 1975-1999

Method	1975	1983	1985	1989	1989	1991	1993-1994	1996-1997	1999-2000
	BFS	CPS	CPS	CPS	BFS1	CPS	BDHS	BDHS	BDHS
Any Method	81.8	98.6	99.6	99.9	100.0	99.9	99.7	100.0	99.9
Any modern method	80.0	98.4	99.5	99.9	99.0	99.8	99.7	100.0	99.9
Pill	63.9	94.1	98.6	99.0	99.0	99.7	99.5	99.9	99.7
IUD	40.1	41.6	65.4	80.4	78.0	88.9	89.4	91.4	89.0
Injectables	u	61.8	74.1	87.5	81.0	95.2	96.3	98.0	97.8
Vaginal methods	10.0	19.4	26.3	25.8	24.0	u	u	u	u
Condom	21.1	59.0	75.5	76.9	83.0	85.6	86.6	91.0	89.0
Female sterilization	53.1	95.5	97.8	99.2	98.0	99.4	98.8	98.9	97.4
Male sterilization	51.4	72.9	84.3	84.0	87.0	87.4	82.9	83.4	76.6
Any traditional method	49.0	54.8	62.8	71.7	u	83.3	75.0	76.6	79.0
Periodic abstinence	28.0	26.4	41.2	40.1	46.0	68.0	64.0	68.2	66.1
Withdrawal	15.1	19.8	20.8	14.4	30.0	48.6	49.0	49.8	55.7
Number of Women	6,515	8,523	8,541	10,293	11,907	10,573	9,640	9,127	10,544

Source: 1974 BFS (MHPC, 1978: A245 and Vaessen, 1980:16); 1983 CPS (Mitra and Kamal, 1985:85;89); 1985 CPS (Mitra, 1987:67,70); 1989 CPS (Mitra et al, 1990:81,84); 1989 BFS (Huq and Cleland, 1990:60); 1991 CPS (Mitra et al, 1993:42); 1993-1994 BDH Survey (Mitra et al, 1994:40); 1996-1997 (Mitra et al, 1997:45)

methods is the lowest among younger women, gets higher with increase in age, such as with regard to women aged 30-34, then declines as they become older. Among the currently married women, only 41% report having ever used a method in the youngest age group, and in the oldest age group 69% report having ever used a method compared with 86% of those in the age group of 30-40 (ibid.).

Contraceptive prevalence rate (CPR) has steadily grown in Bangladesh since 1975 (Figure 4.4). In 1975, only 8% of



Source :NIPORT, Mirra and Associates, and ORC Macro, 2001

Almost all married women in Urban Family Health Partnership (UFHP) catchments populations (98.6%) could describe three modern family planning methods. As many as 93.6% of the pregnant women knew about the complications that threaten the life of a mother during pregnancy, delivery or post delivery. While 71% knew about the relevant complications, 22.6% mentioned other complications as well. It was also encouraging to find that almost all of these women (99.7%) knew that they should seek medical care in case of complications during pregnancy.

It was altogether very difficult to change the minds of the customers, particularly regarding the paradigm shift from home-based to clinic based service delivery, especially with regard to paying for the services. With the introduction of the elements of quality and range of services from a single SDP, along with the extensive effort in informing the community about the benefits of clinic-based services, UFHP was successful in drawing over 850 thousand customers in a single month (March 2002)

currently married women reported using a family planning method compared with 54% in 1999-2000 (ibid.). This shows a seven times increase in the contraceptive prevalence rate for any method over the last 25 years. The prevalence of modern methods has increased even faster, more than eight times, from 5% in 1975 to 43% in 1999-2000. However, increases in the use of modern methods appear to have slowed down over the three years since the 1996-1997 BDH survey.

Between 1996-1997 and 1999-2000, the overall contraceptive use increased by 9% (ibid.) largely due to the use of traditional methods, which increased by 34% (7.7 to 10.3%) among married women. Modern method use has increased only marginally by 4% (41.6 to 43.4%).

Infertility

Reproductive choices include not only the ability to avoid unwanted childbearing but also the possibility of bearing wanted child. The prevention, diagnosis and treatment of infertility – the inability to bear children – are therefore an essential part of ensuring reproductive choice (WHO, 2001).

Globally, infertility affects about 50 to 80 million couples at some point of their reproductive lives with a variety of biological and behavioral determinants. In developed countries, between 8 and 12% of all couples will experience some form of infertility during their reproductive lives. In developing countries where the incidence of reproductive tract infection is high, infertility rates are much higher which in many instances are preventable (WHO, 2001). The overall primary infertility rate in developing countries is between 2 and 5%. Studies conducted by World Health Organization (WHO) have shown that the secondary infertility rate is even higher; between 10 and 33% (IPPF, 2000).

A range of demographic, behavioral and socio-cultural factors has been identified as potential determinants of infertility. Among the recognizable correlates of infertility in this country are sexually transmitted diseases, maternal health factors such as unhygienic delivery, postpartum infection, and unsafe obstetric and abortion procedures linked to sepsis and pelvic infections. Severe malnutrition and anaemia, adolescent sterility, male occupational exposure to noxious agents, and close cousin marriage practices also contribute to infertility.

In Bangladesh, there have been very few studies that focus specially on infertility. A number of small studies, almost all based on data from health facilities examining underlying causes of fertility, report that primary infertility was more common than secondary infertility, accounting for over 60% of all cases. For example 61% cases examined over a 14-year

In November 2000, the UFHP (urban service delivery partner of NIPHP) started its comprehensive clinic program, which was designed to offer customers a full range of choices for family planning methods, including the four long-term methods. The comprehensive clinics were selected for an upgrade of equipment and staff skills based on the outcome of a baseline survey. Thereafter, the UFHP selected 41 clinics to be upgraded to comprehensive clinics.

Family planning performance increased significantly in the UFHP project Service Delivery Points (SDPs). A total of 161,239 customers received family planning services in the month of June 2002 compared to only 31,907 in June 1998. Of them, the number of short-term family planning acceptors was 58,202 and that of long-term family planning acceptors was 3,037.

period in an infertility clinic in Bangladesh were found to be suffering from primary infertility (MOHFW, 1999).

The higher prevalence of primary infertility in women who go to a health facility is probably a reflection of the health seeking behavior of women, and not of the actual patterns in the population. Women who have not conceived at all or have no live births are more likely to seek health services for diagnosis and treatment than those who have borne one or more children. Because of the under reporting of secondary infertility in health facility-based studies, information on causes of infertility is likely to consistently underestimate the role of infections which are the most frequent cause of secondary infertility. In more than half of the infertile couples (55% and above), infertility is the consequence of sexually transmitted diseases or infections following abortion or delivery. A profile of an infertility clinic in Bangladesh finds that in 21% of all respondent couples, the husband had a low sperm count and of these a large number were attributed to STDs (Chowdhury et al., 1981). Ovulatory disturbances emerge as the most frequent cause of primary infertility. Tubal diseases and cervical pathology are other common causes. The study cited earlier found ovulatory disturbances in 32%, tubal problems in 23%, and infertile male partners in 15% of the cases of primary infertility (MOHFW, 1999).

Though infertility is one of the components of ESP, very little facilities are available at the lower level. Only some investigation facilities are present in the tertiary level that is very costly and out of reach of the poor couples. A few investigations have been undertaken such as education of both husbands and wives about the factors contributing to infertility, and orientation of field workers and service providers about the causes of infertility and prevention of secondary infertility by treating STDs and RTI cases.

Although it is very costly, work continues in the field of infertility in the private sector of Bangladesh. There are more than seven centers existing in Dhaka city for infertile couples that work with ovulation induction drugs, antibiotics for STD-related cases, Intrauterine Insemination (IUI) and microsurgery. One of the centers works with In Vitro Fertilization (IVF). In addition to the high cost of IVF, success rates are also limited.

National Policies and Objectives

It has been predicted that the population of Bangladesh will double in the next 47 years, reaching 167 million in 2020, even under very optimistic assumptions (MOHFW, 1996). As the plateauing TFR is a big concern for Bangladesh, strategies to address this issue will have to be worked out and

Infertility according to WHO:

Primary Infertility: The woman has not conceived despite cohabitation and exposure to pregnancy for a period of two years. Clinicians usually use one year of unsuccessful efforts to conceive as the criterion for initiating diagnostic procedure.

Secondary Infertility: The woman has previously conceived but is subsequently unable to conceive despite cohabitation and exposure to pregnancy for a period of two years. If the woman has previously breast-fed an infant, exposure to pregnancy is calculated from end of the period of lactational amenorrhoea.

Childlessness: The woman has no living children at the end of her reproductive life span; in other words woman above 40 years or woman between the age of 40 to 44 years age group who have had no live births or living children. Childlessness includes women who have never been pregnant, those who have suffered pregnancy losses and those with no live births.

According to an Expert Committee of WHO (1971), "Family Planning refers to practices that help individuals or couples to avoid unwanted births, to bring about wanted births, to regulate the intervals between pregnancies, to control the time at which birth occur in relation to the age of the parents, and to determine the number of children in the family."

included in the National plan of Action of the National Population Policy. The larger proportion of CPR is currently contributed by traditional and temporary methods. The GoB aims to improve this situation and emphasizes appropriate method mix with increasing proportion of clinical and terminal methods.

Quality of family planning services will also be improved. Access to clinical services will be improved through offering high quality services in major hospitals, teaching hospitals and district hospitals in addition to the MCWC and UHFWC. Efforts will be intensified to provide client centered family planning information and services, which offer women, men and adolescents choices that meet their needs. The GoB aims to improve the overall standard of living of the people of Bangladesh through improved reproductive health status and contributing to a more desirable balance between population and development. It aims to attain NRR equal to one by 2010 and stabilize the population by 2060. It also aims to reduce maternal, infant mortality further and provide ANC, EmOC and emphasizes on the urgent attention needed to ensure skilled attendance to 100% deliveries by 2010.

The Government also stresses upon the need to reduce child, infant and maternal mortality by providing quality antenatal and postnatal services, EmOC and managing complications arising out of unsafe abortions and preventing malnutrition among children and pregnant women. The National Population Council (NPC), headed by the Prime Minister, provides guidance for the implementation of programs to monitor the progress and evaluate the impact of the initiative.

The National Health Policy, currently under review, aims at achieving replacement level of fertility by the year 2010 with increasing emphasis on the FP program and on making it more effective. It also aims to introduce innovative ways and means for making the program acceptable, easily available, effective and affordable to the poor and to those people with very low income. The policy principles and strategies of the National Health Policy (MOHFW, 2000) also aims to:

- Assure and make available the methods of contraception by integrating, expanding and strengthening family planning program;
- Improve and ensure overall management system including the supply of different family planning methods;
- Form a council on health and population related issues at national level under the leadership of the head of the government. The council will also ensure accountability in the ESP health delivery system;

In October 1994, as an immediate follow-up to Bangladesh's commitment to transformation from family planning to reproductive health, the Ministry of Health and Family Welfare set up a broad-based National Committee for the implementation of the Program of Action of the United Nation's International Conference of Population and Development '94, which developed the National Plan of Action.

As per commitment made in the ICPD by Bangladesh, the NPA stressed on programs on poverty eradication, women's equity, equality and empowerment. The strategic directions for the Bangladesh National Family Planning Program: 1995-2005 was also prepared.

The new strategy based on a client-oriented approach focuses on ways to expand the program to serve couples who intend to use FP services, and improve the quality of services so that more clients use appropriate methods. In order to accomplish the vision, a practical program strategy, called the Quality strategy has been formulated. The National Integrated Health and Population Program (NIPHP) is a major collaborative undertaking of the Government, USAID and its seven partners. The program has been designed in line with the national priorities, giving primary emphasis on enhancing "the quality of life of poor and underprivileged members of society by helping to reduce fertility and improve family health".

Local and regional councils will monitor, supervise and analyze the implementation of primary health care services;

- The National Health Policy would be directed towards opting for the “Client-Centered Reproductive Health” approach that has been shown to be a most effective way to reduce unwanted fertility.

Bangladesh, as a pioneer of a successful population program has shown its commitment through its actions to materialize the Program of Action (PoA) adopted in the ICPD '94. Among various relevant activities and initiatives undertaken, the most important ones are:

- formation of i) National Committee for the Implementation of PoA, ii) National Population Council chaired by the Honorable Prime Minister, iii) National Population Policy Committee chaired by the Honorable Minister of Health and Family Welfare, iv) National Health Policy Committee chaired by the Minister of Health and Family Welfare;
- development of i) National Plan of Action, ii) Health and Population Sector Strategy (HPSS), iii) Health and Population Sector Program (HPSP), iv) National Integrated Population and Health Program (NIPHP), v) National Policy on HIV/AIDS and STD related issues, vi) High Level Committee (HLC) chaired by the honorable Minister of Health and Family Welfare;
- preparation of a document entitled “Strategic Directions for the Bangladesh National Family Planning Program: 1995-2005”,
- establishment of i) National Council for Women’s Development chaired by the Honorable Prime Minister, ii) Partners in Population and Development, iii) South-South Centre;
- formulation and approval of i) National Food and Nutrition Policy, ii) National Women Development Policy, iii) National Reproductive Health Strategy, and iv) Bangladesh National Strategy for Maternal Health.

In order to address the problems of high fertility, mortality and morbidity, RH-FP services are critical and there is considerable scope for improvement in this area. It is estimated that substantial natural increase in population comes from an unmet need for family planning as well as desire for a large family. Hence, more attention on improved quality of care and increased utilization of services will be needed for reducing fertility, maternal mortality and morbidity,

The Government of Bangladesh has a target of achieving replacement fertility (a TFR of about 2.2 to 2.3) by 2005. As per a World Bank projection the population in Bangladesh will reach about 218 million by mid twenty-first century and will stop growing at 263 million in the mid twenty-second century. (Ref. BDH survey 1999-2000 P166)

and infant and child mortality. Contraceptive security is a cornerstone of the Government policy. Some of the services envisaged by the GoB are:

- a. Provision of essential RH-FP services through a comprehensive client centered approach. These services should be provided along with health services at the Upazilla and Union levels;
- b. Special attention to young, low parity and newly married couples and those with unmet need for RH information and services. Freedom to choose contraceptive methods according to individual needs and preferences will be emphasized;
- c. Establishment of Union Health & Family Welfare Centers wherever needed and appointment of a doctor in these centers will be pursued in a phased manner to increase availability and access to quality care;
- d. Uninterrupted supply of required medicines and equipment for all the services centers and strengthening of the contraceptive security system so that supplies are available wherever and whenever needed;
- e. Ensure access to essential information and services especially amongst high-risk population groups to prevent STD, RTI and HIV/AIDS infection.

The sources of family planning methods play an important role in the promotion and maintenance of contraceptive use in the population. The sources are divided into four categories:

1. Government facilities (including Government hospitals, Thana health complexes, Family Welfare Centers, satellite /EPI clinics, Maternal Child Welfare Centers and Government field workers);
2. NGO sector sources (including static clinic, satellite clinics, depot holders and field workers.);
3. Private medical sources (including private hospitals/clinics, doctors-qualified or traditional); and
4. Private non-medical sources like shops, friends/relatives. (BDH survey 1999-2000)

The government (public) sector is the predominant source of family planning methods. About 64% (NIPORT, Mitra and Associates, and ORC Macro, 2001) of current users of modern methods depend on public sector sources (with 36% from a Government facility and 28% from a Government field worker). Twenty two percent of modern method users depend on private medical sources and 7% on



non-medical private sources. Only 5% of users rely on NGO sources.

Areas for Action

The impressive 50% fertility decline that characterized the 1980s has stalled at a little over 3 children per mother (ibid.). If the problem of rising fertility continues for a long time, the process of attaining the replacement level will be delayed further and the momentum will produce a much larger population than expected.

- The future population growth will be determined by three components: *population momentum*, *unwanted fertility* and *big family size*. Of these, population momentum is the predominant factor as more than 80% of the expected 85 million people will be added by the middle of this century due to this factor alone (ibid.). Minimizing population momentum is the major challenge in limiting future population growth;
- More than 40% of the population is below 15 years of age and will pass through reproductive years in the near future. As the young age structure of the population cannot normally be modified in the short term, the only option is to encourage changes that effectively modify or reduce the proportion of the population who are married;
- The options for minimizing the impact of population momentum are generally focused on increasing the average age at marriage and child bearing, and delay of birth especially the first birth and then widening of birth intervals;
- Bangladesh has always exhibited an unusually low female age at marriage, despite the minimum legal age (18 years) of marriage. In the early 90s about 75% of young women married before the age of 18 and by the end of the decade this proportion has fallen to only 66%, which is only a modest decline with virtually no effect on overall proportions of teenage women who have never married (BDH survey). This has only pushed the mean age at marriage from 15.3 years (in 1993-94) to 16.1 years at the end of the decade;
- The age at first birth has also not changed noticeably – about 18 years for all women except those with secondary schooling (NIPORT, Mitra and Associates, and ORC Macro, 2001). The main approaches and policies that will result in delaying marriage revolve around education (secondary level at least) and



employment. Interventions to increase average age at marriage of females is likely to be the most effective in reducing future impact on population momentum. Teen-age marriage and fertility need to be socially discouraged because of the high risk to health;

- Studies have consistently shown that education has a big impact on reproductive behavior, contraceptive use and fertility. Any social or economic policy that increases opportunities to retain young women in secondary school, to provide employment opportunities, and to increase the power of young women to negotiate their own marriages, can be expected to lead to delays in early marriage. The GoB is already taking a lead in this area with the Female Secondary Stipend Assistance Program, as are some NGOs like BRAC with minimum targets for female primary school students. These approaches have great potentials and should be expanded;
- The other areas of action include improvement of child survival, immunization and nutrition. The issue of child survival needs to be given a very high priority. If the child survival situation cannot be improved soon, a further decline in the level of fertility will be a challenging task. The role of infant mortality has been playing an increasingly important role as the level of fertility is approaching the replacement level;
- Contraception can be made more effective through long-term FP methods. Birth spacing can be effectively widened by improving quality of care in the FP programs. There is a need to limit childbirths among a moderately large proportion of women, as such the program for sterilization needs to be given renewed priority to improve effectiveness of the method-mix. The stagnation in the level of TFR indicates that continuation of some modern methods have declined during the recent past. This might be attributed to, among other reasons, the recent change in the doorstep services at the grassroots level to one-stop service being implemented through the HPSP. The impact of the change in the service delivery system on long-term use of contraception in the rural areas of Bangladesh needs to be examined carefully in order to resolve the concerns of different groups of users.
- The GoB has taken up programs to build a large skilled workforce required to sustain the population control activities for quality reproductive health service

delivery, population and development linkages and behavior change communication at all levels of policy and programs. The GoB also recognizes NGOs and private sectors as important partners in the population control program and seeks to pursue the strategy to support registered NGOs in their work in the underserved areas of health, nutrition and population sector;

- NGOs and private sectors are working effectively in community mobilization and RH activities by awareness building and by rendering services for the poor and other vulnerable groups regarding benefits of delayed marriage, delayed birth, and health and nutrition issues. It is necessary to adopt a set of measures in legal, social and cultural areas with a view to achieving positive results. These relate to enhancement of the welfare of women and broadening the scope of participation in the decision-making process with regard to health and other matters. The reforms in the legal framework may include compulsory registration of marriage, birth, death and divorce.



Chapter Three

SAFE MOTHERHOOD

In Bangladesh, maternal mortality represents the end point in a lifetime experience of gender discrimination, neglect and deprivation. Its high rate also represents the failure of the health system to effectively provide services and care for women. The near absence of skills and facilities to cope with obstetric emergencies is matched by a virtual absence of strategic responses and ability of the health system to respond to the dimension of violence. Improvement of Bangladeshi women's health is not just a social and moral necessity; it is also an economic imperative. The Government of Bangladesh thus envisions a fulfillment of the right to safe motherhood by all women in the country with a mission to reduce maternal mortality and morbidity and also to enhance the self-esteem and status of women.



Maternal and newborn health

Bangladesh has one of the highest maternal mortality rates (MMR) in the world, i.e., 3/1000 live births (BBS, 2002). This unacceptably high MMR directly contributes to the high perinatal (newborn) mortality rate in the country. The estimated lifetime risk of dying from pregnancy and childbirth related causes in Bangladesh are about 100 times higher than in the developed countries. The tragic consequence of these deaths is that about 75% of the babies born to these women also die within the first week of their lives. In this country, 14% of deaths of pregnant women are associated with injury and violence, which is on the rise (MOHFW, Oct 2001). Most population based studies show that abortion complications are responsible for the death of nearly 25% of the mothers.

A study on safe motherhood programs in Bangladesh assessed that women's low status in society, the poor quality of maternity care services, lack of trained providers, low uptake of services by women and infrastructure and interdepartmental difficulties all contribute to the high rate of maternal deaths (Haque Z A et al, 1997). The major causes of maternal death are postpartum haemorrhage, eclampsia, and complications of unsafe abortion, concomitant medical causes, obstructed labor, postpartum sepsis and violence/injuries. Around 14% of the deaths of pregnant women are associated with injury and violence (MOHFW, Oct 2001). While the incidence of maternal mortality is decreasing, that of violence against women is rising.

Maternal and newborn health are inextricably linked with each other. If the mother is malnourished and has low

Around the world, people celebrate the birth of a new baby. Societies expect women to bear children, and honor women for their role as mothers. Every year, more than 200 million women become pregnant, and at least 15% are likely to develop complications that will require skilled obstetric care to prevent death or serious ill-health (WHO-1994). In less developed countries, more than half a million mothers die from complications related to pregnancy and childbirth each year. These deaths are only part of the tragic picture: for every woman who dies, about 30 suffer from devastating health problems such as infertility and damage to their reproductive organs. Ninety-nine percent of these deaths occur in less developed regions, and most are due to inadequate medical care at the time of childbirth (Elizabeth I, 2002).

body mass index (BMI) it is very likely that she will give birth to a low birth weight (LBW) baby. Around 16% of mothers of U-5 children have heights of less than 145 cm and 45% of women have BMI of less than 18.5 indicating serious malnourishment (NIPORT, Mitra and Associates, and ORC Macro, 2001). Around 15% of pregnant and 12-15% of non-pregnant women have heights of less than 145 centimetres which indicates that a large percentage of women in the country might be at increased risk of obstetric complications during delivery and at a higher risk of adverse birth outcome (Mitra et al., 1997).



LBW incidence is 37% in urban slums, 21% in rural areas and 18% among the urban affluent class (Nahar N et al., 1998). Most LBW infants (87% in one institutional study and 61% in another) are full-term and hence growth retarded. This growth retardation is intimately linked to maternal health and nutrition. LBW and pre-maturity were associated with high neonatal mortality in a recent hospital-based study that followed up on 776 hospital delivered LBW newborns. Anaemia caused by iron deficiency among women and adolescent girls is one of the growing concerns of the Government. Almost half (49%) of the women are suffering from anaemia (Hb<11.0 gm/dl). Among adolescent girls aged 11-16 years, 43% are anaemic (Hb <12.0 gm/dl), and about 4.6% are below 10.0 gm/dl. Rural women and the poor suffer the most (Helen Keller International, 1998).

Antenatal Care:

According to the BDH survey 1999-2000 data on births that occurred in the five year period before the survey, nearly two thirds (63%) of mothers received no ante-natal care (ANC) during pregnancy, and among those who did receive it, the median number of visit is only 1.8. For about one-fourth (23%) of births, the women received ANC before the sixth month of gestation and for another 9% of the women did not receive ANC until the sixth or seventh month of pregnancy. Among women who received care, the median duration of pregnancy at first visit was 5.4 months.

Although the level of ANC coverage from a medically trained provider is low in Bangladesh it has shown an increasing trend from 29% in 1996-97 survey to 33% in the 1999-2000 survey (NIPORT, Mitra and Associates, and ORC Macro, 2001). Another survey data by the Bangladesh Maternal Mortality Survey 2001 for births that occurred in the three years before survey indicate that nearly half the mothers (48%) received ANC during pregnancy. Only 12% have four or more visits. ANC received from various sources and the number of visits according to background characteristics in the three years preceding the Bangladesh Maternal Mortality Survey 2001 is shown in Table 3.1.

The mother's height is an indicator of her nutritional status. Neonatal mortality rates are higher in cases where mothers have heights of less than 145 cm than in cases where mothers have heights of more than 145 cm. Maternal height is a product of nutrition during childhood and adolescent. A woman's small stature is often associated with small pelvic size, which increases the risk of having newborns with low birth weight. It is evident from the statistics that better nutritional status of a woman during her childhood and adolescence would have an important effect on her health in terms of causing less risk to her health and increasing the chances of survival of her newborn babies. Body mass index (BMI) is another measurement of maternal nutrition, which combines height and weight data. BMI is defined as weight in kilograms divided by the square of the height in meters.

$$BMI = \frac{\text{Weight in Kgs}}{\text{Sq of ht in m.}}$$

Babies born with a birth weight of less than 2.5 Kg are considered as LBW, which is an indicator of intrauterine malnutrition and is higher among mothers with a low BMI. LBW is a major risk factor in neonatal illness and death that afflicts over one million babies annually. Bangladesh has one of the highest LBW rates in the world.

Table 3.1. Antenatal care provider and numbers of visits

Background Characteristic	Antenatal care provider					Number of visits				Number of births
	Doctor	Nurse/ midwife/ Paramedic/ FWV/MA/ SACMO	HA/ FWA	Unqualified medical practitioner	No one	1	2	3	4+	
Mother's age at birth										
<20	23.6	17.9	5.2	2.2	50.2	15.4	13.7	9.9	10.8	12,562
20-30	25.7	15.0	4.2	1.9	52.2	13.8	11.9	9.2	12.7	24,312
35+	15.8	11.8	4.1	2.8	64.8	13.1	8.9	7.5	5.5	2,650
Birth order										
1	32.8	18.1	4.5	2.0	41.7	15.0	14.6	11.2	17.4	11,663
2-3	24.5	16.8	4.5	2.0	51.3	14.4	12.6	9.5	12.0	16,405
4-5	16.9	13.3	4.7	2.1	62.0	13.8	10.0	7.6	6.6	7,102
6+	13.2	9.6	4.5	2.3	69.6	12.5	8.2	6.4	3.2	4,355
Residence										
Urban	42.4	16.7	3.5	1.3	35.6	12.9	13.2	12.1	26.1	6,826
Rural	20.6	15.5	4.7	2.3	55.9	14.5	12.1	8.7	8.6	32,699
Division										
Barisal	19.3	10.5	1.8	0.9	67.2	11.6	8.1	5.9	7.1	2,615
Chittagong	25.7	13.8	1.3	0.9	57.8	12.3	11.1	8.2	10.6	8,247
Dhaka	26.4	14.2	7.2	2.8	48.0	15.8	13.3	9.3	13.4	13,531
Khulna	28.5	19.4	6.1	2.8	42.6	15.8	15.4	11.3	14.7	3,792
Rajshahi	18.2	21.9	2.6	1.2	55.9	12.9	10.8	10.1	10.2	8,359
Sylhet	27.8	10.8	7.3	4.9	47.4	16.5	14.7	10.5	10.4	2,980
Mother's education										
No education	12.0	13.8	5.2	2.4	65.8	13.4	9.8	6.8	4.1	17,668
Primary complete	25.3	17.2	4.7	1.8	50.2	15.6	13.6	9.9	10.5	4,220
Secondary+	49.1	17.3	2.9	1.5	28.3	14.3	15.4	9.9	28.0	10,340
Household wealth index										
1	9.1	13.2	5.6	2.7	68.7	12.7	8.8	6.3	3.4	98,093
2	13.8	15.6	5.1	2.4	62.0	15.0	11.2	7.0	4.7	8,670
3	19.8	17.4	4.9	2.2	54.7	15.3	13.4	9.6	7.0	7,504
4	30.5	18.8	3.9	1.9	43.8	16.5	15.4	11.4	12.8	6,948
5	60.3	14.4	2.4	0.8	21.5	12.0	14.3	14.5	37.5	6,509
Total	24.4	15.7	4.5	2.1	52.4	14.3	12.3	9.3	11.6	39,525

Note: Total includes 49 births for which the number of antenatal care visits was not stated. UHC = Upazilla health complex, MCWC = Maternal and child welfare centre, UHFWC = Union health and family welfare center, FWV = Family welfare visitor

Source: NIPORT, Mitra and Associates, and ORC Macro, 2002.

In most cases, care is received from doctors (24%) or nurses, midwives, family welfare visitors, medical assistants, and sub-assistant community medical officers (15%) on the average. About 5% of mothers receive ANC from health or family welfare assistants. Nearly 2% of pregnant mothers receive ANC from unqualified medical practitioners. The survey results show that there are sharp differences in ANC coverage among subgroups in Bangladesh. Antenatal care is much more common for

Antenatal care during pregnancy is important to the health of both the mother and her baby. The major objective of antenatal care is to identify and treat problems during pregnancy such as anaemia, pre-eclampsia and infections. It is during an antenatal care visit that screening for complications and advice on a range of issues, including place of delivery and referral of mothers with complications occur.

births to younger women and those of lower birth order. The urban-rural differentials in the percentage of births for which the mother had at least one ANC visit, are quite large. Around 63% of urban births had received ANC from a medically trained person, compared with only 41% of rural births. The utilization of antenatal care is strongly associated with the level of education and economic status. Mothers with some secondary education are about twice as likely as mothers with no education to receive ANC and mothers in the wealthiest households are more than twice as likely to receive ANC as mothers in the poorest households. Looking at the number of ANC visits it is observed that for lower order births; urban mother, mothers with some secondary education and women from wealthier households have a higher number of (at least 4) ANC visits.

Delivery Care

In this country, lack of proper medical attention and hygienic conditions during delivery leads to the risk of complications and infections that cause death or serious illness for the mother or the newborn or both. Although Government health facilities are available down to union level, more than 90% deliveries are conducted at home. As can be seen from Table 3.2, three fourths of births in Bangladesh are assisted by traditional birth attendants (TBA) with 12% assisted by trained and 64% by untrained TBAs. Around 12% of births are assisted by medically trained persons, doctors (7%), or nurses, midwives, family welfare visitors, sub-assistant community medical officers and medical assistants (5%). Delivery assistance provided by doctors / trained medical professionals is substantially higher (Table 3.2) in the case of lower-order-births, mothers with secondary education, wealthy households and those with four or more ANC visits. (NIPORT, Mitra and Associates, and ORC Macro, 2001).

Table 3.2 shows that the use of health facilities for delivery is more common in urban areas (21% of births), among mothers with some secondary education (22%), mothers from wealthy households (30%), and among mothers who had at least four antenatal visits (37%). (ibid.)

Many traditional practices and beliefs about childbirth and early care contribute to adverse outcomes for mothers and newborns. Mothers are often deprived of food and water during delivery. Other traditional beliefs attribute maladies during pregnancy, delivery and after birth to attacks by evil spirits or to the kinds of food consumed. Certain food taboos after childbirth are also common, particularly in rural Bangladesh.

Skilled Birth Attendant

Skilled birth attendants are defined by WHO as trained midwives, nurses, nurse/midwives or doctors who have completed a set course of study and are registered or legally licensed to practice. WHO does not define Traditional Birth Attendants, including those who have been trained, as skilled attendants.

Table 3.2: Place and assistance providers during delivery

Percent distribution of births in the three years preceding the survey by place of delivery assistance providers according to background characteristics, Bangladesh 2001 (Majority cases).

Background Characteristic	Place of Delivery			Assistance during delivery					Number of births
	At home	Any public health Facility	NGO/private hospital/ clinic	Doctor	Nurse/ midwife/ FWA/ SACMO/ MA	Trained Birth attendant	Untrained Birth attendant	Relative/ other	
Mother's age at birth									
<20	91.9	5.6	2.3	5.5	5.4	12.9	64.4	10.6	12,562
20-34	90.5	5.7	3.6	7.3	5.2	11.7	62.7	11.0	24,312
5+	97.8	3.6	1.4	3.7	3.2	9.4	69.1	10.8	2,650
Birth order									
1	85.0	9.3	3.0	11.4	7.7	13.2	58.4	8.2	11,663
2-3	91.9	4.9	3.0	5.8	5.0	12.4	63.4	11.5	16,405
4-5	96.2	2.7	0.9	2.7	2.8	11.1	68.0	12.9	7,102
6+	97.3	2.1	0.5	1.9	2.1	8.2	71.6	12.4	4,355
Residence									
Urban	78.6	11.9	9.2	16.6	10.2	11.9	53.6	6.4	6,826
Rural	93.9	4.2	1.8	4.4	4.0	11.9	65.8	11.8	32,699
Division									
Barisal	95.2	3.6	1.1	3.8	4.3	10.5	70.0	9.7	2,615
Chittagong	92.3	5.5	2.2	6.2	5.2	12.0	69.0	6.4	8,247
Dhaka	89.8	5.6	4.2	8.0	4.7	13.2	62.8	9.7	13,531
Khulna	87.9	6.6	5.1	8.4	7.6	13.0	59.0	8.9	3,792
Rajshahi	91.7	6.1	2.1	4.7	5.5	11.1	56.7	18.7	8,359
Sylhet	94.5	3.5	1.9	5.2	3.1	7.9	72.8	9.8	2,980
Mother's education									
No education	97.1	2.3	0.5	1.7	2.3	10.0	70.6	12.9	17,668
Primary complete	93.1	5.2	1.4	4.9	5.1	13.0	64.9	10.7	4,220
Secondary+	77.9	12.4	9.3	17.5	10.8	14.8	49.1	6.6	10,340
House wealth index									
1	97.7	1.8	0.3	1.2	2.2	9.6	70.4	14.1	9,893
2	96.5	2.7	0.6	2.0	3.0	10.5	68.7	13.2	8,670
3	95.0	3.8	1.1	3.2	4.0	12.7	67.4	11.0	7,504
4	91.4	6.4	2.1	6.2	6.0	14.7	63.0	8.6	6,648
5	69.9	15.9	13.7	24.6	12.7	13.5	43.2	5.0	6,509
Antenatal care visits									
None	97.9	1.6	0.4	1.2	1.9	9.0	72.2	13.4	20,714
1-3	90.8	6.7	2.4	6.4	6.6	15.4	60.8	9.0	14,165
4+	62.7	19.5	17.0	30.4	14.8	14.5	34.5	4.7	4,596
Total	91.2	5.5	3.1	6.5	5.1	11.9	63.7	10.8	39,525

Note: Total includes 49 births for which the number of antenatal care visits was not stated. UHC = Upazilla health complex, MCWC = Maternal and child welfare centre, UHFWC = Union health and family welfare center,

Source: NIPORT, Mitra and Associates, and ORC Macro, 2002.

In Bangladesh, there are about 9 million women who have survived the rigors of pregnancy and childbirth, but suffer from lasting complications such as fistulae, uterine prolapse, inability to control urination and painful intercourse. These complications arise during antepartum (37%), during intrapartum (12%) and during postpartum (51%) (MOHFW, 2001). These reproductive morbidities diminish women's fertility, productivity and quality of life, as well as the health and survival of the next generation. They also become social outcasts in some cases – turned out of homes and rejected by their husbands and families.



The proportion of women seeking postnatal care (PNC) from a “medically competent person” is very low both in rural and urban areas. Records show that on the whole, only 2% of women who delivered at home have sought PNC from medically competent persons.

The Bangladesh Maternal Health services and Maternal Mortality Survey 2001 evaluated women’s awareness about specific life threatening complications during pregnancy, delivery and after delivery and found it to be low. The Bangladesh Maternal Mortality Survey also looked into the associated delays in recognition of emergencies, decision making concerning treatment, travel and treatment of complications as well as the costs involved. The survey found that 40% of the pregnancies were free of complications and 60% reported one or more problems. The most common complications (about 50%) reported were headache/blurry vision/high blood pressure/oedema. The other major complications (about 24%) were breach delivery/prolonged or obstructed labor/torn uterus. Other notable ones were abdominal pain (15%) and excessive bleeding (13%). Overall, 45% of all pregnancies with complications were perceived as dangerous or potentially life threatening.

Women face multiple barriers to attaining good health; these include:

- Limited information and options;
- Unequal power relations that constrain women's decision-making ability, physical mobility and access to resources;
- Poor quality of interaction with health care providers;

Emergency Obstetric Care:

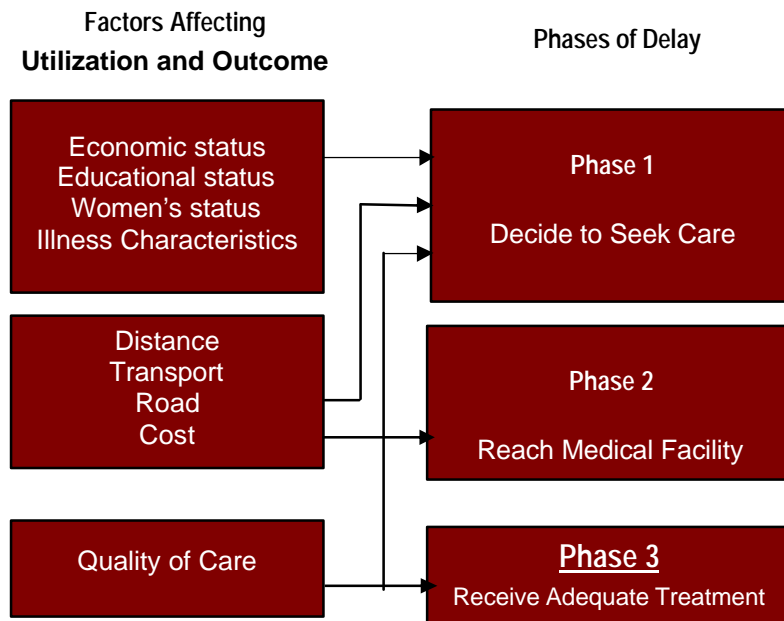
Despite the presence of a well-established service delivery infrastructure in Bangladesh and various measures taken so far, the utilization of essential obstetric care (EmOC) services is still poor. Women in rural Bangladesh are not fully aware of the complications that they may encounter during pregnancy and childbirth, and even those who are aware do not know where to go for help. They also face certain barriers (cultural, geographic and economic) in accessing obstetric care. Although the problem is not exclusively medical, the role of the health system is most crucial to the saving of lives. A large percentage of women with obstetric complications fail to get the care they need in time and die at home or on the way to the hospital. This is because referral linkage in the country is weak and there is a need to strengthen it from the grassroots level to the upper tiers of service delivery (Ahmed S et al., 1998). The “Three Delays” contribute to the low utilization of care and consequently, the outcome of pregnancies.

These following three delays need to be overcome if the mother is to receive timely services (NIPHP, 2002):

- Delay in deciding to seek medical care;
- Delay in reaching a medical facility where adequate care is available; and
- Delay in receiving care at that facility.

Figure 3.1 illustrates how the various factors influence delays affecting the utilization and outcome:

Figure 3.1



Source: EmOC Manual NIPHP, 2002

An intervention designed and tested by the Prevention of Maternal Mortality (PMM) network has shown evidence of reducing maternal death. Its findings regarding utilization of EmOC suggest that more people utilize services when they know them to be functioning well. Community efforts, including education and mobilization have a role to play in improving utilization once services are in place. Improving EmOC services need not be costly, because in many areas, the necessary facilities exist and staffs are already in place. The interventions of the PMM Network are based on a strategic model that focuses sharply on the interval between the obvious onset of serious obstetric complication and the provision of EmOC (ibid.).

Link between maternal and child health and mortality

Maternal health and mortality issues are inextricably linked with perinatal health, as the well being of the child is dependent entirely on the mother's health during the foetal period. In the less developed countries, more than half a million mothers die each year from complications related to pregnancy and childbirth. These deaths are only part of the tragic picture: for every woman who dies, about 30 suffer from devastating health problems such as infertility and damage to their reproductive organs. Ninety-nine percent of these deaths occur in less developed regions, and most are due to inadequate medical care at the time of childbirth.

The following table shows the overall availability and status of the utilization of various RH services in Bangladesh:

Table 3.3 Availability and status of RH services

Service	HPSP Target		Factors influencing availability of services
	Availability	Utilisation (Status)	
Antenatal Care	At all service points	65% (33%)	<ul style="list-style-type: none"> ➤ Not prioritised by women/family ➤ Poor targeting
Skilled birth attendance	Unclear	30% (13%)	<ul style="list-style-type: none"> ➤ Not universally available for home deliveries ➤ Who to train? ➤ 3 million births a year ➤ Women do not leave HH for 40 days after delivery ➤ Not prioritised by women/family ➤ Training and permission for FWVs to use parenteral drugs ➤ Supplies ➤ 24 hrs availability of FWV
Post natal care (incl. Vit A supplementation)	At all service points	80% (2%)	
Obstetric First Aid	H&FWC	100% (0%)	
Basic EmOC	UHCs	75% (3%)	<ul style="list-style-type: none"> ➤ skill and motivation of service providers ➤ necessary drugs and equipment ➤ monitoring
Comprehensive EmOC	MCH DH MCWC UHC (25%)	100% (100%) 100% (70%) 100% (50%) 100% (3%)	<ul style="list-style-type: none"> ➤ posting, motivation and residential status of specialists ➤ drugs and equipment ➤ quality of care ➤ monitoring
Met need of EmOC	Relevant service points	60% (27%)	<ul style="list-style-type: none"> ➤ 24 hrs. functioning ➤ posting, motivation and residential status of specialists ➤ drugs and equipment ➤ quality of care ➤ monitoring.

Source: MOHFW, October 2001.

Neonatal Health

Although Bangladesh has made significant progress in child survival initiatives and has cut the infant mortality rate by half, every year 150,000 babies are lost within the first 28 days of their lives. Added to this loss, another 100,000 babies are stillborn in late pregnancy bringing the total perinatal (still births and early neonatal) and neonatal deaths to 250,000 annually. This is a tragic loss – more painful given the fact that these are losses that are preventable. The BDH survey 1999-2000 recorded a sharp decline in neonatal mortality from 63/1000 live births over the period 1985-1989 to 42/1000 in 1995-1999.

Numerous small-scale studies and the experience of various organizations working in Bangladesh give a reliable picture of the state of the newborn and maternal health care in the country and point to changes that must be made to reduce newborn illness and mortality. The National Integrated Population and Health Program

Research show that newborns whose mothers die are less likely to survive. Insufficient maternal care during pregnancy and delivery is largely responsible for the estimated 8 million stillbirths and newborn deaths that occur around the world each year. These deaths occur just before or during delivery or within the first week of life. Older children's survival is also affected by the loss of their mothers. A study in Bangladesh showed that children under the age of 10 were 10 times more likely to die following the death of their mothers than those whose mothers were alive.

(NIPHP) has identified the common newborn illness in Bangladesh as:

- Poor condition at birth
- Low birth weight
- Neonatal jaundice
- Birth asphyxia and
- Neonatal septicaemia

Saving newborn lives (SNL) Bangladesh (an initiative of Save the Children USA) analyzing the recent situation has identified three leading causes of the newborn's death:

- Infection (sepsis, pneumonia, diarrhoea and tetanus)
- Complications during delivery (leading to birth asphyxia and birth injury)
- Complications of pre-maturity

The child survival revolution that has reduced infant mortality by half in the last decade in Bangladesh has largely ignored the newborn, an oversight that is readily apparent in today's high neonatal mortality rate. The simple, inexpensive, and proven measures that can solve this problem are both well-known and well within our reach; the challenge is to spread the knowledge of proper maternal and newborn care to the millions of families and thousands of health care providers responsible for the health and survival of the newborns of Bangladesh. In collaboration with the GoB, NGOs and international development agencies, Saving Newborn Lives has identified the following strategies to reduce newborn mortality in the country;

- Introduce Essential Newborn Care (ENC) interventions through community-based programs as a direct, cost-effective means of reaching rural communities through the existing infrastructure.
- Integrate newborn care into maternal and child health programs in public sector health care facilities, and help strengthen community-facility links to ensure that sick newborns get timely access to quality care. Because newborn survival is closely linked to maternal health, it must be integrated fully into safe motherhood as well as child survival programs;
- Improve household practices through Behavior Change Communication (BCC) strategies that aim to introduce families and communities to the value of ENC and access to appropriate health care when required;
- Train professionals in newborn care;

The neonatal mortality rate (NMR) is the number of babies who die in the first 28 days after birth per 1000 live births. Deaths of babies in late pregnancy (foetal deaths or stillbirths) are closely related to early neonatal deaths, as the causes are similar.

For most part, reducing newborn mortality in Bangladesh does not require medical breakthroughs, expensive technology, or restructuring the national health system. Major strides can be made by simply putting existing solutions into general practice, while continuing to search for the most effective ways to bring about desired behavioral changes and to treat certain complications, such as asphyxia and infections in the newborn. Improving the health of newborns is largely a matter of applying sound health care practices at the appropriate milestones in the development of a newborn: that is during pregnancy, at the time of birth, and after birth up through the first 28 days. Since newborn survival is inextricably linked to maternal health, newborn care must be integrated fully into safe motherhood as well as child survival programs. A truly effective approach to newborn health would start even earlier, of course, by addressing the health of future mothers.

- Support research to demonstrate the applicability and feasibility of new models and techniques to improve newborn health;

Promote newborn health nationwide: As part of the new Bangladesh maternal health strategy, Save the Children will join efforts to make maternal and newborn care a priority in the national health plan;

So far, research in the field of newborn health has been sporadic (Save the Children USA, 2001), without a clear agenda of improving newborn health practices. Some preliminary data have been gathered on mortality but have mostly ignored stillbirths.

Care of the LBW newborn has also recently received attention, as the impact of the “kangaroo mother care” (KMC) on LBW infants is being studied in the community by the Population Council in collaboration with BRAC. There are substantial gaps in newborn health interventions, and considering the sheer numbers that are at presently dying in the perinatal period, there is an urgent need to move concurrently with programs for newborn health. The Government has already laid the framework of such a program under the ESP. This is a progressive and challenging plan to provide newborn services at the community, union and thana levels. Operational research is needed to design a program with the ESP in mind to inform and subsequently take to scale a program that incorporates the basic planks of ENC. Available clinical care facilities for newborns are not adequate in Bangladesh. Only tertiary care hospitals and some of the district hospitals are meeting current needs, and those attract people primarily from surrounding urban and semi-urban areas.

The Maternal Mortality Rate (MMR) of a country is considered as an indicator of the overall status of women. Maternal mortality is a social issue with predominance of health care. The sluggish decline in maternal mortality and morbidity is rooted in the powerlessness of women and their unequal access to resources in families and the society. Reducing maternal deaths is not possible solely through a “health” intervention/initiative. Since maternal mortality is considered an indicator of the overall situation of women in a nation, the approach therefore needs to be of a more comprehensive nature – one of social development.

National Policies and Objectives

One of the main aims of the National Health Policy is to improve the health of mothers and children at the union level and to ensure the provisions of facilities for the safe and clean delivery of children at the village level. The Government envisages ensuring safe birth and survival to all children through provision of appropriate and adequate family planning services, prenatal and postnatal health care as well as essential obstetrical services and encouraging all mothers to breastfeed their children. One of the objectives enumerated in the fifth five year plan (FFYP) is to ensure universal access for the people of Bangladesh to essential health care services of acceptable quality and to reduce maternal mortality and morbidity, improve nutritional status and reduce fertility so as to reach the replacement level of fertility by the year 2010.

The GoB's maternal health strategy in its principles/priorities emphasizes strategies for reduction of maternal mortality and morbidity, social mobilization, caring practices, decision making at home level and service delivery through:

- Focus on EmOC in order to reduce maternal mortality by designing implementing and monitoring strategic activities to offset the “three delays”;
- Provisions of EmOC/Basic maternity care services for the promotion of “good practices”, early detection and appropriate referral of complications;
- Promoting women’s access to resources by behavior change, development and by focusing on the role of men;
- Ensuring quality of services by involving professional bodies.

Maternal Health Services

Family Welfare Visitors (FWVs) provide reproductive health services at satellite clinics once a month in the villages of Bangladesh. A study shows that over 75% of the women in Khulna-Rajshahi and 72% in Barisal-Dhaka report to satellite clinics for care which is more than in Chittagong-Sylhet (62%). The percentage of women visited at least once by a FWA was less in the Sylhet-Chittagong divisions. These data indicate the relative weakness of the health and family planning programs in these regions (Save the Children USA, 2001).

Table 3.4 The Government’s Millennium goal of the maternal health strategy

The Government’s Millennium goal of the maternal health strategy is to reduce maternal mortality to 240/1000 by the year 2010. The aims and objectives in general are (MOHFW, 2001) as tabulated below:

Aims	Objectives (by 2010)
Strengthen essential (including emergency) obstetrical care and improve referral and utilization of services.	<ul style="list-style-type: none"> ▪ Increase met need of EmOC to 70% (from 27%) ▪ Increase skilled attendance at birth to 50% from 20% ▪ Increase PNC to 30% (from 2%)
Improve the nutritional status of women and adolescent girls	<ul style="list-style-type: none"> ▪ Reduce incidence of LBW to <30% ▪ Reduce the prevalence of anemia among pregnant and lactating mothers by 1/3 ▪ Reduce the proportion of women with BMI<18.5 from 50% to <30%
Ensure that people with the right skills are trained to provide quality maternal health services (MHS) at all levels of the health system	<ul style="list-style-type: none"> ▪ Ensure skilled human resources to provide midwifery and comprehensive EmOC services in all district hospitals, district level MCWCs and 40% Upazila Health Complexes. Midwifery and Basic EmOC services in the remaining 60% UHCs and 50% UH&FWCs, and Upazila and Union level MCWCs ▪ Ensure that appropriate personnel in every static center are able to provide the full package of appropriate MHS
Promote women friendly health services	<ul style="list-style-type: none"> ▪ Make health service providers more responsive to women's needs and concerns
Bring about positive changes in the perception and behavior of individuals, family, service providers and the community to support women in the realization of their right to safe motherhood and a life free from violence and discrimination	<ul style="list-style-type: none"> ▪ Achieve universal knowledge about the danger signs of pregnancy/childbirth, and referral to centers with EOC services ▪ Motivate couples so that women do not have first childbirth before 20 years of age ▪ Ensure that communities/families take responsibility to transport obstetric and neonatal emergencies immediately to nearest EmOC center, and mobilize blood donation ▪ Eliminate all types of misconceptions and wrong practices from families/ communities including under-nutrition of pregnant and lactating women ▪ Campaign for zero tolerance of violence

The GoB recognizes the need for ensuring skilled attendance at birth. Challenges remain in identifying appropriate cadres, training the required numbers and ensuring back-up services. While all services needed are mandated within the various policy documentation and frameworks, there are certain issues which require focus if the gap between policy and implementation is to be avoided. These include:

- Mode of maternal health service delivery, particularly in underserved urban and rural areas;
- Addressing violence during pregnancy;
- Need for improving utilization of services through communication and social mobilization;
- Transportation (community and facility);
- Co-ordination on required administration action and focus on effective referral.

The adolescent group, particularly married adolescent girls, are especially vulnerable to the risks of pregnancy and childbirth and will need added focus.

Safe Motherhood and newborn healthcare services

The government has developed an infrastructure for maternal and child health services over the years. Under the Safe Motherhood Program, the GoB is trying to ensure safe delivery by skilled attendants in all its health facilities. Maternal health services are provided at community and facility levels through a network of domiciliary field workers, satellite clinics, health clinics and hospitals.

According to the findings of SNL the Bangladesh health system must meet two major challenges to reduce maternal and newborn mortality:

- A skilled health staff to assist deliveries and provide post-delivery care at the community level, and
- A strengthened referral system, particularly the capacity to manage life-threatening complications in thana and district hospitals.

The National Maternal Health strategy has a ten-year perspective with specified aims and objectives to be achieved by 2010. The strategy focuses on service delivery mechanism and management, HRD/HRM plan, quality assurance, advocacy, BCC and community participation, and research and evaluation. The estimated cost for implementation of the strategy has also been indicated. Though the strategy focuses on the MOHFW service delivery system which is primarily rural based, it provides a framework for functions in the urban service

Making motherhood a safer time in women's lives requires commitment at all levels: in the home, in the community, in the clinic, in the country, and at the international level. This is a commitment to reducing inequities, improving women's autonomy, and ensuring that motherhood is a safe, joyful, and rewarding experience.

Good quality maternal health care is the single most important intervention to prevent maternal and newborn mortality and morbidity. Maternal health services, including essential obstetric care for complications, must be made available to all women during pregnancy and childbirth.

Families and communities have critical roles to play in ensuring that safe motherhood is achieved. Public education programs, at national and community levels, should focus on the following supportive actions: improving nutrition for girls and women; facilitating women's access to maternal health care during and after pregnancy and delivery; educating women and families to recognize and respond to emergency situations; and ensuring that women get the rest they need during pregnancy and after delivery.

delivery points and wherever possible references and partnerships have been highlighted.

Over the past decades, Bangladesh has continued to struggle with attempts to reduce maternal mortality. Intensified efforts in the field of TBA training and focus on increasing ANC have not brought about the desired results. Based on the experience from these attempts, increasing the availability of EmOC has been recognized as a key intervention to reduce maternal mortality. The assessment of availability and utilization of EmOC services in Bangladesh are as follows:

- The unmet need of EmOC – proportion of women with obstetric complications treated at facilities – has decreased from 95% to 75%;
- Private sector facilities are a major source of EmOC services. Of concern is the fact that though 25% of women experiencing obstetric complications avail private sector services, half of the caesarean sections are performed in this sector, raising questions as to the access to this service by the poor;
- The situation of record keeping and reporting is far from adequate and requires urgent action;
- Non-availability of services in district hospitals is primarily a function of the availability of trained consultants – either Obstetrician or Anaesthesiologist or General Practitioners (GPs);
- In UHCs non-availability of services is due to the lack of both human resources and equipment/drugs

To ensure safe delivery at the community level an agreement between UNFPA, WHO and the GoB (MOHFW) was signed on 18 August 2002 for the pilot training of 300 Family Welfare Assistants (FWA) and Family Health Assistants (HA). The training is on safe delivery and referral techniques. The training will take place in 6 divisional districts and 6 upazilas with WHO and UNFPA assistance. The Obstetrics and Gynaecology Society of Bangladesh (OGSB) will implement and manage the project under the supervision of the Line Director IST, DGH. The present SBA training program also aims to increase skilled attendance at birth from the present 13% (2001) to 50% by 2010 (MOHFW, October 2001). The expected outcomes of the program SBA training are:

- Deliveries attended by skilled birth attendants will be increased at the community level.
- FWAs and female HAs in the community level or clinics in selected upazillas would be given a six-month long training on ANC, PNC, newborn care, safe normal delivery and referral for complications.

Antenatal Care: WHO recommends that pregnant women require four antenatal visits for:

- **Health promotion:** advice on nutrition and health care, as well as counseling to alert women to danger signs and help plan for the birth;
- **Assessment:** history taking, physical examination and screening tests;
- **Prevention:** early detection and management of complications, and where needed, prevention of malaria, hookworm and tetanus; and
- **Treatment:** management of sexually transmitted diseases, anemia or other conditions.

Delivery care: WHO recommends a skilled attendant at every birth who can:

- Provide good quality care that is hygienic, safe and sympathetic on an ongoing basis;
- Recognize and manage complications, including life-saving measures for mother and baby; and
- Refer promptly and safely when higher-level care is needed.

Postpartum care: WHO recommends integrated postpartum care that includes:

- Identification and management of problems in mother and newborn;
- Counseling, information and services for family planning; and
- Health promotion for the newborn and mother, including immunization and advice on breastfeeding and safe sex.

Source: Family Care International and the Safe Motherhood Inter-Agency Group

Areas for Action

The Government envisages setting up EmOC, ANC PNC, skilled birth attendance (SBA), FP, MR, nutrition and other services to reduce maternal mortality and to improve maternal health (MOHFW, 2001). In order to achieve these objectives, the GoB has categorically identified facilities and service providing units (MCH, DH, MCWC, UHC, NGO/urban clinics, etc.) and personnel (like specialists/trained MO, FWA, HA, FWV, nurses, NGO paramedics, TTBA, etc.). The Bangladesh National Strategy for Maternal Health prioritizes actions for HPSP up to 2003 in the following areas:

- Development of a pool of trained MOs for deployment in the UHCs to ensure full teams, and to ensure their retention in the respective facilities;
- Ensuring technical support and quality at the UHCs by monitoring performance by senior professionals;
- Interaction with pregnant women and their families to ensure ANC;
- Building of capacity of FWVs and female HAs and strengthening of existing FWV training for skilled birth attendance. Also, creation of awareness on critical needs and ensuring optimum use of available trained nurses for skilled birth attendance;
- Ensuring birth registration as well as interaction with pregnant women and their families to ensure PNC visits;
- Emphasizing long-term family planning (LTFP) and strengthening of male involvement in family planning;
- Finalization, approval and implementation of services for women and girls subject to violence by the relevant ministries (Health, Woman's Affairs and Home)
- Recognizing and identifying involvement/roles of private sector and NGOs.

The HNPSP strategies for reducing maternal mortality and the prioritized elements of reproductive health include:

- Safe motherhood ensured by services of ANC, Skilled Birth Attendants (SBA), EOC, perinatal and postnatal, ENC, and maternal nutrition;
- The on going pilot program on training of SBAs with WHO/UNFPA support will be gradually expanded to cover at least 30 districts by the end of the program.
- Local area specific mechanisms of community involvement in transporting pregnant women to facilities, and information campaigns targeting

Saving by investing in maternal health

Reproductive health programs, including maternal health, are among the most cost-effective investments in health. Providing women in low-income countries with care during pregnancy, delivery and after birth, as well as postpartum family planning and neonatal care, would cost about \$3 each year per person. Basic antenatal, delivery and postpartum care alone can cost as little as \$2 per person. Investing in women's health yields significant savings:

- Infant and child health: poor care of the mother often means death of the child: even if the mother survives, poor maternal health jeopardizes a newborn's chances of survival.
- Poor maternal health and nutrition contributes to low birth weight infants. Each year, 20 million low birth-weight babies are born.
- A mother's death makes survival and education uncertain for her children. A study in Bangladesh found that when a mother dies, surviving children are 3 to 10 times more likely to die within two years.
- Poor health contributes to poverty among women
- Strengthening maternal health services benefits the health system.
- Building women's trust promotes preventive care.

Source: Family Care International and the Safe Motherhood Inter-Agency Group

family and community members;

- The priority outputs in reproductive health are to improve access and use of EmOC services;
- By 2006, it is intended to bring a 35% increase in deliveries by skilled birth attendants, including FWAs and female HAs who have had six months of training in the conduct of normal deliveries and referral of complicated deliveries. Coverage of antenatal care, defined as 'three visits', will have been increased from 48% as of 2001 to 60% by mid 2006;
- Comprehensive EmOC, available at 30 UHCs, will be made available at other selected UHCs based on population needs. UHFWC services will be strengthened to provide safe delivery as well as Obstetric First Aid with a provision for facilitated referrals;
- Maternal nutrition services will be provided based on the BINP model by mid-2006.

CHAPTER FOUR

UNWANTED PREGNANCY / UNSAFE ABORTION

Each year women around the world experience 75 million unwanted pregnancies. Millions of women around the world risk their lives and health to end unwanted pregnancies. The situation is no different in Bangladesh. Overall, one-third of births in Bangladesh can be considered as unplanned, 19% are mistimed and 14% unwanted. Low contraceptive continuation rates, method failure and high unmet need for contraceptives are some of the leading causes of unwanted pregnancies and abortions.

Situation Analysis

In Bangladesh, women's ability to control their fertility is limited. Though family planning methods are available everywhere in the country, a woman may not use them because of financial constraints, personal beliefs, opposition from family members or concerns about the perceived adverse effects on health or future fertility.

If all unwanted births were avoided, the fertility rate in Bangladesh would fall from 3.3 to the replacement level of 2.2 children per woman (NIPORT, Mitra and Associates, and ORC Macro, 2001). Thirty-three percent of all births are unplanned of which 13% are unwanted and 20% are mistimed. Added to this statistics is the proportion of the numbers of menstrual regulation procedures and the backstreet abortions, which yields a startling figure of 45% of unplanned pregnancies (Singh et al., 1997).

The reasons for which people are not using contraception for the prevention of unwanted pregnancies include lack of access to family planning information and services, personal or religious beliefs, inadequate knowledge about the risks of pregnancy following unprotected sexual relations, women's limited decision making ability with regard to sexual relations and contraceptive use, and incest or rape. On the other hand, contraceptive methods, even the most effective ones may fail for a variety of reasons related to the technologies themselves and/or to the way they are used.

Unwanted pregnancies and births can have many negative consequences, for the children themselves, their siblings, their parents, and the society as a whole. Women bear the physical, emotional and financial burdens and heartache of unwanted pregnancies. Deciding whether to carry the pregnancy to full term or to have an abortion presents a painful dilemma. A woman may not be mentally or physically prepared to bear a child. Often she must weigh serious risks to her own health and the health of her existing children against another pregnancy. When abortion is her chosen option, she faces continuing trauma as she has to either go

Unwanted Pregnancy is a pregnancy that pregnant woman or girl decides, of her own free will, is undesired.

Unsafe Abortion is the termination of a pregnancy carried out by someone without the skills or training to perform the procedure safely, or in a place that does not meet minimal medical standards, or both.

Spontaneous Abortion or **Miscarriage** can result in complications, although these are relatively rare.

The World Health Organization (WHO) estimates show that 19 out of every 20 unsafe abortions take place in the developing regions of the world. Although unsafe abortion is a public health problem at all age, it is particularly so among young women. They often have poor access to family planning and are less likely than older women to have the contacts and money to obtain safe abortion. Also young women are more likely to delay seeking help, thereby seeking termination when the pregnancy is much more advanced. Abortion related morbidity and mortality are much higher in the second trimester of pregnancy (MOHFW, 1998).

to an untrained practitioner for clandestine abortion or put herself through humiliation and disrespectful treatment by the male doctor. Often a woman has no one to turn to for moral support and sympathy before, during or after an abortion even when medically safe services are available (Sandra M K, 1998). Adolescents are particularly susceptible to unintended pregnancy. They are often completely uninformed or, at best, misinformed about sexuality and the risks associated with early and unprotected sexual activity.

In such circumstances, many women resort to either menstrual regulation or clandestine abortion. These abortions, mostly performed by unskilled persons using hazardous techniques in unsanitary conditions, are extremely unsafe. Women who seek abortion at unauthorized facilities or from unskilled persons put not only their health but also their lives at risk. Unsafe abortion is one of the neglected problems of health care.

Unsafe abortion may be induced by the woman herself, by non-medical persons or by health workers in unhygienic conditions. The majority of the women in the villages of Bangladesh depend on the services of the village doctor, herbal practitioner, homeopath, and religious healers. These village practitioners are conveniently located in the community, and the women are more familiar with them. However, about 15% of the women choose medically trained people in the community as their first provider (Ahmed et al., 1997).

Although induced abortion is illegal in Bangladesh except when done to save a woman's life, the practice is believed to be common. Approximately half of the admissions to gynaecology units in major urban hospitals of the country are for complications of abortion. Every year 2.8% of all pregnant women undergo Menstrual Regulation (MR) and 1.5% undergo induced abortion. These services are usually provided by untrained paramedics and ill trained doctors in a logistic constraint setting (MOHFW, 1998).

According to a recent study, the abortion rate in Bangladesh is about 26-30 per 1000 live births. The annual number of induced abortion is about 730,000 of which menstrual regulation is 430,000. The overall rate of hospitalization for abortion is 2.4 per 1000 live births and about 75% of these complications are due to unsafe abortion and the remainder is due to menstrual regulation. The annual estimated number of complications requiring hospitalization that result from MR is about 19,300, which is approximately 4% of the 468,000 MR performed annually (Singh et al., 1997). Induced abortion other than menstrual regulation is estimated to have a complication rate of about 40% and a hospitalization rate of about 20% (Chowdhury et al., 2002).

Health workers in 795 health centers were interviewed under a study about complications arising from induced abortion in rural Bangladesh. A total of 1590 cases of complications

The risk of resulting disability or death depends on a variety of factors - including hygiene, skills of the persons carrying out the abortion, method used, general health of the woman, her age and parity, presence of reproductive tract infections, and pregnancy stage. The risk also depends on the accessibility of treatment facilities once complication occurs (MOHFW, 1998).

The most frequent complications are incomplete abortion, sepsis, haemorrhage and intra-abdominal injury, such as puncturing or tearing of the uterus. These can be fatal if they are not treated promptly. One of the commonest complications of unsafe abortion is when parts of the products of conception stay in the uterus. This is called incomplete abortion. WHO recommends the use of vacuum aspiration for managing incomplete abortion. Long-term health problems caused by unsafe abortion include: chronic pelvic pain, pelvic inflammatory disease, tubal blockage, secondary infertility, ectopic pregnancy and increased risk of spontaneous abortion or premature delivery in subsequent pregnancies. Such problems can limit women's productivity inside and outside the home and care for children and adversely affect their sexual and reproductive lives (WHO, 2000).

from abortion were reported. Dais (Traditional Birth Attendants or TBAs) and traditional practitioners were reported to be the main groups of operators (42.1% and 18.1%, respectively). Menstrual regulation (MR) or dilatation and curettage (D&C) – the medically approved procedures, was reported to have been used 9.1% of the time.

Nearly half of the complicated abortions were reported to have been induced by inserting a foreign object, such as a stick or root (sometimes treated with herb), into the uterus and leaving it there until it resulted in either abortion or complications. As many as 498 abortion related deaths were reported in the study. The proportion of complicated abortions resulting in death was the lowest for medically approved procedures (4.9%) and the highest for vigorous physical activity (100%) and abdominal pressure (66.7%), although the last two together accounted for only 2.3% of the abortion procedures. Many of these deaths might have been prevented if a means of safe, affordable termination of unwanted pregnancy had been available (Anthony et al, 1991).

Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling, so that they can adopt an appropriate method and prevent another unwanted pregnancy. About 15% of the women had repeated abortion (Ahmed S et al., 1996). Findings from another study revealed among those who intended to have abortions in future 39% comprised those who have had one previous abortion, 39.5% of those who have had two previous abortions, and 22% of those who have had no previous abortions. The higher the previous abortion exposure the more likely they are to intend to terminate pregnancy in future, if needed (Akhter H H et al., 1998). This highlights the importance of post-abortion contraceptive counselling.

National policies and objectives

In addressing future challenges the Government plans to reduce maternal mortality by providing adequate support and antenatal care, post delivery services and emergency obstetric care. The Government policy also emphasises management of complications arising from unsafe abortions. To achieve these objectives it is envisaged to ensure that skilled service providers attend up to 100% of deliveries by 2010.

Addressing unsafe abortion

Existing laws in Bangladesh derived from the Penal Code of India, 1860, prohibit abortion, except to save the life of a woman. However, menstrual regulation (MR), an early termination within 6-10 weeks without pregnancy confirmation, is widely provided through a network of the government health services since 1978.

“Prevention of unwanted pregnancy and prevention and management of unsafe abortion are key interventions for safe motherhood. Enabling women and families to choose whether, when, and how often to have children is central to safe motherhood. The availability of family planning information and services to women, including adolescents, helps to limit pregnancies in which complications may occur.”

“Pregnancies among very young women and women with many children, and unwanted pregnancies are all associated with increased likelihood of mortality. Women whose pregnancies are unwanted may seek terminations; even when safe termination is prohibited by law or unavailable. Complications of unsafe abortion are responsible for 13% of all maternal deaths, yet these deaths are among the most easily preventable.

“Whatever a country’s legal position on abortion, all women suffering from abortion-related complications have a right to treatment and high quality post-abortion care, including family planning counseling and services, offered with compassion and full confidentiality. Safe motherhood programs should include promotion of family and community support for delayed marriage and childbearing, timely and planned pregnancies, and improved health, nutrition, and education for all girls and women.”

From: Reduction of maternal mortality. A joint WHO/UNFPA/UNICEF/World Bank Statement.

Since the mid-eighties, the number of MRs performed in the country reported by the MOHFW has remained at around 1000,000 annually (Rob and Ahmed, 1996). Several researchers have speculated that the reported number represents only a small fraction of the number of MR cases actually performed each year. The 1999-2000 BDHS data indicate that nearly 20% of women had a pregnancy termination at some point in their reproductive lives. In the absence of specific knowledge, about one-third of MR clients are rejected, since they turn up too late (Ahmed Y. H. 1997). Another study shows that 64% had accepted MR services within 8 weeks of conception and 11% received the service after 12 weeks of conception (Ubaidur Rob et al., 2002). Most of these late comers, along with those who do not have any information on MR, usually end up with traditional / non-medical abortion providers. Result: Of the estimated 262,000 back-street abortions, 20% end up in hospitals with abortion related complications (Ahmed, 1997).

Usually women do not use the government services and resort to unsafe abortion. It has been estimated that 51% develop complications and finally go to rural hospitals for management (Ahmed et al., 1997). Pregnancy outside of wedlock is seen as unacceptable by the Bangladesh society. As a result, an unmarried woman will rarely seek help from trained providers or institutional services for fear of public exposure (Hossain et al., 1997).

Accurate estimates of the annual number of procedures are not available, primarily due to a weak reporting system and the tendency of MR performers to under-report the performance. It is not fully clear why this under reporting persists, but the phenomenon is also confirmed by Caldwell et al. (1997). Their research points to a problem of reporting associated with charging for services. In theory, MR is provided free of charge by government hospitals and health facilities. In practice, however, that is often not true (Piet-Pelon, 1999). The social stigma attached to MR and abortion may inhibit reporting, and moreover, the reporting system by any standard is poor.

The public health facilities providing MR services include District hospitals, Maternal and Child Welfare Centres (MCWC), Upazilla Health Complexes (UHC), and Union Health and Family Welfare Centres (UH&FWC). In addition, some government training centres/model clinics (Mohammadpur Fertility Services and Training Centre) also offer MR services. At present there are 6,500 Family Welfare Visitors (FWVs) and 8,000 doctors trained on MR who are posted in different government health facilities. Below the upazilla level, FWVs are the main providers of FP-MCH services and MR. The FWVs have at least ten years of formal schooling and receive an 18-month training on family planning and MCH. They receive MR training after their formal posting in health facilities.

WHO has long advocated the issue of unsafe abortion, including focused efforts to investigate the determinants and consequences of abortion; establish norms and standards for the effective management of complications due to unsafe abortion, develop technical managerial and clinical guidelines for abortion services; provide guidance for post-abortion family planning services; and prevent unsafe abortion through research and development in the area of fertility regulation and non-surgical abortion.

Fertility regulation or 'fertility control' refers both to the possibility to regulate one's own fertility and to practical means for doing so.

The main methods for fertility control, used today all over the world include:

- Social control of sexuality and reproduction
- Contraception (traditional and modern methods)
- Abortion, safe/unsafe abortion

Fertility regulation – by prevention or termination of an unwanted pregnancy – has been practiced in all societies throughout history. The balance between prevention and termination of an unwanted pregnancy – between the use of contraception and abortion – varies with the circumstances.

Only a limited number of NGOs provide MR services and these include Menstrual Regulation Training and Services Programme (MRTSP), Bangladesh Association for the Prevention of Septic Abortion (BAPSA), Bangladesh Women's Health Coalition (BWHC), Marie Stopes Clinic Society (MSCS), Family Planning Association of Bangladesh (FPAB) and Bangladesh Rural Advancement Committee (BRAC). All NGOs except MRTSP provide services in their own facilities. MRTSP provides MR services at government medical colleges and district hospitals.

There is also a wide network of private providers who range from qualified physicians and FWVs to untrained MR practitioners. However, there is very little documentation on MR services in the private sector.

The Fourth Population and Health Project Management Information System (MIS) unit of the Directorate of Family Planning compiles MR performance statistics. The functional responsibility of the Unified MIS (service, logistics, personnel, financial) is to organise collection, compilation, analysis and dissemination of all information, especially those related to ESP. However, the October 2001 annual report of HPSP documented that in practice the new system was not functioning well and data collection and reporting had now come to a virtual stand still.

In the NGO sector, each NGO has its own record keeping and recording system and compiles its own data. Each month NGOs submit a performance report to the Government on Family Planning services including all the MR cases. NGOs also separately compile, publish and disseminate data on MR through BAPSA. As the Unified MIS (UMIS) is not fully functional, it has affected the systematic compilation of MR statistics. There is no specific strategy to address the issue of poor record keeping and reporting (Chowdhury et al., 2002).

Emergency Contraception (EC) occupies a unique position in the range of family planning methods currently available to women. EC enables women to prevent pregnancies after they have unprotected sex. Thus, it averts unplanned and unintended pregnancies, which, in turn, reduces unsafe abortion. Emergency contraception has not yet been included in the Bangladesh national family planning program. Unintended pregnancy risks are becoming pronounced in women who have infrequent intercourse. This may result from extramarital or premarital relationship, sexual violence or abuse and mobile occupation of their husband. Here, emergency contraceptives can help those women to fend off unwanted pregnancies and unsafe abortions. A variety of hormonal contraceptives like high doses of ordinary birth control pills, high doses of mini pills, and Progesteron are the only preparations that have been identified as emergency contraceptives.

At the International Conference on Population and Development in 1994, governments recognized unsafe abortion as a major public health issue. They called for:

- prompt, high quality and humane medical services to treat the complications of unsafe abortion;
- compassionate post-abortion counseling and family planning services to promote reproductive health, and reduce recourse to abortion;
- safe induced abortion services where they are not against the law.

The **GATHER** approach to post-abortion family planning counselling.

The **GATHER** approach is used around the world for counselling and training and to help family planning providers on the job to recall the elements of counselling.

- G** – GREET the Client (warmly/asking her name)
- A** – ASK why she has come/what her needs are
- T** – TELL or share the information, which she needs
- H** – HELP the client think through her options
- E** – EXPLAIN how to use the method or anything else she needs to know
- R** – RETURN – remind her of her next visit

The concept of emergency contraception is relatively new in Bangladesh. Despite availability of the methods that may be needed as emergency contraception there have been very little effort to offer women emergency contraception as a choice to prevent unwanted or mistimed pregnancies. Despite the development of nation-wide family planning and MR programs, maternal mortality remains unacceptably high. Rural and urban women alike suffer from a continued lack of knowledge about safe pregnancy terminations, which results in unnecessary back-street abortions. It may be argued that if women were given a choice, they would prefer to accept contraception over abortion.

Areas for Action

- Consistent and correct use of modern methods of contraception can prevent many unwanted pregnancies and, in turn, save lives. The Government, NGOs and private sector can intensify their efforts to improve access for men, women, unmarried individuals, and adolescents to high quality, client-centred information and services that offer a range of methods appropriate for people at different stages of their lives. It must also be ensured that clinics are accessible and staffed with well-trained, caring providers.
- Augmenting women's access to sexual and reproductive health care, both through action at the national level and at the community level (through public education for women, their families and communities) will provide them with better access to reproductive health care and information on Emergency Contraception which in turn will reduce the number of unwanted pregnancies and the possible need for abortion.
- Even where contraception is available, some women will experience unwanted pregnancy and some will seek to terminate unwanted pregnancy. Therefore, there may be
 - Provision of acceptable MR and follow-up services, free of charge, at all levels – at the UH&FWC, UHC, MCWC;
 - Training of health providers, in decentralised settings, on all aspects of abortion & MR;
 - Counselling for couples, prior to leaving the hospital after an MR, covering issues such as post-abortion health care, immediate return to fertility, and the couple's choice of post-abortion contraception; and
 - Inclusion of target groups who have previously been overlooked, such as lactating mothers and older women.

"I dream of the day when all children born are welcome, when men and women are equal and when sexuality is an expression of closeness, joy and caring"
- Elise Ottesen-Jensen, 1928.

"Abortion is more than a medical issue, or an ethical issue, or a legal issue. It is, above all, a human issue, involving men and women as individuals, as couples, and as members of societies."
- Christopher Tietze, 1978.

"Unsafe abortion is a major public health issue, whose humane management should encompass all levels of prevention – education, contraception, safe services, and proper treatment for those who have suffered an unsafe abortion."
- Dr. Fredrick Sai, Chairman, Main Committee, International Conference on Population and Development.

"We must do everything we can to prevent unwanted, unintended and information high-risk pregnancies, including making family planning information and services universally available. The technologies and techniques needed are all well known. Countries need only the will to act."
- Dr. Nafis Sadik, Executive Director, UNFPA.

- Each woman needs to have access to care to manage the complications of unsafe abortion, along with post-abortion counseling and contraception to avoid repeated abortions i.e., Post Abortion Care (PAC). Women with incomplete abortions (either spontaneous or induced) can be treated safely and effectively with procedures such as manual vacuum aspiration (MVA).
- In the past decade very limited research was conducted on MR and abortion. In the changing concept of the health sector it is crucial to work with program managers and policy makers and identify research issues for further improvement of the programs.

Chapter Five

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Adolescents in Bangladesh are exposed to the same reproductive health risks as adolescents in other developing countries. Adolescent pregnancy and its impact on maternal and infant mortality rates, sexually transmitted infections in adolescents, initiation to tobacco and substance abuse and violence have serious public health implications. The Program of Action of the ICPD identified adolescents particularly as a vulnerable group, and suggested that governments, in collaboration with non-government organizations, should meet their special needs.



Situation Analysis

Adolescence has been defined by WHO as the period of life spanning the ages between 10 and 19 years (WHO, 1997). Adolescents constitute a significant portion of the population of Bangladesh. A large number of them are out of school, malnourished, working in vulnerable situations, getting married early and are sexually active although most of them do not have knowledge about contraception and safer sex.

According to The National Census of 2001, as many as 36.3 million Bangladeshis are adolescents (10-19 years of age) constituting 23% of the population. Among them 8.8 million girls and 9.3 million boys fall in the age group of 10-14 years while 8.7 million girls and 9.5 million boys belong to the 15-19 years age group. It is estimated that about 10.8 million adolescents/youths will be added to the existing population making the total 49.3 million, i.e., 36% of the total population in 2006 (Rob and Alauddin, 1997).

Table 5.1: Percent distribution of population according to age group

Age Group	Both Sex (Percent)	Male (Percent)	Female (Percent)
Less than 10	25.7	26.5	25.0
10-14	13.5	13.4	13.6
15-19	11.5	10.4	12.6
20-24	8.6	7.6	9.6
25-49	29.1	29.5	28.6
50+	11.8	12.8	10.7
Total	100	100	100
Total Population (million)	123.8	63.5	60.3

Source: Mitra et al., 1999-2000

One in every five people in the world is an adolescent who is defined by WHO as a person between 10 and 19 years of age. Out of 1.2 billion adolescents worldwide, about 85% live in developing countries. The ICPD Program of Action emphasizes on investing in adolescents: "Full attention should be given to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexually." (*Statement from the 1994 ICPD Program of Action - Para 7.3*).

- Of the Bangladeshi population, adolescents constitute a significant proportion: 36.3 million.
- The literacy rate among adolescent girls increased from 24% in 1990 to 43% in 1998.
- The average age at marriage for girls is 14.6 years.
- About 86% of female adolescents are forced into marriage by their parents.
- The average age of first pregnancy is 17 years.
- About 36% of adolescent girls are either currently pregnant or already have a child.

The primary school enrolment rates for boys is 80% and for girls 83%, whereas secondary school enrolment for boys is 52% (UNICEF, 2002). Between 1990 and 1998, the literacy rate for the adolescent girls rose from 24% to 43% indicating a great achievement in the movement for universal education (BBS, 1998). However, 25% of the male adolescents enroll in the secondary school compared to only 13% of the female adolescents (ibid.). As the girls reach adolescence, social norms restrict their mobility. Moreover, household duties or family financial hardships may lead girls to seek employment in the agricultural or formal sectors such as garment industry or informal sectors such as domestic service. They are also driven to early marriage.

There are several factors, all inter-related, that affect the normal development of adolescent girls. These include poverty, violence against adolescents, sexual exploitation, family conflict, unwanted pregnancies, gender bias, malnutrition and forced prostitutions, etc. (MOHFW, 2002). Nutrition is also an important issue to be considered in the development of the adolescent. More than 90% of children under five suffer from malnutrition (Mitra et al., 1997). Among adolescents girls of the ages 11-16 years 43% are anaemic (Hb <12.0 gm/dl) and about 4.6% are below 10.0 gm/dl (MOHFW, 2002).

In addition, they are at a stage associated with an increased likelihood of sexual activity, and thus, run an increasing risk of contracting sexually transmitted diseases (STDs), including human immuno-deficiency virus / acquired immuno-deficiency syndrome (HIV/AIDS) if they practise unsafe sex. A falling trend in age of menarche, combined with rising age at marriage, have resulted in an increased number of sexually mature, but unmarried adolescent girls with consequent potential for unplanned pregnancies (Nahar Q, et al., 1999).

In general, knowledge of reproductive health among adolescents is low. The majority has no idea about the changes associated with puberty (e.g., menstruation or wet dreams) until they experience them. In Bangladesh, the strong family structure plays a major role in the lives of adolescents but fails to respond to their needs for reproductive health information (Rob and Bhuiyan, 2001). Their information sources regarding sex and sexuality are usually grandmothers, peer groups, and canvassers, but the scope for acquiring academic or institutional knowledge is very limited (Hossain, S M I et al., 1998).

Early Marriage and Child Birth

In a BIRPERHT study, 7% of girls of the ages 14-15 years were found to be married, as well as 36.6% of the ages 16-17 years and 71% of the ages 18-19. By the age of 19

Although there is great diversity both between and within geographic region most women and men married and unmarried become sexually active during adolescence. Whereas, in the past, sexual activity was generally associated with early marriage, rising age at marriage and falling age at menarche mean that many more adolescents now become sexually active before marriage. Surveys in seven sub-Saharan African countries showed that more than half the women aged 15-19 are, or have been, sexually active. A study in Uganda, for example, showed that the mean age of first sexual intercourse for women was 15.5. Studies indicate that unmarried women in some parts of Asia and Latin America begin sexual activity later than their counterparts in sub-Saharan Africa; in Singapore, for example, fewer than half of young women report having sex before age 25. In Sri Lanka, less than one third of women reported having sex by age 20.

more than two thirds of adolescent girls were found to be married (Akhter H. H., et al., 1999). According to another source, 31% of teenage girls are mothers and another 5% are pregnant with their first child (Shahriar A, 1999). A baseline study for the Adolescent Reproductive Health Program (Associates for Community and Population Research, 2002) revealed that 85.9% of female adolescents were forced to get married early by their parents. Early marriage leads to early pregnancy and poor health, both for the adolescent mother and her child. The average age of first pregnancy is 17 years whereas the stated legal age of first pregnancy is 21 to 22 years.

About 18% of women in their late forties reported their first childbirth before the age of 15. Comparatively only about 7% of the women of the ages 15-19 reported having child at the age below 15 years. In the early 1990s, three quarters of young women of the ages 20-24 years had married before the legal age of 18. By the end of the decade, this proportion had fallen two-thirds, still a substantial proportion (NIPORT, Mitra and Associates, and ORC Macro, 2001). In addition, as they migrate to cities and towns in search of employment more and more girls run the risk of having unplanned pregnancies because of the falling age of menarche and the rising age of marriage.

A large proportion of the married female adolescents are unaware of the need for antenatal check-up during pregnancy, post natal care services, number of Tetanus Toxoid (TT) doses required for first pregnancy and throughout life, emergency obstetric care, emergency preparedness for delivery, and danger of performing abortion by untrained person. A substantial proportion of male adolescents and youths believe that mothers have a role in determining the gender of the child (Barkat, Abul, 2001).

Health risks from lack of information

There are an increasing number of anecdotal reports of adolescents accessing commercial sex workers as well as information that indicate high level of premarital sexual activity among adolescent boys in Bangladesh in spite of the fact that social customs discourage premarital or extramarital sexual relationships (UNICEF, July 2002). Around 7% of the adolescents (both unmarried and married) and 21% of the unmarried youth reported experience of premarital sex and over 50% of unmarried adolescent and youth did not use condom during first premarital intercourse (Barkat, Abul, 2001).

The primary source of reproductive health information for unmarried sexually active adolescents are friends (Rob and Bhuiyan 2001). Boys suffer a great deal of anxiety over wet dreams and masturbation due to myths and misinformation about these phenomena. They believe

Some facts on adolescent pregnancy and motherhood:

- One in every 10 births worldwide is to teenage mothers. In least developed countries, 1 in every 6 births is to young women of the ages 15 to 19.
- Pregnancy before the age of 18 carries many health risks. Girls' of the ages 10 to 14 are five times more likely to die in pregnancy or childbirth than women of the ages 20 to 24.
- At least 1 to 10 abortions worldwide occurs to women of the ages 15 to 19. More than 4.4 million young women in this age group have an abortion every year, 40% of which are performed under unsafe conditions.
- The younger the adolescent with an unwanted pregnancy, the more likely she is to seek abortion. An induced abortion, often done clandestinely and by untrained practitioners, poses grave danger to the reproductive health and life of the adolescent girl.
- In Bangladesh, 31% of teenage girls are mothers and 5% are pregnant with their first child. Thus, 36% of the teenage girls are already in the childbearing process.

* * *

Pregnancy robs adolescent mothers of nutrients needed for their own growth. Pelvic bone and muscle growth may not be complete before they have their first child, which often leads to obstructed labor and maternal death. It can also result in chronic poor health for both the under-weight mother and child. Adolescent mothers also suffer from deficiencies of various micronutrients including iron, vitamin A and iodine. Anemia is particularly prevalent during adolescence because of rapid growth and menstrual blood loss, as well as pregnancy (UNICEF, 1999).

that night emission, masturbation, and urethral discharge are illnesses for which they may seek treatment. Knowledge about STIs and the use of condoms remain very low among adolescents. Unmarried but sexually active adolescents reported that they did not feel comfortable seeking family planning or STD services from nearby clinics and pharmacies and perceived the providers to be judgmental and unfriendly (Bhuiyan et al., 2000).

As they mature and become sexually active, adolescents become vulnerable to contracting STDs/RTI/AIDS. In a ICDDR,B study, less than 20% of the adolescents perceived that they had ever suffered from the diseases of reproductive organs. A higher proportion (17%) of the urban slum girls believed that they suffered from such diseases than those of non-slum areas (7%). Similarly, a higher proportion of slum boys (6%) reported experiencing an RH-related illness compared to those from the non-slum areas (3%). However, 19% of rural boys and rural girls believed that they had suffered from the diseases of reproductive organs. Sixty-three percent of the rural boys and 54% of the rural girls, who had experienced a problem, had consulted healthcare providers for their perceived RH problems. In the urban area, a high proportion of boys from the non-slum areas (60%) consulted the healthcare providers compared to boys (50%) living in the slum areas (Nahar Q, et al., 1999).

Most adolescent boys and girls in the urban areas had heard of AIDS. Regarding the route of transmission of AIDS, about half of the adolescents interviewed, irrespective of whether they live in the urban or rural areas, admitted their ignorance about the topic. About 90% of both rural and urban adolescents mentioned TV and radio as the prime sources of information regarding AIDS and 15% boys mentioned friends as another source (ibid.).

Exposure to occupational hazards and violence

Adolescents in this country are involved in various occupations that range from domestic work to prostitution. The most common occupations include domestic work, factory work, assisting in various professions, vendors, rickshaw pullers, porters, and prostitution. It is believed that the employers recruit adolescents as they can offer them low wages, and can expect less resistance to repression. In Bangladesh, physical and psychological torture of young domestic servants is common – the punishment, such as beating or locking the person inside a room, is often given out for merely breaking a glass or eating something without the employer's permission. According to the National Census (1991) 12% of the labor force in Bangladesh consists of children under the age of

About 73 million adolescents between the ages of 10 and 14 are working worldwide and many of them live and work on the streets putting them at high risk.

A study "Adolescent Reproductive Health & Rights: Perception, Attitude and Knowledge" carried out by *Concerned Women for Family Planning*, reveals all the adolescent girls in the married group had been beaten at least once by her husband. However, ironically, their opinion regarding such violence was "whenever a wife does something wrong, the husband has every right to punish her; it is up to us women to make ourselves perfect in every way to avoid being beaten".

14. According to the International Labour Organization (ILO) (1995) 30% in the age group of 10-14 and 67% in the age group of 15-19 years are employed.

In a study (Hossain, 1993) sixty six percent of the delinquents studied were in the age group of 13-16 years, while the rest (34%) are of the ages 9-12. The majority (60%) of these delinquents came from urban areas and over 90% had some level of education. The most commonly reported crimes were robbery (15%), bad companion (13%), and disobedience (12%). More than half of the delinquents reported that they were deprived of love and affection from their parents.

National Policies and Objectives

Focusing the programs of reproductive health and family planning on married as well as unmarried adolescent is imperative for internalizing the behavior that supports the use of modern health care services to improve the quality of life. Besides, the sooner the adolescents pick up FP practices as a routine behavior, the greater are the prospects of slowing down the momentum of population growth after reaching replacement fertility. Intersectoral approaches and focused sectoral approaches have to be devised to cater to the needs of the in-school and out-of-school adolescents.

Goals:

- **Health:** The diseases or conditions that contribute to the ill health for adolescents include non-communicable and communicable diseases, injuries, maternal, prenatal and nutritional conditions as well as conditions associated with risky behavior. The goals envisaged are: reduced maternal mortality, increased age of first sexual experience and pregnancy, delayed age at marriage, reduced maternal malnutrition and reduced STI/HIV/AIDS transmission.
- **Education:** Although school enrolment has increased, many adolescents still do not attend or complete schools. This results in high dropout rates. Even for those adolescents who do attend school, many fail to achieve basic literacy level before dropping out. The goals envisaged are: high rate of education in adolescents, broadening of the education curricula with the addition of relevant vocational and innovative subjects, and access to higher education.
- **Economic opportunity:** Many adolescents either work voluntarily or are forced to work and are thus deprived of the opportunity for education. The goals envisaged are: assisting adolescents to at least

Help-seeking Behavior

Adolescents of the same age group have varied service needs. Marital status, gender, educational qualification, environment, etc., determine the kind of help and social support required. Reid (1989, cited in Costello, Pickens & Fenton, 2001) offers a broad definition of social support that is of four specific kinds:

- *Instrumental support*, which is direct support to an individual in the form of financial assistance, skills training, health services, transportation, etc;
- *Informational support*, which includes providing information about a need or referrals for help, including health related information;
- *Affinitive support*, which means simply, being with other individuals who have mutual interests; and
- *Emotional support*, which includes close friends or family members, or professionals, who provide help for emotional needs or personal crises.

complete their schools and providing them with opportunities for appropriate skill development to enable them to take up trades of their choice during adulthood.

- **National policy on adolescents:** Adolescents have been identified as an underserved priority target group under the HPSP, and subsequently in the revised 3-year Health and Nutrition Program (HNP). Although numerous programs have been undertaken through relevant ministries and agencies, there is no comprehensive national policy addressing the multi-dimensional needs of adolescents. There are overlaps in terms of age groups of the adolescents, for example, most of the adolescents are covered under the National Children Policy (a child is defined by the United Nations agencies to be a person below 18 years of age); while the rest are covered under the National Youth Policy. However, policies and programs for adolescents cannot exist in isolation, and their success will depend on the extent to which they are embedded in the social and family interventions.

The *Adolescent Health Care* program undertaken by HPSP is one of the pivotal sub components of ESP. The program includes the development and wide circulation of Behavioral Change Communication (BCC) message to create awareness about:

- The reproductive process
- Safe sex
- STD/HIV/AIDS
- Proper nutrition and hygiene
- Proper sibling care
- Adolescent contraception
- Demerits of early marriage and early childbearing
- Treatment of iron-deficiency anemia
- Treatments of gynecological problem, such as analgesic for dysmenorrhoea.

Under the current HNPSP (July 2003 – June 2006), the adolescent health problem will be addressed through multicultural efforts with involvement of NGOs and adolescents themselves. For this purpose an Adolescent Health and Development strategy will be developed involving all stakeholders. Initial interventions will include, among others, creation of health clubs linked with the District sports officers as

UFHP (Urban Family Health Partnership - a health sector project of USAID) successfully imparted ToT to 108 schoolteachers of 26 schools in Dinajpur, Thakurgaon, Hilli, Khulna and Dhaka, on reproductive health education to adolescents. A total of 7,500 adolescents, both male and female are expected to benefit directly from this initiative every year as these teachers conduct special classes on ARH issues. Between January 1999 and June 2002, adolescents comprised almost 15% of the total customers in clinics where the intervention was piloted.

well as BCC activities to encourage physical exercise (MOHFW, 2003).

- **School health:** An essential package of health promotion interventions for school children will be developed. This will also include services such as eye check-up, anthropometry, de-worming, TT, immunization especially for girl students, etc. The major emphasis will be on BCC aimed at promoting health and reducing risk to health. A strategy on school health will be formulated with the objective of protecting and promoting the health of school children as well as utilizing them as agents of change in the households to promote a healthy lifestyle. The development of the strategy will be carried out in close collaboration with the Ministry of Education, PMED, Girls Guide and Bangladesh Scouts (MOHFW, May 2003).

Adolescent sexual and reproductive health services

Adults visualize adolescents as a problematic section of the population. Adolescents are the parents, workers, and leaders of tomorrow. Family pressure, lack of knowledge and access to contraceptives put adolescents in this kind of high-risk situation. Social and religious restrictions may limit adolescents' access to sexual and reproductive health information and services. Negative attitudes of service providers, non-confidentiality, unfriendly services and inappropriate opening hours or locations are often reasons why adolescents do not seek sexual and reproductive health services in places where such services are available. Meeting the reproductive health needs of today's adolescents requires more than solving their problems.

Education program

Formal education:

GoB continues to advocate making basic education for all, especially girls, a national priority. To encourage girls to enroll and remain in school for a certain period, the Government has introduced free formal education for girls up to the higher secondary school level and for boys up to the primary school level. Forced marriages have been made illegal so that girls may complete their schooling and have more opportunities for personal growth. About 3034 girl students attended secondary school in 1999, whereas it was only 1180 in 1990.

School project / AFLE:

The Adolescent Family Life Education (AFLE) is a GoB and Swedish SIDA funded pilot project in 39 thanas of four selected districts. Its main objective is to increase adolescent awareness in order to positively affect their

UNFPA has funded the development and inclusion of family life education (FLE) in school curricula in 79 countries over the past three decades, with technical assistance from UNESCO. In contrast to earlier curricula that focused on the population-development linkage, today's curricula are more likely to add reproductive health and physiology, family planning information and training for responsible parenthood, encouragement of sexual abstinence, STD/HIV prevention, and training in gender equality.

reproductive health and lives and to develop an effective curriculum by obtaining information from a variety of stakeholders like students, teachers, parents and community leaders.

Other NGOs, like BRAC, Nari Maitree, FDSR, and CWFD also implement programs for adolescents. In 2000, BRAC implemented its education intervention in 249 secondary schools, 5 Madrashas, and 240 Kishoree Pathagars. The other NGOs have introduced interventions like the Adolescent Health Development Program, Rural Adolescent Boys' Program and Adolescent Empowerment Program, etc. Their activities are mostly to develop curriculum for non-formal education (NEPE), implement the adolescent family life education (AFLE) program, provide Training of Trainers (TOT) to teachers and other resource persons, data collection and interpretation, etc. BPHC is also providing financial support to three NGOs for the AFLE program.

Sex education:

Reproductive and sexual health education is aimed at developing the capacity of adolescents to understand their sexuality in the context of biological, psychological, socio cultural and reproductive dimensions and to acquire skills to take responsible decisions and actions with regard to sexual and reproductive health behavior. Several social barriers work against the introduction of sex education in school curricula. Many believe that this may increase promiscuity in the country while others believe that it already exists in the society. However, it has been suggested that receiving correct knowledge on reproductive health matters will reduce the irresponsible sexual behavior of adolescents.

Media and other sources of information:

Public electronic media, which include radio and television, are vital sources of information for adolescents. Other sources of information are the print media, i.e., books, leaflets, posters, etc. The Government and different NGOs have developed various print materials, short dramas, TV and radio spots, etc., to encourage adolescents to go to school.

Name	Programs
BRAC	AFLE
FPAB	AFLE
CWFD	AFLE, Skill Training, TT service
FDSR	AFLE,
BWHC	AFLE, Clinic service
NM	AFLE, Clinic Service
OMI	AFLE
WV	AFLE
PSTC	AFLE
CMES	NFPE
CDS	AFLE

Source: Proceedings of the first stock-taking workshop on adolescent health activities in Bangladesh by ICDDR,B/ORP and GOB in 1999.

Table 5.2: Percentage distribution of the adolescent and husbands by exposure to mass media on a regular basis

Categories of respondents	Colonies (%)		Well-off (%)		Slums (%)		Poor (%)	
	TV	Radio	TV	Radio	TV	Radio	TV	Radio
Female Unmarried	81	22	74	33	44	12	44	21
Female Married	68	20	54	28	17	14	20	17
Male Unmarried	64	28	60	37	23	17	34	29
Husbands	42	18	42	45	20	16	25	23

Source: Study of Adolescent: Dynamics of perception knowledge and use of reproductive health care by Population council in 1997

The table shows that television is a powerful medium for targeting adolescents both in rural and urban areas.

Peer education:

Peer education can play a vital role for adolescents. Young people can easily be influenced by their peers in their sexual and other behaviors like smoking, taking drugs, etc. The Urban Family Health Partnership (UFHP), World Vision, Village Integrated Development Association (VIDA) etc., are the organizations working to motivate adolescents through peer groups. They develop peer groups in the community that provide guidance and information to adolescents.

▪ **Family planning services:**

Knowledge of contraceptive methods is universal among married female adolescent and younger men of the ages 10-19 use condom more than the national average (Mitra et al., 1997). Although a large number of married female adolescents take the oral pill, condom use by the youth indicates a positive turn to male involvement (Piet-Pelon, N. J. and U. Rob. 1996). According to an NIPHP evaluation survey (Mitra et al., 2002), the overall CPR among currently married adolescents was about 46% and for modern methods 41%. The oral pill was the most widely used contraceptive method among this group (27%) followed by the condom (6%).

In Bangladesh, the adolescents are unlikely to use contraceptives at first intercourse before marriage as they are ashamed and scared of being found out. This particular behavior increases the chances of unwanted pregnancy.

Educational books for adolescents entitled "Nijeke Jano or "Know Yourself" has been developed with financial support from USAID. These materials contain sexual and reproductive information along with personal hygiene and other important topics. A radio program has also been developed for adolescents called "Janke Chai, Janaty Chai" or "Want to know, Want to Inform".

In Sri Lanka, a survey found that only half of 15-29year-olds were aware that condoms protected against HIV/AIDS and other diseases. A UNFPA-funded project that began in October 1998 has provided more than 100,000 young people with reproductive and sexual health information and 32,000 have received specific counseling.

Table 5.3: Current use of Contraceptives

Percentage distribution of currently married adolescents women and men by contraceptive method currently used, according to age, Bangladesh 1999-2000								
Age	Modern Method							Traditional method
	Any method	Any modern method	Pill	IUD	Injectable	Condom	Norplant	Any traditional method
Currently Married Adolescent Women								
10-14	25.7	16.1	11.5	0.0	0.9	3.8	0.0	9.6
15-19	38.1	31.2	21.0	0.7	4.9	4.3	0.1	6.9
Currently Married Adolescent Men								
15-19	*	*	*	*	*	*	*	*

Note: an asterisk indicates fewer than 25 un-weighted cases.

Source: Mitra et al., 1999-2000.

▪ **Programs on pregnancy and unsafe abortion:**

The high risks associated with teenage pregnancy are pronounced in Bangladesh. A good number of adolescent women below 20 years undergo unsafe abortion each year with a third of all women seeking hospital/clinics care for abortion complications. The Government provides special antenatal support to adolescent mothers through the ESP. Government health facilities like community clinics, district hospitals undertake regular checkup of the pregnant mothers.

▪ **STIs / HIV / AIDS Programs:**

Only 17% adolescent married girls have heard about AIDS, and if they need treatment for the disease, they visit quacks, pharmacists ('compounders'), Kabiraj, Hekim and other homeopath doctors. The GoB undertook a project in 1996 on the "Prevention and Control of Sexually Transmitted Diseases", and the year later approved the National Policy on AIDS. A strategy plan of action for the National AIDS Program of Bangladesh (1997-2002) for HIV/AIDS prevention and care has been also developed. There is a HIV/AIDS Committee at the district level which is headed by senior government officials and which develops local plans of actions. NGOs have also taken up special initiatives to resist HIV/AIDS in Bangladesh. Organizations like VIDA, UTPS, Terre Deshomes Foundation / Lausanne, PDAP, NUS, MSUS, GK, etc., provide STD/AIDS services for adolescents.

▪ **Nutrition Programs:**

Issues like economy, knowledge, food habit, cultural norms etc., influence the nutrition status of adolescents. The GoB has undertaken several initiatives in this regard, e.g., the Bangladesh Integrated Nutrition Project (BINP), Control of

So far about 62,000 AIDS cases have been reported in South-East Asia. It is estimated that about 4 million persons have acquired HIV/AIDS in the South-East Asia region; the majority of new infections occur in the age group of 15-24 years.

Most adolescents in many developing countries (including Bangladesh) do not practise safe sex.

STDs are often undiagnosed and untreated, especially in adolescent females.

Adolescent females are both biologically and psychosocially vulnerable to STDs.

Iodine Deficiency Disorder (IDD); Vitamin-A capsule (VAC) for lactating mothers, etc. The Bangladesh National Nutrition Council also plays a significant role in these issues. NGOS are also working on the issue of adolescent nutrition, e.g., *Concern* has developed the "Urban Nutrition and Food Security Program" for poor adolescents living in slums.

▪ **Protection against violence:**

Violence can be committed against adolescents by the family or at the workplace. From January to December 2002, the total number of acid attack victims was about 450 and rape cases about 1200. Of this adolescent rape and acid attack cases were around 643 and 114, respectively. Battery and verbal abuse cases are the most frequently reported. Most parents and community leaders suggest stepping up social awareness building activities to prevent such violence.

The GoB has enacted laws specifically prohibiting all forms of discrimination against women, including the Dowry Prohibition Act (1980), Cruelty to Women Act (1983), Family Court Ordinance (1985), Child Marriage and Divorce Registration Act, Women and Children Repression Prevention Act (1995), and the Acid Offenses Prevention Act (2002).

TT programs:

Tetanus Toxoid (TT) injections are given during pregnancy for the prevention of tetanus among the newborn. Around 13.7% of pregnant mothers below 20 years receive at least one dose and 71.8% receive two or more doses of the injection. The GoB undertakes and promotes initiatives such as TT school programs, TT camps and TT services provided at clinics.

Policies and programs for youths

The World Health Organization defines youth as the period of life spanning the ages between 15 and 24 years. Adolescence constitutes a major part of youth. The GoB has initiated different policies and activities for this youth group, which also covers adolescents.

National Youth Policy:

To combat the challenges of the 21st century the government has taken steps to update the existing National Youth Policy (addressing individuals 10-24 years of age). In this respect, a national level Youth Policy Formulation committee has been formed.

National Youth Day:

A decision has been taken to celebrate National Youth Day on 1st December. Successfully trained male and female

A study conducted in Kingston, Jamaica found that 17% of 452 random selected primary school girls between the ages of 13 and 14 reported having experienced an attempted or actual rape. A National study in Kenya surveyed 10,000 secondary school girls aged 12 to 24 and found that about 40% of those who were sexually active said they had been "tricked or forced" into having sex

Yet many adolescents do die prematurely. Every year, an estimated .7 million young men and women between the ages of 10 and 19 lose their lives mostly through accident, suicide, violence, pregnancy related complications and illness that are either preventable or treatable.²

youths who can show exemplary contribution on self-employment projects are awarded the National Youth Awards. So far 123 successful male and female youths have received such awards.

Commonwealth Youth Program:

The Department of Youth Development organizes distance training courses, workshops, seminars, youth exchange programs, etc., with assistance of the Commonwealth Youth Program, Asia Centre. A total of 76 officers and youth leaders have so far obtained the Diploma in Youth Work and Development from CYP, Asia Centre. A diploma course is also being conducted by the Bangladesh Open University.

Advocacy on Reproductive Health and Gender Issues through the Youth Clubs project:

The objective of the project was to involve adolescents and young people in primary health care and other health related issues. The project has been implemented in 292 upazillas of 64 districts through 402 youth clubs of the country with financial assistance from UNFPA (Department of Youth Development, 2001).

Areas for Action

- One big challenge is to introduce appropriate services for married adolescents that address difficult subjects, such as sexuality. Both men and women need to be prepared for a healthy reproductive life through education about premarital sex and the risks associated with unsafe practices. Community leaders, including religious leaders, need to learn about the risks of early marriage and consequences of early childbirth. The immediate policy implications are:
 - Bangladesh has a marriage law that sets the age of marriage at 18 through with parental consent it can be 16 years. This law needs to be enforced and strengthened to protect the reproductive health of female adolescents. Policy makers should take necessary steps to publicize the law and enforce it;
 - There is an emerging trend of contraceptive use prior to the first birth. This should be encouraged by the national programs through information and services specifically designed for newly married couples or those about to be married. Field workers should give special emphasis on reaching these couples. Special events, such as village fairs and street dramas for newlyweds, with health education as theme, should be organized at clinic and community levels;

Some proposed youth projects include:

- Projects for land acquisition and construction of a Juba Bhaban (Youth Center)
- Community development through youth clubs
- Rural training project
- Socio-economic upliftment projects for young people in the Chittagong Hill-Tracts.
- Entrepreneurship development project for the educated unemployed youth, etc.

Besides these there are many other programs for adolescents and youths have been undertaken in Bangladesh with the cooperation and assistance from UNDP, UNFPA, ESCAP, ILO, UNESCO, JICA and KOICA.

The national program should encourage the use of media to disseminate messages about safe sex before and after marriage. The radio seems to be particularly effective at reaching young people;

- Data on the reproductive health knowledge and behavior of unmarried adolescents should be enriched to develop appropriate information and service programs. Adolescent programs should include social messages about gender equity in relationships, delaying sexual initiation as well as marriage, and other essential reproductive health messages;
- In-depth information on reproductive health-related knowledge, attitude and practices among unmarried adolescents needs to be collected;
- More programs should be designed to target adolescent boys;
- Efforts to improve services for adolescents should be complemented with campaigns targeting elders in the community (e.g., parents, guardians, teachers);
- Mothers and female guardians/ and other family members need to be informed about the consequences of malnutrition and early marriage of adolescent girl;
- Appropriate policy and programmatic measures should be undertaken immediately to reduce the incidence of early childbearing;
- More concerted family planning programs focused specifically on newly married adolescent couples are needed;
- Pre-marital contraception counseling for adolescents should be reinforced;
- Community leaders need to be more involved in providing information to adolescents about the bad outcomes of late marriage, drug abuse, pre-marital sex as well as information on the prevention of STD/HIV/AIDS, etc., to ensure a healthy future.

Alor Pothe Amra
(Towards Enlightenment)
Adolescents' Reproductive Health Curriculum



Target Audience

- In-school adolescents of grades 8, 9 and 10
- Out-of-school adolescents (13 to 19 years old)

Curriculum Content

- Introduction
- Changes during adolescence
- Personal Hygiene
- Environment and safe water
- Food and nutrition
- Gender
- Population
- Marriage law and legal rights
- Sexual relations and sexual abuse
- Drug abuse
- Reproductive Tract Infections, sexually transmitted infections, HIV / AIDS
- Childbirth and family planning
- Prenatal, natal and postnatal care
- Child health and immunization

Curriculum Implementers

- Teachers of grades 8, 9 and 10
- Health ambassadors (peer educators)

Curriculum Structure

- 14 chapters
- 17 sessions
- Average forty-five minutes per session
- Didactic and participatory methods.

CHAPTER SIX

Addressing STIs / HIV / AIDS

Sexually transmitted infections (STIs) represent a major public health problem in developing countries, including Bangladesh. Millions of individuals, especially women and girls in these countries suffer from STIs and reproductive tract infections (RTIs) and in most cases do not receive proper care. RTIs /STIs are a significant cause of morbidity and mortality in both men and women, especially in women of the reproductive age.

Prevalence of STIs / RTIs

Though the prevalence of RTIs /STIs is still underestimated, these diseases are emerging as a growing public health problem in Bangladesh. Amid lack of literacy, the conservative environment associated with various religious, cultural and social taboos acts as major obstacles to obtaining information about the actual situation of RTIs and STIs. As a consequence, widespread RTI/STI transmission continues due to risky sexual behavior, gender and power imbalance, shame and stigma, and weakness in the health care system. (Khan R F and Akhter H H, 2001)

The actual incidence and prevalence of RTIs / STIs are difficult to measure because many of the patients suffering from RTIs / STIs conceal their diseases. Female commercial sex workers (CSWs) are considered to be an important source of STIs and a high-risk population for STIs and HIV. In Bangladesh, there are approximately 100,000 CSWs who are distributed over urban, semi urban and rural areas. They are either organized in brothels or work as independent sex workers (Choudhury M R, et al., 1997). An etiological study of STIs was conducted among female commercial sex workers in 1998 in Dhaka, which showed that 84% were positive for the STI pathogens studied. Among the STI positives 35.5% were positive for *N. gonorrhoeae*, 25% were positive for *C. trachomatis*, 45.5% were positive for *T. vaginalis*, 32.6% were seropositive for *T. pallidum*, 62.5% were seropositive for HSV-2, and 51% had infections with two or more pathogens (Rahman M et al., 2000).

However, the prevalence of these STIs is relatively low in the general population. *N. gonorrhoeae*, *C. trachomatis*, and *T. vaginalis* infections constituted only a minority of the RTI among married women attending a basic healthcare clinic in Dhaka. The overall prevalence rate of *N. gonorrhoeae*, *C. trachomatis*, *T. vaginalis* and *T. pallidum* was 0.5%, 1.9%,

STI accounts for 15% of the total disease burden worldwide (WHO) and affect both men and women. It is estimated that there are 333 million new cases of STIs per annum and that 10 to 15 million people are infected with human immunodeficiency virus worldwide every year. Southeast Asia is an important area for STIs, with an estimated 150 million new cases in 1995 (WHO, 1995).

2.0%, and 2.9%, respectively. Overall, 35% of the women had antibodies to Hepatitis B core antigen, 0.9% had HCV, and 12% HSV-2 infection. Repeated serological examination indicated that only 32% of women with serological evidence of syphilis had active disease. Risk factors for *N. gonorrhoeae*/*C. trachomatis* infection were husband not living at home or suspected of being unfaithful. HSV-2 infection was associated with the same risk factors and with a polygamous marriage (J Bogaerts et al., 2001). A population based survey of RTIs/STIs prevalence which was conducted in a rural area also showed low prevalence of STIs, with only 3% of married women having a current infection (including 1% with chlamydial infection or gonorrhoea), and 1% of men having either chlamydial infection or recent/untreated syphilis infection (Hawkers S et al., 2002). Under a hospital based study when the blood samples of 800 pregnant women who came for antenatal check-up were analyzed by the Rapid Plasma Reagin (RPR) method and by ELISA, they indicated a low prevalence of syphilis (3%) and high levels of HBsAg positive (5.5%), and anti-HCV positive (3.4%), respectively. None of them was HIV positive (Hussain M et al., 1997).

Bangladesh, like many other developing countries in the world, is undergoing rapid urbanization accompanied by high rates of internal and external migration. Male out-migrants are mostly young, less educated, single, and seek job opportunities abroad, mainly in Asian countries. A medical screening of 43,213 Bangladeshi job seekers was carried out during the period 1994 to 1996. Serological tests revealed that 4.4% of individuals were positive for hepatitis B surface antigen (HbsAg), 1.7% for *Treponema pallidum* hemagglutination (TPHA) and only 0.2% for antibody to human immunodeficiency virus (anti-HIV). These results may represent a cross-sectional view of the prevalence of different infectious diseases and abuse of drugs among the young adult population of Bangladesh (Rumi MAK et al., 2000).

Truck drivers have been identified as having high-risk life styles for STDs. As elsewhere, work conditions in Bangladesh for truck drivers and helpers are conducive to high-risk sexual activity (frequent absences from home and easy access to sex workers located near truck stops). The high prevalence of HSV-2 (25.8%), and to a lesser extent syphilis (5.7%), and the lower levels of condom use (73% never using) despite high numbers of casual sexual partners (54%), illustrate the importance of promoting condom use, particularly in commercial sexual encounters, to men in Bangladesh's trucking industry (Gibney L et al., 2002). The level of HSV-2 (32%), syphilis (5.7%) and gonorrhoea (6.3%) infections among the women living in close proximity to truck stands was very similar to the rate in a cross sectional population based study conducted between January and December 1998 at

Reproductive tract infections (RTIs) are a group of diseases that cause infection of the genital tract and include sexually transmitted infections (STIs), non-sexually transmitted infections like endogenous infections caused by the overgrowth of the organisms normally present in the reproductive tract, and iatrogenic infections caused by improperly performed procedures. RTIs are distinct from STIs as the former include all infections of the reproductive tract, whether transmitted sexually or not. On the other hand, pathogens, which are commonly transmitted by sexual contact (human immunodeficiency virus (HIV), hepatitis-B, C, D, etc.), do not necessarily cause an infection of the reproductive tract. These RTIs / STIs expose individuals to serious consequences such as enhanced HIV transmission, ectopic pregnancy, infertility, adverse outcomes of pregnancy, cancer, and even death. RTIs / STIs include infections or diseases such as syphilis, gonorrhoea, chancroid, granuloma inguinale, lymphogranuloma venereum, chlamydial infections, herpes genitalia, ano-rectal herpes, warts, trichomoniasis, genital candidiasis, molluscum contagiosum, pediculosis, scabies and AIDS.

at the Tejgaon truck stand in Dhaka (Gibney L et al., 2001).

As in the developing world, drug addiction is increasing in Bangladesh. The sexual life of addicts is in a vulnerable state where risky sex behaviour is common. A found that seven percent of the addicts were found to be bisexual, where 87% of them had multiple sex partners of either commercial or residential category. Most of the drug addicts (72%) did not use condoms and 57% of them were observed to have sexual diseases. The drug addicts (38.7%), who used mostly injection (87%) shared needles. Young adults (79%), secondary educated (46%), low-mid income (60%), businessmen (46%) and married people (60%) were found to be highly involved in addiction. Curiosity and friend's incitements (50.2%) were revealed as the most important influencing factors for taking drugs. Frustration, poverty, family breakdown or instability, etc., are also found to influence addiction (Islam Sk N et al., 2000).

Table-6.1 compares the RTI/STI prevalence (including Syphilis, Gonorrhoea, Chlamydia, Herpes Simplex 2, Hepatitis B, Trichomoniasis, Bacterial Vaginosis) rates for different population groups identified from a collection of nearly 70 RTI/STI related studies other than the National Surveillance surveys.

Table-6.1

RTI/STI prevalence information for Different Population Groups reported by Various Studies other than the National Surveillance surveys

Study Population	Percent	Number
Brothel based female sex workers	6.8-57	296
Street based female sex workers	84	269
IDU	4-28.6	241
Pregnant women	3-5.5	800
Women (non-sex worker)	1.6-32	384
Female patient	2.3-54	1534
Female patients with vaginal discharge	2.3-47	345
Truck driver and helper	0.8-25.8	388

Source: Rob U et al., 2002.

In the studies reviewed, the RTI/STI prevalence rate for street based female sex workers was 84%, while it was between 6.8% and 57% for brothel based sex workers. Among the injecting drug users (IDUs) the RTI/STI prevalence rate was between 4 and 28.6%. The range of RTI/STI prevalence rates varied mostly for female general patients, female patients with

vaginal discharge, and truck drivers including helpers. RTI/STI prevalence rates varied between 2.3% and 54% for female patients, between 2.3% and 47% for females with vaginal discharge, and between 0.8% and 25.8% for truck drivers and their helpers (Rob U et al., 2002).

Knowledge and behavioral indicators related to RTIs / STIs

In Bangladesh, the majority of men still do not use condoms in commercial sex encounters, and the female sex workers report the lowest condom usage in the region. The alarming reality is that about two-thirds of the rickshaw pullers and truck drivers surveyed during 4th round (2002) of national HIV and behavioral surveillance, had never used a condom even once and very few even realized that they were at risk of exposure to HIV. About 36% of the brothel based sex workers used condom at last commercial sex with new clients and only 27.2% used condom with regular clients. The percentage of condom use at last commercial sex with female among truckers was 23.4% and among students 35.3% in 2001-2002 (MOHFW, June 2003). At an average of 18.8 clients a week, sex workers in Bangladesh brothels report among the highest turnover of partners anywhere in Asia, and among hotel based sex workers it is higher still, averaging 44 clients a week (FHI, 2001).

There is also a trade in sex between males. Hijras and other males sell sex to a wide range of clients, and men have sex with one another without payment, too. In Central Bangladesh, among the truckers and rickshaw pullers 9.8% and among MSM 24.9% used condom at last commercial sex with male/hijra (MOHFW, June 2003). It is worth nothing that current levels of condom use are low by any standards. Almost everyone buying sex in Bangladesh is having unprotected sex some of the time, and a large majority are having unprotected sex most of the time.

General people having STIs initially keep it secret and when they start facing problems they would first discuss with their friends, relatives or elders. At the primary stage they go to the traditional (kobiraj/hekim) and faith healers, quacks and roadside medicine vendors. They go to the qualified doctors only when the condition becomes severe. In the clinic-based RTI study it was found that 6% of clients attending Health and Family Welfare Centres (H&FWCs) and Satellite Clinics (SCs) sought services for RTI symptoms (e.g., white discharge, genital itching/burning, etc.); half of the RTI clients did not know the causes, modes of transmission, or means of prevention of RTIs; and one-third of the female RTI clients reported that their husband had some kind of genital problem (Khan R F et al., 2001). In a study among 540 street based

The Government of Bangladesh set up a surveillance system in 1998 to track sexual and drug taking behaviors that carry the risk of STIs / HIV infection. The serological and behavioral surveillance was carried out among groups of men who are clients of sex workers, male and female sex workers and transgenders, men having sex with men (MSM) as well as injecting drug users.

The country has been divided into 5 areas for the purpose of this survey: Central, Northeast, Northwest, Southeast and Southwest. The 3rd and the 4th rounds of national HIV and behavioral surveillance showed high prevalence of ulcerative STIs especially in the IDUs which indicate the increased risk of HIV spreading in the country. Among the IDUs the syphilis prevalence rate changed from 18.2% in 2000-2001 to 19.4% in 2001-2002 at a site in Central Bangladesh. The 4th surveillance also showed that the IDUs also had very high rates of Hepatitis C (ranging from 59.8% to 79.5%). But the reported level of syphilis among the brothel based sex workers decreased from 43.2% in 2000-2001 to 40% in 2001-2002 and at the same time for street based sex workers, syphilis prevalence rate decreased from 42.7% in 2000-2001 to 29.8% in 2001-2002.

The syphilis rate among male sex workers decreased from 18.2% to 14.2% and among MSM from 5.3% to 3.7% in 2000-2001 and 2001-2002 accordingly. Hotel based sex workers, many of whom are new to the trade, had the lowest syphilis rates (11.4%) among the female sex workers in 4th surveillance. Among the male clients of sex workers, *babus* (permanent customer) had the highest rates (23.0%) of syphilis as might be expected. Truckers (7.0%) and launch workers (5.0%) also had higher rates of syphilis at a site in Central Bangladesh in 2001-2002 (MOHFW, 2001 and 2003).

CSWs in Dhaka, 29% of these women were not treating their symptoms and the highest proportion (48%) had bought medicine at pharmacies or medicine shops, followed by traditional practitioners at 36% (Wasserheit J N, 1998).

Table 6.2 show the percent distribution of the ever-married women and currently married men by knowledge of signs and symptoms associated with sexually transmitted infections (STIs) other than HIV / AIDS, according to background characteristics. Eighty-nine percent of women and 81% of men did not know of any STI other than AIDS. Although about 6% of respondents knew about STIs, they were not aware of any symptoms of STIs. Nine percent of men and 2% of women were able to cite two or more symptoms of STIs.

Table 6.2
Knowledge of specific signs or symptoms among ever-married women and currently married men

Background Characteristics		Knowledge of specific signs or symptoms			
		Ever married women (%)		Currently married men (%)	
		No knowledge of STI	Knows one symptom only	No knowledge of STI	Knows one symptom only
Residence	Urban	82.8	4.0	73.4	3.9
	Rural	90.7	2.3	83.1	3.8
Division	Barishal	88.2	1.9	85.1	1.5
	Chittagong	91.6	1.9	79.5	3.2
	Dhaka	85.1	3.7	77.1	5.7
	Khulna	87.4	2.6	78.9	4.1
	Rajshahi	92.7	2.3	85.6	2.6
	Sylhet	91.6	1.7	90.1	1.5
Education	No education	92.8	2.2	91.0	2.8
	Primary incomplete	90.0	2.3	90.1	2.4
	Primary complete	90.0	3.0	87.0	2.0
	Secondary+	81.5	3.6	64.0	6.1
Total		89.1	2.7	81.2	3.8

Source: Mitra and Associates, and ORC Macro, 2001.

Initiatives taken for the prevention and treatment of STIs

In both urban and rural areas there are limitations, particularly in government facilities, to provide quality and comprehensive services for RTIs/STIs. By 2002, about 5,000 health personnel had been trained. This number is however quite small compared to the need. It is estimated that only about 18% of all doctors, 15% of nurses, about half of the lab

technicians and almost all the managers received training on syndromic management of RTIs/STIs (Haider S J, 2002). There are also limitations in the availability of necessary logistics (drugs and instruments) of the syndromic approach. Besides, providers of these facilities are not skilled in risk assessment, physical assessment, physical examination, counseling and partner management. There are also constraints with privacy and confidentiality. Therefore, in the government facilities, particularly at the rural level this approach has not been organized till date (MOHFW, 1999). However, following the training the reported number of STIs cases being managed at different levels of government facilities has increased, although there is absence of a comprehensive Management Information System (MIS).

In Bangladesh like other developing countries the centers for disease control have recommended a first-line therapeutic regimen based on fluoroquinolones and cephalosporin. Despite a sharp decline in the incidence of gonococcal infection during the last decade, antimicrobial resistance in *N. gonorrhoeae* has become a major public health problem.

A study concerning the prevalence of gonococcal infection among CSWs was conducted in Bangladesh. Some 66% of the isolates were resistant to penicillin, and 34% were moderately susceptible to penicillin. Among the resistance isolates, 23.4% were penicillinase producing *N. gonorrhoeae* (PPNG). Sixty-one percent of the isolates were resistant and 38.3% were moderately susceptible to tetracycline, 17.5% were tetracycline resistant *N. gonorrhoeae*, 11.7% were resistant and 26.6% had reduced susceptibility to ciprofloxacin, 2.1% were resistant and 11.7% had reduced susceptibility to cefuroxime, and 1% were resistant to ceftriaxone. Since quinolones such as ciprofloxacin are recommended as the first line of therapy for gonorrhoea, the emergence of significant resistance to ciprofloxacin will limit the usefulness of this drug for treatment of gonorrhoea in Bangladesh (Bhuiyan B U et al., 1999). Again the positive predictive value of the algorithm for cervicitis was extremely low (about 5%). The syndromic approach for vaginal or cervical discharge at the primary health care level in Bangladesh should focus on vaginal infections and not on cervicitis (Bogaerts J et al., 1999).

The advantages of syndromic management include immediate care, treatment at the first visit, cost saving for not using expensive laboratory tests, and an increased client satisfaction. The main disadvantage of syndromic management is the cost of over-diagnosis and over treatment when multiple antimicrobials are given to a patient with no or only one infection. The high rate of over treatment in the population studied carries both financial and social costs.

There are three approaches for the treatment of any disease including of RTIs/STIs: clinical, etiological and syndromic. Clinical and etiological approaches are only possible in selected urban facilities where the services of expert clinicians and expert pathologists together with facilities are available. The World Health Organization/Global Prevention of AIDS (WHO/GPA) has developed a set of standard syndromic flowcharts that take into account the most common etiologies for each syndrome. The NIPHP of the Ministry of Health and Family Welfare has developed a technical standard and service-delivery protocol for the management of RTIs/STIs. This protocol is used by the providers at the primary-level health facilities. In developing countries, laboratory diagnosis of most conditions can be difficult, and is often unavailable in the setting of primary health care (PHC) clinics. The Syndromic management of RTIs/STIs in low-resource settings is a practical tool of diagnosis and treatment for health workers. The syndromic approach is thought to be simple, feasible and cost effective.

There is a social cost in potentially exposing women misdiagnosed as having an STI to threats of domestic disruption or even violence (Hawkes S et al., 1999). A recently conducted validation exercise showed that the flowchart in the syndromic management protocol (with and without speculum) needed further modifications and should put emphasis on the specificity and sensitivity for cervical infections by using the speculum. The study result may put additional contribution to the efforts of standardization and improvement of the management of vaginal and cervical infections (Rahman S et al., 2002). NGOs are an important source of RTI/STI service delivery particularly in the urban areas as a part of the ESP programme in the field of reproductive health.

RTI/STI related interventions implemented by NGOs are of two kinds: communication related and provision of services. The NGO Service Delivery Programme (NSDP), a countrywide programme funded by USAID and implemented by 42 NGOs, is a large urban-based NGO programme covering 14 districts, and interventions by a number of other small NGOs include strong components of RTI/STI services. The STI/AIDS network that has a membership of 103 NGOs, mostly at the grassroots level, and includes NGOs who have interventions in the area of RTI/STI related communication and BCC.

In Bangladesh, the private sector providers are the first point of contact of patients in more than two-third cases. In rural areas, where the government has a well laid out infrastructure, only about 18% of service recipients accessed the government sector (Hawkes S et al. 2002). Though a significant proportion of the doctors in private practice are government employees, the knowledge of the syndromic approach has also remained confined to a handful of trained doctors in the government and NGO sectors, and has not been disseminated to the private sector.

HIV /AIDS

Estimated rates

The first HIV-positive case in Bangladesh was detected in 1998. According to Government sources, a total of 248 HIV positive cases have been reported mostly among males. So far 26 of these HIV infected patients have developed AIDS, among whom 20 have died (MOHFW, 2002). Thus, in 2002 a total of 60 new HIV/AIDS cases were detected by confirmatory tests: 37 (29 males and 8 females) at the Department of Virology, Bangabandhu Sheikh Mujib Medical University (BSMMU); 7 (6 males and 1 female) at BIRDEM; 6 (5 males and 1 female) Armed Forces Institute of Pathology

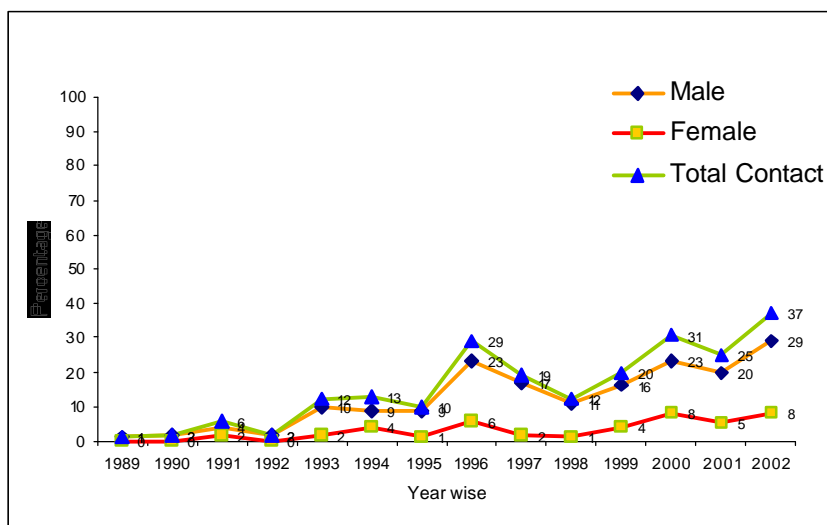
Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV has created a major global health crisis. The number of people living with HIV in the world today has risen to 42 million from 40 million at the end of 2001. According to a new UNAIDS and WHO update on the global HIV/AIDS epidemic, five million people were newly infected and 3.1 million people were killed by the disease in 2002.

In South and Southeast Asia, 6 million adults and children are estimated to be living with HIV/AIDS. In this region the largest number of people, about 4 million, are infected with HIV/AIDS in India. HIV infection was first detected in this region in Thailand in 1984 and in India in 1985. More than 95% of people infected with HIV live in developing countries (Population Reference Bureau, 2002). The impact of HIV/AIDS on a nation is tremendous. AIDS kills million of adults in their prime, thus weakening the workforce, fracturing and impoverishing families, and leaving millions of children orphaned, with concomitant effects on the whole political, social and economic fabric of a country (UNAIDS, 2002).

(AFIP); and 10 (7 males and 3 females) at ICDDR,B (UNAIDS, 2002). The Department of Virology, BSMMU, reported the detection of 219 HIV-positive cases on the basis of confirmatory tests up to December 2002 (Figure 6.3).

Figure 6.1

HIV/AIDS cases detected in Bangladesh at BSMMU as of 1 December 2002



Source: Department of Virology, BSMMU, 2002

AIDS was first recognized as a disease among the homosexuals in USA in 1981. In 2001, the world marked the 20 years of AIDS. Now it has become the most devastating disease that mankind has ever faced (MOHFW, December 2002). HIV/AIDS can be transmitted by many ways. Sexual transmission occurs more frequently from male to female than female to male. Higher rate of transmission of HIV also occurs when a man has sex with another man. STIs aggravate the possibility of the transmission of HIV. The important means for HIV transmission are blood and blood product transfusion, contaminated syringe, needle and dental instruments, barber's razor, ear piercing, etc. HIV transmission also occurs from mother to baby during intra-uterine period and delivery. A baby can be infected by breast-feeding. The important infection materials, among others, are blood, semen, vaginal fluid and breast milk (South-South Centre, 2000).

Modes of Transmission

The reason for great concern in Bangladesh is the increased mobility of the economically productive people, particularly men within and outside the country during the last two decades. Most of these migrated people live alone keeping their spouses at village homes. The adult people who remain away from families are among the high risk groups who go for unsafe sex leading to infections like Reproductive Tract Infections (RTIs) / Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Viruses (HIV). (South-South Centre, December 2000)

Table: 6.3

Prevalence and estimated number of HIV/AIDS cases in SAARC countries

Countries	Adult prevalence rate (15-49 years), end-2001	Estimated number of people living with HIV/AIDS, end-2001		Children orphaned by AIDS (0-14 years), 2001
		Adults and children (0-49 years)	Children (0-14 years)	
Bangladesh	<0.1	13,000	310	2,100
Bhutan	<0.1	<100	-	-
India	0.8	3,970,000	170,000	-
Maldives	-	-	-	-
Nepal	0.5	58,000	1,500	13,000
Pakistan	0.11	-	-	-
Sri Lanka	<0.1	4,800	<100	2,000

Source: The State of The World's Children 2003, UNICEF.

(Note: - Data not available)

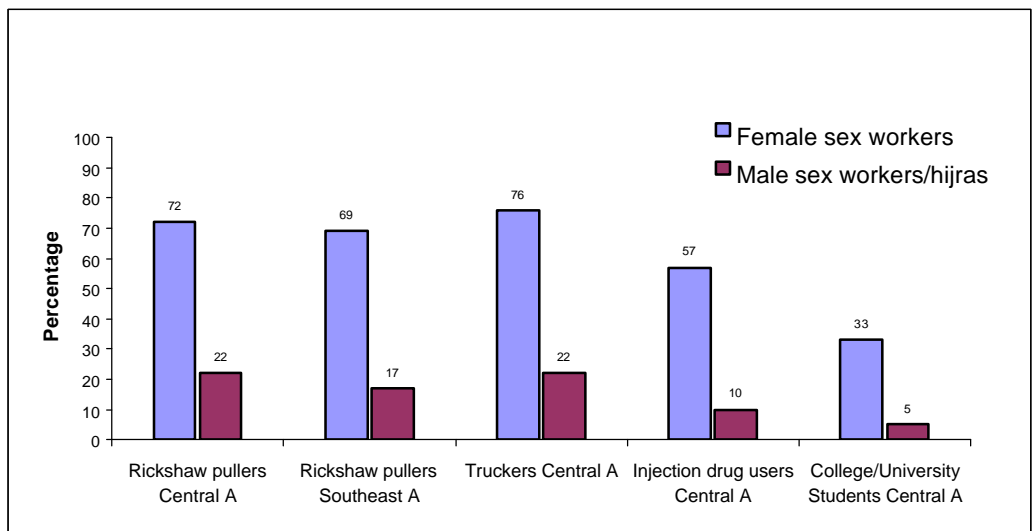
All of the known HIV-risk behaviors and factors – Commercial Sex Workers (CSWs), Men who have sex with Men (MSM),

Injecting Drug Users (IDUs) and high rates of STI – are acknowledged to be present in Bangladesh. As a result, there is an increasing concern that a marked epidemic of HIV might occur in a manner similar to that witnessed in the neighboring countries. Predictions that HIV would reach epidemic proportions in Bangladesh if the high-risk behavior continued have come true. The 4th surveillance has detected 4% HIV infection among IDUs in Central Bangladesh – just short of the 5% mark of a concentrated epidemic. The number of IDUs is also increasing and needle sharing continues to be routine among them.

In the past five years, every year roughly 10 to 20% of the drug users were new injectors. In the Southeast part of Bangladesh this is even worse. Sixty percent of all injectors started injecting in the last two years. Evidence shows that some of this influx to injection drugs is due to drug users switching to injecting after taking other drugs for four to five years. IDUs are not isolated, rather they are linked in with the rest of society – they have regular sex partners, they buy sex from women, as well as other men, they sell blood, and they also move between cities (MOHFW, June 2003).

Commercial sex is still very widespread in Bangladesh. Women work in brothels, in hotels and in their own homes, they meet clients on the streets or at massage parlours, beauty parlours, or over the telephone. The clients are equally diverse. They range from the unemployed, laborers and transportation workers to students, civil servants and businessmen. Some are married, and many have very high number of sex partners, both paid and unpaid.

Figure 6.2
Men reporting commercial sex in 2002



Source: MOHFW, June 2003.

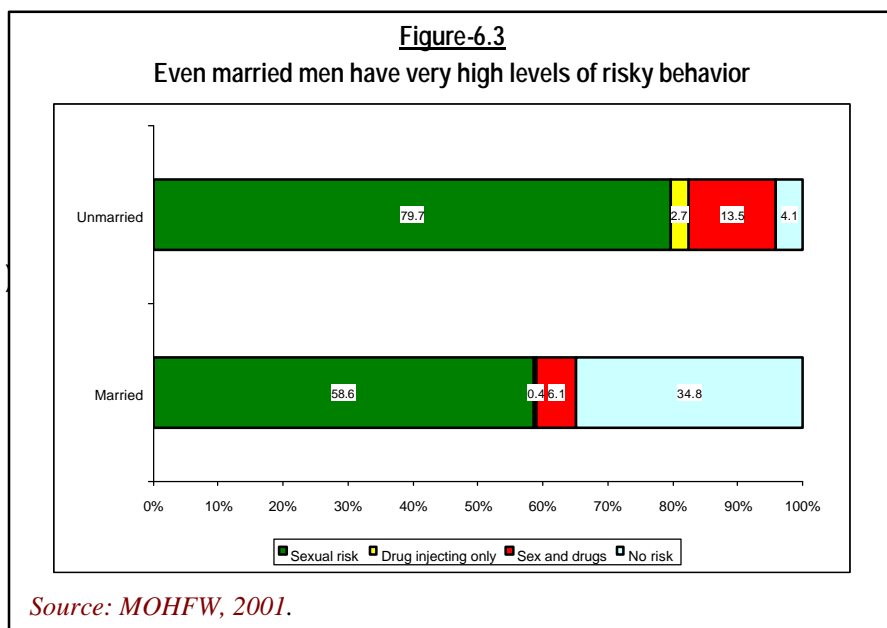
As Figure 6.2 shows, about three-quarters of truck drivers and rickshaw pullers, and 60% of male injecting drug users reported sex with female commercial sex workers in the past year. A significant percentage of these male groups also buy sex from male sex workers. There has been almost no change observed in this behaviour since it was measured previously in 3rd surveillance where 69.4% of truck drivers and 68.6% rickshaw pullers reported sex with female CSWs in the last month. The prevalence of this type of behaviour among IDUs in 2000-2001 was 32.8% that was far less than recent. The daily client turnover of female sex workers in Central Bangladesh is among the highest in Asia. Hotel based sex workers average as many as 44 clients per week, and nearly one in five report having clients who inject drugs.

With regard to the other risky behavior among the IDUs, i.e., needle-sharing – despite the presence of a large number of NGOs offering needle exchange services, and fairly high coverage through programmes in Central (46%) and Northwest (88%) Bangladesh, drug injectors still routinely share needles (Guinness et al., 2002).

The 4th round of behavioral surveillance revealed that about 15% rickshaw-pullers in Central Bangladesh and 14.4% in South-eastern Bangladesh and 15.9% truckers and 9.7% IDUs in Central Bangladesh had sex with a hijra or other male in the last month.

Conversely, many people may be exposed to high-risk behavior even when they themselves do not engage in it. As Figure-6.3 shows, a majority of married men reported unprotected sex with a sex worker, street girl, a hijra or another man in the past month, and several also reported injecting drugs. Almost all of these men had had sex with their wives in the last week. Even if none of these women have any risk behaviours besides having sex with their husbands, a total of two thirds are exposed to the risk of STDs, HIV and Hepatitis through their husband's behaviour (MOHFW, Nov 2001)

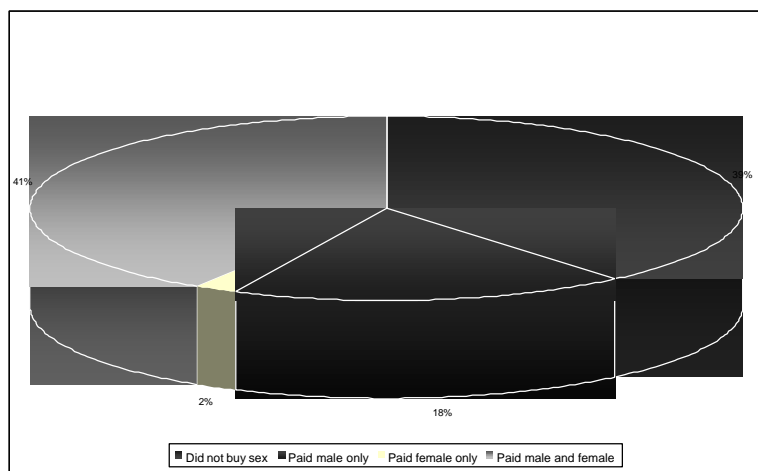
Virtually all male sex workers used a condom occasionally when selling anal sex, but almost none used condoms all the time. Anal sex – the most common



sexual practice between males – carries a large risk of membrane trauma, which helps HIV to spread easily. If HIV begins to spread rapidly among men who have sex with men, as Figure-6.4 suggests it may also spread rapidly into the population of female sex workers. Most of these women probably do not know that their clients are also having sex with men (ibid.).

Figure-6.4

Many men who have sex with men also go to female sex workers



Source: MOHFW, 2001.

Table 6.4 presents the prevalence rates for syphilis and HIV in high-risk groups tracked by the 3rd and the 4th round of national HIV and behavioural surveillance in Central Bangladesh. The data reveal low prevalence of HIV and high prevalence of ulcerative STIs which indicate an increasing risk of HIV spreading in the country.

The prevalence of HIV among the brothel based female sex workers was found in 2000-2001 to be between 0.3 and 0.5%. As for street based sex workers, the HIV prevalence rate went down from 0.5% in 2002-2001 to 0.2% in 2001-2002. For IDUs, the HIV rate increased from 1.7%

Table 6.4
Prevalence rate of syphilis and HIV in Central Bangladesh in 3rd and 4th round of national HIV and behavioral surveillance

Study Population	Syphilis (percent)		HIV (percent)	
	2000-2001 (3 rd)	2001-2002 (4 th)	2000-2001 (3 rd)	2001-2002 (4 th)
IDUs	18.2	19.4	1.7	4.0
Heroin smokers	-	13.9	-	0
Brothel based sex workers	32.2-43.2	-	0.3-0.5	-
Street based sex workers	42.7	29.8	0.5	0.2
Hotel based sex workers	-	11.4	-	0.2
Truckers	5.7	7.0	0	0
Male sex workers	18.2	14.2	0	0
Hijra	-	34.9	-	0.8
Men having sex with men	5.3	3.7	0	0.2
Babus	-	23.0	-	-

Source: MOHFW, 2001 and MOHFW, June 2003.

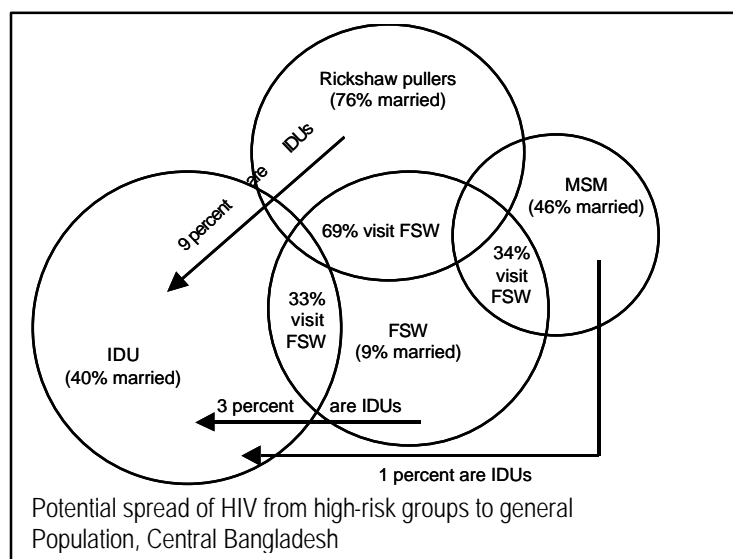
in 2000-2001 to 4.0% in 2001-2002. No case of HIV was found in both these rounds for truckers. Only a small percentage of MSM (0.2%) and hijra (0.8%) were reported to be HIV positive in 2001-2002, but none in 2000-2001.

Even though condom is widely available and despite the AIDS awareness and condom promotion programmes being conducted by several NGOs, the level of condom use is still low among the high-risk population. The high-risk subpopulation using condom at last commercial sex with females were IDUs (29.3%), rickshaw pullers (12.2%), truckers (23.4%), and students (35.5%). Only 12.7% of IDUs, 1.2% of rickshaw pullers, 11.2% of truckers, and 30.2% of students consistently used condom with female commercial partners in the past year (MOHFW, June 2003). The findings clearly indicate that condom use is infrequent. In Bangladesh, condom is widely known as a contraceptive method, but unless it is regularly used, the risk of RTI/STI as well as HIV/AIDS infection will rise greatly.

The potential of spread of HIV from high-risk groups to the general population in Central Bangladesh is depicted in figure 6.5 which shows that the clients of female sex workers include rickshaw-pullers, men who have sex with men, and injecting drug users. Many of these client groups are married. Therefore, once HIV enters any one of these communities, it has the potential to spread rapidly into the general population.

Monitoring the AIDS Pandemic (MAP), in their Provisional Report on the Status and Trends of HIV/AIDS/STIs Epidemics in Asia and the Pacific, explained how risk behaviours among vulnerable groups of population in an area with apparently low prevalence of HIV can accelerate the transmission of the disease to reach an epidemic level within a short time.

Figure 6.5
Potential spread of HIV from high-risk groups to general population, Central Bangladesh



Source: ICDDR,B, 2001

A safe and effective blood transfusion service is an essential component of the infrastructure required for providing

adequate health services. The GoB is committed to ensuring that all patients have access whenever needed to adequate, appropriate and safe blood. Despite the initiatives, policy guideline and legislation, blood transfusion practices in the country are complex, and conducive to transmission of RTI/STI infections.

According to a Population Council report, almost no rules are followed by the private blood banks for the collection, testing, processing, storage and distribution of blood. Medical histories and a history of risk behaviour, drug use or blood donations are not obtained routinely, and donated blood is not screened for HIV, hepatitis B or C. As of 1996, approximately 200,000 units of blood were reportedly used for transfusions every year in Bangladeshi hospitals and clinics. Most of the blood is donated by professional blood donors (PBDs) who representing an estimated 65-90% of the supply (Hossain S M I et al., 1996). Sandhani, an organization of medical students that campaigns for voluntary blood donation, reported that 65% of the annual blood donations came from 1000 repeating professional donors (Gibney L et al., 1999). These donors had been selling blood for varying time periods, from one week to 40 years. When queried about the maximum number of units they had sold in a single day, it was reported that 0.7% had sold 5 units, 12.2% had sold 4 units, 16.3% had sold 3 units, 32.3% had sold 2 units, and 38.5% had sold one unit. Particularly alarming with respect to their potential as carriers of HIV is the lifestyle of many of these PBDs. Sixty one percent of the PBDs in a study were found to be addicted or habituated to some drug or substance. Of this 61%, as many as 82% used marijuana, 39% liquor, 15% heroin (smoked), 14% sedatives, and over 2% intravenous pethidine. Thirty three percent and 73% of the PBDs reported that they had engaged in extramarital and premarital sex respectively, with CSWs being the primary partners in extramarital sex. Over 30% of the donors interviewed had suffered from penile ulcers or purulent urethral discharge. Ten percent of the PBDs had risky sexual behavior. Of them, 24.1% reported oral and anal sex, 82.8% men who have sex with men, and 17.2% bisexual relationships (Hossain S M I et al., 1996).

Sexual intercourse during menstruation, a practice associated with increased risk of transmission and acquisition of the HIV virus is also not culturally sanctioned, though it may exist in these PBDs. But there is a protective factor present in Bangladesh. As a predominantly Muslim nation the men are generally circumcised. While evidence of a relationship between circumcision and HIV infection is not consistent, many studies have found significant associations or evidence of trends between being uncircumcised and HIV seroconversion (Gibney L et al., 1999.)

Adolescents and HIV/AIDS

In Bangladesh, extramarital and premarital sexual activity, especially among younger males, is on the rise. It has been found in a study that with the exception of married and unmarried adolescent women in rural areas, all categories of respondents had increasing prevalence of premarital sexual intercourse with increasing age or age at marriage (Haider et al., 1997). The majority of the urban unmarried males (88%) had already experienced premarital sexual intercourse at all ages and large minorities of urban unmarried women (47%) had already experienced sexual intercourse by their late teens if they had not yet married.

Husbands of adolescent women were enquired if they had had extramarital sexual experience. For both in urban and rural locations at least one in six men married for five or more years acknowledged having extramarital experience. Of those who had sex with partners outside of marriage, 71% mentioned CSWs, 40% mentioned girlfriends and 15% mentioned other partners. As in the case of premarital sexual experience, very few women admitted to have extramarital experience. The female adolescents demonstrated better knowledge about the process of transmission of RTI compared to their knowledge on STDs. On the other hand, the male adolescents and the husbands showed better knowledge on the process of transmission of STDs than that on RTIs. Unmarried adolescents, males or females, and husbands demonstrated better knowledge on the process of transmission of AIDS than the female married adolescents (Ibid.).

There is much evidence that HIV infection among drug users does not remain confined to the persons. An increasing cross over is being observed in some countries as in India, Thailand and Bangladesh, between IDUs and CSWs, which contributes to the spread of the virus to the clients. This together with the sexual networks among the drug users and the sharing of injecting equipment, increases the risk of HIV infection not only among the drug users but also facilitates the transmission of the virus to their partners, wives, and to their children (UNICEF, March 2002). The majority of the drug users (79%) are young adults (Islam Sk N et al., 2000) and prevalence of HIV was found to be 2.5% among the IDUs (Azim T et al., 2000). This is a great concern for Bangladesh. The major factors which increase the vulnerability of young people to both drug use and to HIV infection are closely linked to rising poverty and decreasing vocational training, employment options accompanied by changes in values and breakdown of communication within families.

Though many of the adolescents have heard about HIV/AIDS, most of them live in a traditional context, with few discussions regarding reproductive health in the family, community,

Adolescence represents a window of opportunity to prepare for a healthy adult life. Adolescents lack information and understanding about their own sexuality. Both the male and female adolescents are found to be almost equally vulnerable, the girls being especially more vulnerable. Boys suffer from peer pressure to indulge in early sexual activities, smoking and drug abuse to prove that they are men. As they mature and become sexually active, know little about STI/AIDS, and cannot identify diseased partners, they are vulnerable to contracting RTIs/STIs/HIV. In early initiation of sex, adolescents are more likely to have multiple sexual partners. In addition, STD pathogens can more easily penetrate the cervical mucus of adolescents than that of older women (Hossain et al., 1998). Although some adolescents appear to weigh the pros and cons of engaging in certain behaviors, not all decisions are made rationally. Much of adolescent participation in unprotected sexual intercourse may, in fact, be due to a simple failure to make a decision (or the making of default decisions) because of ambivalence about pregnancy or STIs, particularly among younger adolescents. As part of their decision-making process, adolescents often look to their teachers, peers, and school environment for clues regarding various aspects of sexual behavior and to evaluate the degree, to which their beliefs agree or disagree with group norms (Shahriar A et al., 1999).

school, and the media. They are bound by traditional values, but are increasingly exposed to alternative cultural norms. They also engage in premarital and extramarital sexual activities. Studies indicate that many children and adolescents are victims of sexual exploitation and abuse and are forced into unsafe sex. Sexual molestation does take place within the home and immediate community (Kabir R. 2001).

However, current government policies and cultural norms still limit the ability of healthcare providers to provide services such as condoms to unmarried young people. At the same time, unmarried adolescents rarely visit reproductive health services for fear of social stigma. Very few health interventions involve young people in decision-making and programming. Adolescent Family Life Education (AFLE) and Life Skills Education are the key interventions supported by donors for NGOs and civil society partners to improve reproductive health awareness, including HIV/AIDS. Some of the lead agencies working in Bangladesh in this area are: BRAC, CMES, CAAP, Save the Children Alliance, Aparajeyo Bangladesh, NSDP, Plan International, and FHI. Bangladesh Girl Guide Association supported by UNICEF, Bangladesh Centre for Communication Programme supported by USAID, Population Services and Training Centre (PSTC), Nari Maitree, ARISE- a programme for street children, etc., are also working for the adolescents. But their efforts are faced with many constraints. The change in behavior takes time, and involves several intermediate stages. When working on prevention of HIV/AIDS, parents, teachers, community leaders and religious leaders can act as gatekeepers to protect the new generations.

Human Rights and STIs / HIV / AIDS

In Bangladesh discrimination, stigmatization and relatively low access to human rights increase vulnerability to HIV infection and AIDS. Fear of discrimination often prevents people from seeking treatment for AIDS or admitting their HIV status publicly. People with HIV or those suspected of having HIV, may be denied employment, evicted from home by their families and rejected by their friends and colleagues. Generally people who are socio economically disadvantaged and deprived of their rights have little or no access to HIV/STD prevention programs.

Such human rights violation adds to stigmatization of persons having the highest risk of infection. They urgently need information, protection and preventive treatment. In Bangladesh such vulnerable groups include sex workers and their clients, injecting drug users, MSMs etc. Some data however suggest that therapeutic practices such as unsterile

The Bangladesh National AIDS policy acknowledges that persons most at risk of HIV transmission – such as sex workers, men who have sex with men, and injecting drug users – are essential partners in any successful fight against AIDS. Both sex workers and men who have sex with men are regularly abducted, raped, gang-raped, beaten, and subject to extortion by the police and by powerful thugs termed mastans. And even when rape is not part of the abuse, harassment of HIV/AIDS outreach workers directly interferes with efforts to disseminate information and build awareness of HIV and to distribute condoms and clean needles. More generally, the abuses faced by sex workers, men who have sex with men, and injecting drug users further alienate these already marginalized persons from society and decrease the degree of control they have over their own lives. They become more difficult to reach with prevention and care information and services and they are in less of a position to protect their own health and the health of others (HRW, August 2003).

injections and blood transfusions with tainted blood may also be risk factors (Gibney L et al., 2001). For many in rural Bangladesh appropriate treatment for STDs has not been obtained early due to the fact that medical personnel are not adequately trained in STD management. As a consequence, poorly informed health – care workers are uncomfortable discussing sexuality with patients. High rates of STDs and existing risk behaviors among CSWs in Bangladesh set the stage for an epidemic spread of HIV. The situation calls for implementing prevention program involving effective treatment of STD, condom and sexual health promotion for CSWs and other high-risk populations in Bangladesh. Actions should therefore aim at prevention of spread of HIV epidemic in Bangladesh (Sarker S et al., 1998)

In the recent past there have been some reports of violation of the rights of sex workers in Bangladesh. In 1997 sex workers were evicted from Kandupatti brothel in the old town of Dhaka. In December 2002, the century old brothel in Magura was demolished. In 1999 the largest brothel in the country in Tanbazar, Narayanganj, and another at Nimtoli were closed and the sex workers evicted (Shirhir M and Philip G, 2003). Nearly 30% of all brothel based sex workers of the country lived in these brothels where the HIV prevalence is 15 per 1000 persons and syphilis prevalence in about 50 percent (HRV-2). Besides violation of human rights such mass eviction of sex workers is in contravention of the HIV and STD reduction policies of the WHO and UNAIDS as impact of dispersal of these sex workers will result in spread of the HIV epidemic all over the country. Naripokkho (a feminist NGO) along with 23 other organizations has expressed its solidarity in support of the sex workers (ILGA 1999).

Bangladesh is vulnerable to HIV/AIDS

In the context of a conservative society such as Bangladesh, the issues surrounding sexuality and STDs are stifled, stigmatized and hence hidden. Economic inequality, inequity and endemic poverty in Bangladeshi society also facilitate the transmission of viruses like HIV and make people vulnerable to infection. Adolescents who are the most vulnerable segment of the population have access to little or no information and services for sexual and reproductive health issues in Bangladesh. There are some internal and external factors that make Bangladesh more vulnerable to HIV/AIDS.

Internal factors:

- Lack of awareness: Only 37% of unmarried adolescent boys and 29% of unmarried adolescent girls know about HIV/AIDS and STD (MOHFW, 2002).

- High-risk behaviours: There are around 100,000 CSWs in the country most of whom are highly infected who entertain five times as many clients mostly with unsafe sex. An increasing number of IDUs practise needle sharing. Moreover, unsafe blood transfusion services, over 250,000 truckers plying all over the country, unknown number of men who have sex with men (MSM), low use of condom etc. all combine to make the country vulnerable to HIV/AIDS.
- Lack of knowledge on reproductive health and sex education.
- Rapid urbanization: Increasing mobility of people from village to urban slums leading to vulnerability to HIV infection through high-risk behavior.
- Reluctance and inability of people to seek health care services.
- Lack of empowerment of women: Unaware and unemployed women are more vulnerable to HIV infection than men.
- Existence of promiscuity: Increasing trend of practice of extramarital and premarital sexual relationship in Bangladeshi society.

External factors:

- High prevalence of HIV in neighboring countries: Bangladesh is surrounded by countries with high prevalence of HIV and has highly permeable international borders.
- High mobility of economically active people: Around 75,000 job seekers, unaware of HIV/AIDS, go abroad every year as migrant workers and many of them come back after being infected by HIV (South-South Centre, Dec 2000).

The current coverage of interventions is less than 20% for high-risk populations (MOHFW, 2002). Currently Bangladesh is a low prevalent country but worldwide evidence suggests that if the risk behaviours in Bangladesh worsen, it is only a matter of time before HIV spreads far and wide.

Areas for action

- The prognosis of people infected with HIV is bleak. There is no cure, no vaccine. Death is often preceded by a series of long illness and suffering with high treatment costs since AIDS is a combination of several infections including tuberculosis. The life expectancy and quality of life of many people with HIV or AIDS can be increased

through the use of low-cost essential drugs including antiretroviral, anti-tubercular and others.

- No other disease increases human suffering to the extent that AIDS does. It threatens basic human rights and affects human dignity through blame, stigma and discrimination. Ending the stigma that still surrounds STDs and HIV/AIDS and promoting safe sexual behaviour are critical to reducing infection rates. STD and HIV/AIDS awareness campaign need to be strengthened at national and local levels through partnerships among governments, donors, the media, the private sector, and NGOs to speak out openly on HIV/AIDS, to reduce stigma, prevent discrimination and to protect the rights of people living with AIDS.
- There is a lack of skilled technical manpower like trained doctors especially in syndromic management of STIs, pathologist and technician to carry out RTIs/STIs/HIV tests and nurses in the healthcare facilities. An effective policy along with the periodic supervision of the pathology centers by the concerned authority, training of the doctors, technicians and finally external quality assurance programmes, are urgently needed for providing quality services in Bangladesh.
- Strong political commitment and the support of parents and communities is required to prioritize policies and interventions that will address the needs of youth for reproductive health and HIV/AIDS related information, rights and services, leading to concrete behaviour change. Interventions must elicit contributions from young people in decision-making and programming, as worldwide evidence indicates that this does make a difference in the effectiveness of strategies.
- Before the situation worsens, the Government, NGOs, members of civil society and development partners should join hands and act in a concerted manner to combat the HIV/AIDS epidemic and prevent its spread. For example, better quality and larger epidemiological and behavioural research studies on HIV/AIDS and STDs can be undertaken especially on adolescent behaviour and needs. More studies on drug use and sexual behaviour among people throughout Bangladesh need to be conducted and closely monitored.
- All out efforts need to be taken to mobilize the community and raise awareness with regard to the danger of HIV/AIDS epidemic and take preventive steps. Mass media including electronic and print media can be effective channels for increasing knowledge and awareness and even influencing attitudes, behaviours

The Syndromic approach:

The syndromic management of RTI/STI endorsed by WHO is based on identifying the various syndromes and managing the patient by using the respective flowcharts and algorithms. The Syndromic Approach has been shown to be valid, feasible and cost effective in most settings and has been applied successfully in different countries throughout the world.

Early and effective diagnosis and treatment of STIs is one of the major components for an effective HIV infection prevention program.

In Bangladesh, the Technical Standard and Service Delivery Protocol for Management of RTIs and STIs has recently been developed based on the Syndromic Approach for STI case management adapted from WHO guidelines. This protocol is approved by the Technical Review Committee and is to be followed by all levels of health care providers.

In Syndromic management of RTI/STI, four basic health education messages, known as the four 'C's, are used for educating and counseling patients and /or their partners(s):

The Four 'C's:

Compliance with treatment;

Counselling for prevention;

Condoms with demonstration of correct use;

Contact tracing and treatment.

and political will to launch an aggressive action programme on HIV/AIDS.

Male and Female condoms are the only technology available that can prevent sexual transmission of HIV and other STDs. Persons exposing themselves to the risk of sexual transmission of HIV should have consistent access to high quality condoms. The activities of AIDS Programmes to increase both availability of and access to condoms should be monitored and resources mobilized to problem areas.

- A set of health care indicators may help to identify the general strengths and weaknesses of the country's health system. Specific indicators, such as access to testing and blood screening for HIV help to measure the capacity of health services to respond to HIV/AIDS related issues.
- Monitoring different components of STD control can provide information on HIV prevention within the country. Clinical services offering STD care are an important access point for people at high risk for both AIDS and STDs, not only for diagnosis and treatment but also for information and education.

The areas of action may include (but not necessarily be limited to) the following:

- Comprehensive prevention programmes to reduce the dangers of injecting drugs and commercial sex should be designed and implemented.
- Condom promotion especially among the commercial sex workers and their clients should be strengthened.
- The issue of safer sex should be addressed in interventions as high proportions of injecting drug users have unprotected sex with a number of partners including female, male and hijra sex workers.
- Behavioral communication messages need to be developed that focus on increasing the risk perception not only of the at-risk population but also the context in which the risks take place. The programme should also take into account the low literacy of the people including the drug users.

The efforts should aim at:

- Preventing the spread of HIV.
- Providing care and support for those infected and affected by the disease.

- Reducing the vulnerability of individuals and communities to HIV/AIDS; and
- Easing the socio-economic and human impact of the epidemic.

National policies and objectives

Realizing the gravity of the HIV/AIDS situation in Bangladesh, the GoB undertook a project on 'Prevention and Control of Sexually Transmitted Diseases' in 1996. Later, in 1997, the National Policy on HIV/AIDS and STD-related issues was approved. The National AIDS Policy is a landmark document, which outlines the various aspects of HIV/AIDS prevention and care and covers public health aspects like surveillance, HIV/AIDS counseling and testing, diagnosis and treatment of sexually transmitted diseases. The GoB also developed in May 1997 a strategic plan for the National AIDS Programme of Bangladesh (1997-2002) for HIV/AIDS prevention and care. A National AIDS Committee was also formed in 1995 to suggest ways and means for preventing HIV/AIDS.

Furthermore, in order to address all social, ethical and personal issues related to HIV/AIDS infection, the GoB has adopted policy guidelines for the National AIDS Programme (NAP). These technical policy guidelines refer in particular to the following areas:

- Surveillance and reporting of AIDS cases
- Testing guidelines
- Management of AIDS and HIV infection to include special groups, e.g., TB
- Behaviour Change Communication
- Counseling of HIV/AIDS patients and confidentiality
- National blood transfusion services
- HIV/AIDS and women, men, children, adolescents, sex workers, IUDs, people staying away from their partners, prisoners, minority populations, etc.
- Human rights issues
- HIV/AIDS education in and out of school
- Maternal and child health
- HIV/AIDS and the work place
- Relationship of the NAP with other programme areas
- Legal/ethical aspects
- Social/behavioural/clinical research

Prime Minister's Initiative

An initiative aimed at addressing violence against women in general that could potentially help sex workers is Prime Minister Khaleda Zia's plan, announced in March 2003, to create twenty-four-hour crisis centers in all divisional hospitals to provide treatment and legal aid to women survivors of violence. A survivor would be able to file an FIR at the center itself. One such center is already active in Dhaka. In its first year, the center has investigated 100 cases. Seventy-two were in criminal proceedings as of March 2003, and five had resulted in convictions (HRW, August 2003).

As programme needs continue to develop, the National STD/AIDS Policy needs to be reviewed (and possibly amended) to ensure consistency.

Strategies

The major strategies adopted by the Government are to prevent HIV transmission, reduce the impact of HIV/AIDS on individuals and the community, prevent STD transmission and provide STD management.

The following strategies need to be considered for implementing specific programmes related to HIV/AIDS.

- Advocacy and Epidemiological Surveillance;
- Behaviour change support and IEC;
- Promotion of condom use;
- STD management;
- Safe and appropriate use of blood transfusion adhering to universal safety regulations;
- HIV/AIDS counseling, care and legislation.

Behaviour change support in the context of HIV/AIDS is a package of intensive activities and services aimed at assisting and monitoring changes in behaviour to safer practices. These are to be provided through GoB, NGOs and CBOs on an emergency basis to those practising high-risk behaviors as a cost-effective means to reduce or avert the consequences of HIV/AIDS for the general population. Technical competence needs to be developed at the institutional level through provision of training to different categories of personnel. The surveillance mechanism needs to be strengthened and adequate logistic support ensured for establishing laboratory facilities. Mobilization of political commitment and multi-sectoral response to prevention/control of HIV/AIDS has a critical strategic importance in the successful implementation of the programme.

Prevention services

The activities undertaken for the prevention of HIV/AIDS are:

- Formation of a high-level multi-sectoral National AIDS Committee with three sub-committees, such as; i) Technical Committee, ii) Motivation-cum Publicity Committee, and iii) Monitoring and Evaluation Committee.
- Approval of a Safe Blood Transfusion Act. Ninety seven blood transfusion centers have been established throughout the country under the Safe Blood Transfusion Programme by the Ministry of Health and Family Welfare and with the financial assistance of UNDP under the guidance of the Blood Transfusion Sub-committee of the

The basic strategies of successful prevention are communication (including sexual health education) and behaviour change, the creation of an environment that enables people to protect themselves against the virus, condom promotion, HIV counseling and testing and the

In the area of political commitment, the GoB recognizes that AIDS is a priority health and development problem in Bangladesh and expresses its commitment to allocate adequate financial and human resources to effectively address the growing HIV/AIDS problem. The Government has urged all its ministries, as well as the NGO and private sectors to get more

National AIDS Committee. Screening tests are being carried out in these centers for five important infections transmitted through blood transfusion (HBV, HCV, HIV, Malaria and Syphilis).

- Third round of sero and behavioural surveillance has been completed and 4th round is underway.
- Completion of a Geographical Information System (GIS) on brothels in Bangladesh
- Orientation of 55 thousand health and family welfare workers on HIV/AIDS and STDs.
- Observation of the World AIDS Day every year throughout the country.
- Community orientation about HIV/AIDS:
 - a) Ward Commissioners/members of city corporations and municipalities.
 - b) Teachers/students of schools and colleges.
 - c) Religious leaders including imams of mosques.
- Billboards with specific messages on HIV/AIDS at division, district and upazila levels.
- Regular broadcasts of TV spots.
- Dissemination of messages through the print media.
- Messages on double-decker buses.
- Plans chalked out for multi-sectoral collaboration:
 - a) Ministry of Health and Family Welfare is the lead Ministry for the prevention of HIV/AIDS and STDs in Bangladesh.
 - b) Other relevant ministries like, Home, Women and Children, Youth and Sports, Education, Religious Affairs and Local Government are involved in the programmes.
 - c) The private sector, NGOs and CBOs are also involved in the programs.
- ICDDR,B has set up a center for pre-test and post-test counseling in collaboration with the Government and UNAIDS.
- Some NGOs like CARE Bangladesh and ASHAR ALO are working on care and support of people living with HIV/AIDS (PLWHA).
- Home-based care and management of PLWHA are encouraged. At present the number the of PLWHA is insignificant in Bangladesh. There is provision in the

To prevent/control the HIV/AIDS epidemic in Bangladesh, the National AIDS/STD Programme is currently implementing separate packages for preventing HIV/AIDS among:
 Vulnerable youth, vulnerable women (other than female sex workers), drug users, brothel-based female sex workers, street based and “floating” female sex workers in major urban areas, hotel and residence based high-risk groups, and vulnerable males (MSM, hijras and transgender) Transport and other key male sectors, internal and external migrant labourers
 STD services and Technical Support on Condom Promotion among Vulnerable Populations
 Capacity building in project management with NGOs and services for a pilot project on social marketing of female condoms and lubricants, a pilot project on training health workers in STI management in selected urban areas and development of HIV Voluntary Counseling and Testing (VCT) Services at national and divisional levels.

- programme for training of doctors and nurses together with development of facilities for care and management of the PLWHA.
- *IDA/DFID funded activities*: 19 packages for goods and 58 packages for services have been approved by the Government and the World Bank.
- Issuance of invitation to NGOs and other organizations for various programme packages.
- The application for second round of Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has been duly sent.

The Government implements HIV/AIDS prevention projects with funding from the International Development Association (IDA) and DFID.

Chapter Seven

APPROACHES IN REPRODUCTIVE HEALTH

Documents of the ICPD and the Fourth World Conference on Women (FWCW) emphasize the concepts of sexual and reproductive rights, including the right to sexual and reproductive health, voluntary choice in marriage, sexual relations and childbearing, freedom from sexual violence and coercion and the right to privacy, which are essential to gender equality. Women in Bangladesh are not in a favorable position with regard to gender equity and equality, even though the Constitution of the country provides for equal status and rights for women. Age-old tradition, social norms and values, economic dependence, illiteracy and prevalence of rigorous family laws create and legitimize discrimination and inequality against women in this country.

Rights Based Approach

Bangladesh is one of those countries where the economy is characterized by low growth, overpopulation, critical land-man ratio, acute joblessness and growing numbers of the absolute poor. Women comprise half of the population and their situation is worse than men. They suffer not only from abject poverty they live in but also the gender disparity prevalent in the society. They are in a subordinate position since birth. Since infancy, a girl child often has unequal access to nutrition, health care and education. At work place women are paid less than men and they also do not have easy access to credit and income generation opportunities. There is a social preference for early marriage, and the consequent early age at first pregnancy increases the risk to their health. In Bangladesh, gender inequality, economic dependence of women on their husbands and the patriarchal system reinforce each other to perpetuate and promote violence against women (Khan, M E., et al, 2002).

This kind of situation calls for a rights-based approach to sexual and reproductive health. Such an approach is concerned with gender equity and equality, sexual and reproductive rights and client-centered sexual and reproductive health care. Over the years, a human rights-

Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female (UNFPA).

Gender equality means equal treatment of women and men in laws and policies, and equal access to resources and services within families, communities and society at large (Gender and reproductive rights Glossary, WHO).

Gender equity means fairness and justice in the distribution of benefits and responsibilities between women and men. It often requires women-specific programs and policies to end existing inequalities (Gender and reproductive rights Glossary,WHO).

Reproductive rights include “the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents” (UNFPA).

Sexual rights include “the human right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence” (UNFPA).

based approach to reproductive health has evolved which emphasizes the rights to health, to have children by choice, and to have a safe and satisfying sex life. WHO defines the rights-based approach as a conceptual framework for the process of human development that is normatively based on international human rights standards, and operationally directed to promoting and protecting human rights. It integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development. A rights based approach includes reproductive health services that protect a woman's general health and well-being, that allow for well-informed decisions, and are respectful of individual choices.

The Platform for Action adopted at the **Beijing Women's Conference** advances women's wider interests. Paragraph 96 states:

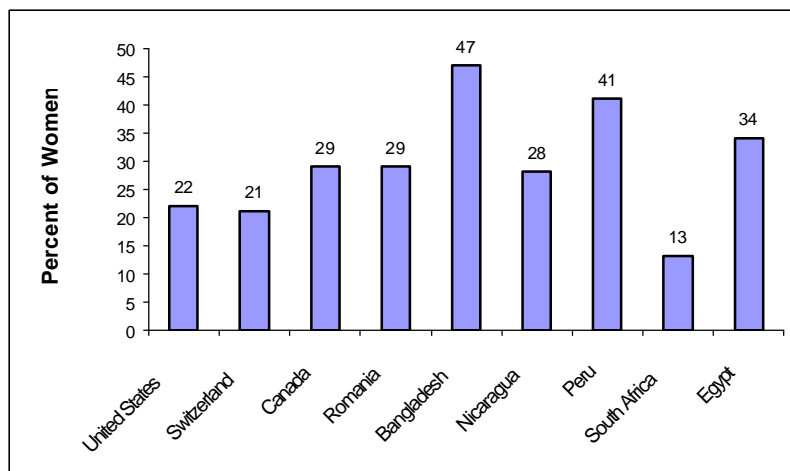
"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences."

Violence Against Women (VAW)

Violence against women is a serious violation of women's human rights. Women's reproductive and sexual health clearly is affected by gender-based violence. In Bangladesh, violence against women is common, particularly by husbands. The nature of violence ranges from scolding to severe beating, forced sex and in extreme cases, murder. A U.S. study found that women who experienced intimate partner abuse were three times more likely to have a gynaecological problem than were non-abused women (Campbell, J. et al., 2002).

Figure 7.1

Intimate Partner Violence in Selected Countries



Source: Outlook, Volume 20, Number 1, September 2002.

Domestic violence: In Bangladesh, a half of all murders are of wives by husbands. Bangladeshi women are the most

battered in the world. Surveys indicate that 47% of adult women have been physically assaulted by an intimate partner in Bangladesh (Barbara Shane and Marry Ellsberg, 2002). Many in our communities believe it is acceptable to hit women. Cultural norms strengthen this belief and may lead women into believing that violence is deserved.

Acid attacks remain one of the most barbaric acts against girls and women in Bangladesh. Hundreds of young women are attacked with sulphuric acid simply because they dared to say no to men. Experts say three to five young women a week are being burned with acid in Bangladesh, and the numbers are increasing at an alarming rate. By throwing acid, men not only destroy a women's face but also her future, the chances of her getting married and enjoying a normal life. Rape is now probably one of the most common forms of violence against girls. Unfortunately, despite the fact that in most cases the violator is known to the victim, nothing is done to bring the former to justice (Prof. B A Majumdar, 2002). In Bangladesh, where both the prime minister and opposition leader are women, nearly 50 percent of murder cases against women are linked to marital violence, and by an inability to meet dowry demands and to handle polygamous men (Dawn, September 2000). Despite the fact that demanding, giving and accepting a dowry is an offence under the laws of Bangladesh, the practice, however, still prevails in many sections of society.

Sexual Abuse, especially forced sex can cause physical and mental trauma and limits women's sexual and reproductive autonomy. In addition to damage to the urethra, vagina, and anus, abuse can result in STIs, including HIV/AIDS. A survey data show that during the last one year 15 percent women had experienced forced sex by the intimate partner (M E Khan et al., 2000). The fundamental cause of violence is the inequality between men and women in all spheres of life. Various existing social, religious and cultural constraints not only help in perpetuating the inequality but also facilitate its justification. The women in Bangladesh, as in other South Asian countries, are made to believe that women are inferior to men; they are expected to serve their husbands, obey them, and satisfy their sexual needs.

Case Study:

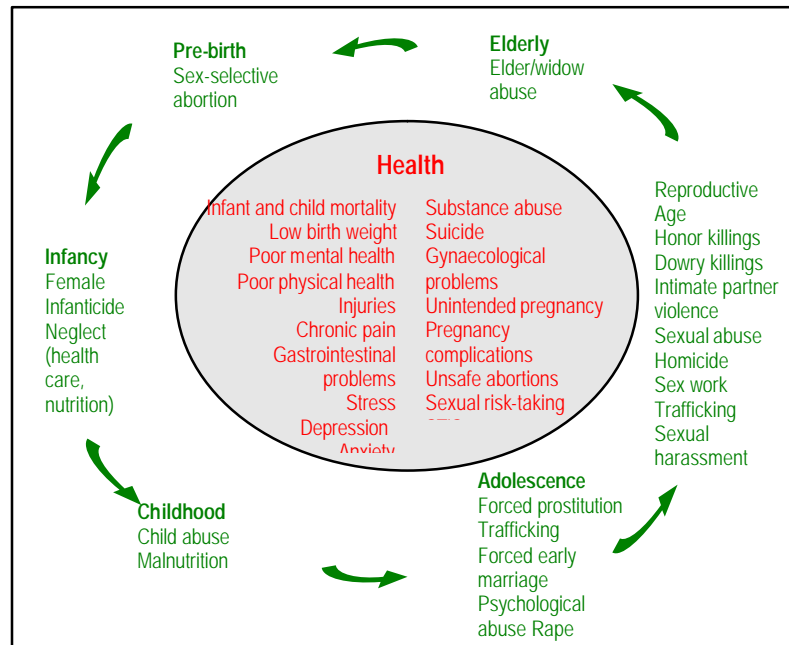
At the time of marriage I was 14 years old and my husband, 28. After the initial experience of sex I started disliking it. But he wants sex all the time. As I do not enjoy it, I refuse to do it but my husband never listens to me and does it by force... At times he even does it during my menstrual period... It mentally hurts me and I have started hating myself. Now I am 28 years old. I do not like sex and I have told him to go outside for enjoyment... He does it in any case (28-year old informant).

Another 35 year-old woman expressed a similar view: All my life I have been subjected to this (forced sex). I never want to have sex with him. I do not like any kind of sexual activity but he never listens to me. He always scolds and beats me for refusing it to him.

- M E Khan et al., 2000

Figure 7.2

The Life Cycle of Violence Against Women and Its Effects on Health



Source: *Sexual and Reproductive Health—Family Care International, 1999.*

Reproductive Rights

Early Marriage and Childbearing also has multiple impacts on the reproductive health of women and girls. At the time of marriage they are hardly aware of the sexual life into which they would be entering after marriage. The initial trauma through which they pass immediately after marriage is often instrumental in developing a negative attitude towards sexuality (ibid). In Bangladesh, in 37 percent of all marriages registered, the brides were underage and 82 percent involved a dowry payment, both of which are illegal. Moreover, marriage entails social isolation for the young bride, dropping out from school, her post marital residence is usually patrilineal, and restrictions on her mobility set strong limits on the social networks that are accessible to her in her husband's home (MOWCA, October 2002). The adolescents are unlikely to use contraception at first intercourse before marriage due to shame and privacy. This particular behavior increases the chances of unwanted pregnancy, unsafe abortion, pregnancy related complications like obstructed labor, vecico-vaginal fistula etc. The deaths of mothers due to pregnancy related complications are highest in

Challenges of 21st Century:

- Ensure Reproductive Health Care.
- Reduce Maternal Mortality Rate.
- Ensure Adolescents' Reproductive Health Care.
- Reduce/prevent unsafe abortion and ensure care of health risks caused by unsafe abortion.
- Prevention of HIV/AIDS.
- Elimination of discrimination existing between men and women.
- Ensure equal opportunity for all in case of education.
- Ensure nutrition of mother and child.
- Ensure improved quality of life.
- Ensure empowerment of women.
- Ensure health care for population aging above 60 years including other basic rights.
- Ensure availability of safe and effective family planning services.

Bangladesh among the developing countries (Hossain SMI et al., 1998).

Maternal Mortality can be considered as a human rights violation. Women must have ready access to essential obstetric care, well-equipped and staffed maternal health-care services, skilled attendance at delivery, emergency obstetric care, effective referral and transport to higher levels of care when necessary, pre and post natal care and family planning. But in Bangladesh maternal mortality rate is very high even by the standards of other developing countries. This persistently high mortality rate shows the risk that Bangladeshi women face during their reproductive life span.

Abortion or termination of pregnancy, especially when it is unwanted or mistimed, is a complicated process in Bangladesh. Individuals have to consider the attitude of their husbands, family and the society in addition of their own compelling needs before having an abortion or MR. Septic abortion is more common in teenage unmarried women and such deaths are far less reported as parents and relatives tend to hide the cause of death of an unmarried daughter following an induced abortion. Pregnancy out of wedlock is socially unacceptable and there is no sympathy from the community if it ends in death (Fauveau & Blanchet 1989).

Barriers in Decision Making: Gender inequality affects women's timely use of health services. The subordinate status of women in society limits their autonomy in decision-making, it limits their access to transportation, and leads to discrimination in health care utilization (Dey K D, 1998) In Bangladesh, eight percent of women mention that their husband is opposed to family planning use (Piet-Pelon N J et al., 2000).

Son preference on Childbearing: In Bangladesh, sons carry on the family name, inherit immovable property, conduct religious rites, and provide security for the parents in their old age. Daughters on the other hand are considered as a liability for the family because – they marry early and outside the family, any investment in them is lost to the family, they require large dowries and expensive weddings, they provide no support to the family of origin after marriage (Dey K D, 1998).

It is indeed a grim reality that the range of gender based violence is devastating, occurring quite literally from womb to tomb. Starting even before they are born, and continuing throughout their lives, girls are subjected to violence,

"The fact is that women have been trapped. Reproduction is used, consciously or not, as a means to control women, to limit their options and to make them subordinate to men. In many societies a serious approach to reproductive health has to have this perspective in mind. We must seek to liberate women."

-Dr. Nafis Sadik

-Executive Director,

UN Population Fund.

"Much of the violence against women occurs in the context of sexuality and reproduction. The health consequences of violence often occur in the context of reproductive health and seriously contribute to the burden of diseases in women and young people."

-Dr. Hiroshi Nakajima

-Director General

World Health Organization

exclusion, and exploitation based simply on the fact that they are female.

In order to accelerate the process of gender equality, equity and empowerment of women, the Government's initiatives include, among others, enhanced advocacy campaign and IEC on 'Dowry Prohibition Act', 'Cruelty to Women Act' (deterrent punishment act), 'Child Marriage Restraint Act', 'The Muslim Family Ordinance', 'Second Amendment Ordinance' (for capital punishment for acid throwing, etc), 'Family Court Ordinance' and 'Anti-terrorism Ordinance'. The National Council for Women's Development chaired by the Honourable Prime Minister has been constituted. A cell has been established under the Ministry of Women and Children's Affairs (MOWCA) to prevent violence against women. A 15 member inter-ministerial coordination committee headed by the Minister of MOWCA has been constituted. The committee submits periodical reports to the Prime Minister. Among other post-ICPD actions, mention may be made on women quota in the Parliament and in the local government bodies; women quota in the Public administration; 60% women quota for primary school teachers; massive non-formal education programmes for girls; family life education in the school curriculum; and enhanced emphasis on the activities relating to the promotion of inter-spousal communication about sexuality and reproduction.

The Bangladesh National Women Development Policy was adopted in March 8, 1997. This policy document, first of its kind in Bangladesh delineates government's firm commitment on some board areas – implementation of the human rights and fundamental freedom of women; elimination of all discrepancy against girl child and enactment of relevant laws; elimination of all forms of violence against women, war and women; education and training; sports and culture; ensure active and equal participation of women in all spheres national economy; eradication of poverty among women; economic empowerment of women; job opportunity for women; other secondary assistance and services; women and technology; food security for women; political empowerment of women; administrative empowerment of women; health and nutrition; housing and shelter; women and environment; women and mass media; specific distress and disadvantaged women (MOHFW, February 1999).

According to Article 1 of the Universal Declaration of Human Rights, "All human beings are born free, and equal in rights and dignity". Through birth, girls inherit the rights of all human beings. They are born with the same fundamental rights to life, food, shelter, education, healthcare, and employment.

Our Constitution guarantees equal status of women and men in all spheres of life. According to Article 28(2), "Women shall have rights with men in all spheres of the State and of public life." Successive governments have also signed and ratified the Convention on the Elimination of All Forms of Discrimination (CEDAW), the Convention on the Rights of the Child (CHC), and the Beijing Declaration and Platform for Action.

Life Cycle Approach

The life-cycle approach to women's health anticipates and aims to meet a woman's health needs throughout her life cycle, from infancy to old age. This approach emphasizes the importance of health-seeking behaviour throughout life and the provision of appropriate services to meet women's need.

Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health is basic to their empowerment.

Issue at a glance:

- Women are more likely than men to be poor; have minimal schooling and low social status; and are burdened with heavy work from an early age. As a result women tend to have special health needs, limited access to health services, and little sense of entitlement to health care.
- Girls face considerable health risks, often resulting from family preference for boys. Million of girls do not receive sufficient preventive health care or treatment for illness and are poorly fed. An estimated 450 million adult women in developing countries are stunted, a direct result of malnutrition in early life.
- During adolescence (10 to 19 years) women are exposed to a new set of health risks. Lack of knowledge about their bodies and limited access to appropriate health services put adolescent women at risk of early childbearing, unwanted pregnancy and unsafe abortion as well as STDs, including HIV/AIDS.
- During their reproductive years (15 to 49 years), women's risk of death and disability is high: one out of every 48 women in the developing world will die from pregnancy related complications. It is estimated that 50% of pregnant women in developing countries are anaemic, significantly increasing their risk of dying in childbirth.
- In their post-reproductive years (45 years and older), women face health risks associated with ageing.
- Cervical cancer now accounts for more new cases of cancer in developing countries than any other type of cancer.

Status of Women and Reproductive Health in Bangladesh:

- Due to the lower socio-economic status of the girl child and women, they are subjected to discrimination in all sectors including health, nutrition and education. Due to the existing inequality between males and females many women are tortured physically and mentally.
- 3 mothers die every hour due to complications of pregnancy and delivery.
- Maternal Mortality Rate is 3 per thousand live births.
- Every year 4 million women become pregnant and out of them 600,000 face different types of complications.
- Only 13 percent of deliveries are conducted by doctors and trained personnel.
- Persistently lower nutritional status of women.
- Preference of son in the society.

Figure 7.3

The Life Cycle Approach
Identifies key health risks throughout a woman's life



Source: Adopted from the report of an interagency working group on Life Cycle Approach, September 2000.
(BASICS Project – USAID, Institute of Child Health, UNICEF, WHO, World Bank, Local NGOs)

The life cycle approach identifies certain key health risks throughout life and gives voice to the poor. It –

- will improve the health of women and children
- will help break the vicious cycle of illness and poverty
- draws on the synergy of intergenerational links
- more effectively delivers essential services
- engages partners, communities, NGOs, governments and agencies for better use of resources

The life cycle framework is guided by certain key principles:

- Health interventions have a cumulative impact
- Interventions must be prioritised at several points across the life cycle
- Interventions in one generation bring benefits to successive generations

The new approach demands that the governments think of women in a holistic fashion and stress on a rights based, gender sensitive approach to health. Governments have been encouraged to recognize that the improved health status of women could only be achieved by a life cycle approach and that health depended not only on good family planning information and services, but also on women's empowerment in all spheres – legal, status, employment, and education and their simultaneous achievement.

The Government of Bangladesh responded to this emerging need, started the process of health sector reform in 1997 and developed the Health and Population Sector Strategy (HPSS). The Health and Population Sector Programme (HPSP) was the fifth five-year sector wide program for health and population of the Government of Bangladesh (GoB) and is based on the HPSS formulated by the government. Its overall goal is 'improved health and family welfare for the most vulnerable women, children and poor of Bangladesh'. For that purpose several new policies and strategies were formed and National Reproductive Health Strategy was adopted in 1997 based on the principles set forth at ICPD.

The strategy prioritises four services areas in Reproductive Health:

- Safe Motherhood
- Family Planning
- MR and care of post abortion complications
- Management of RTI/STDs

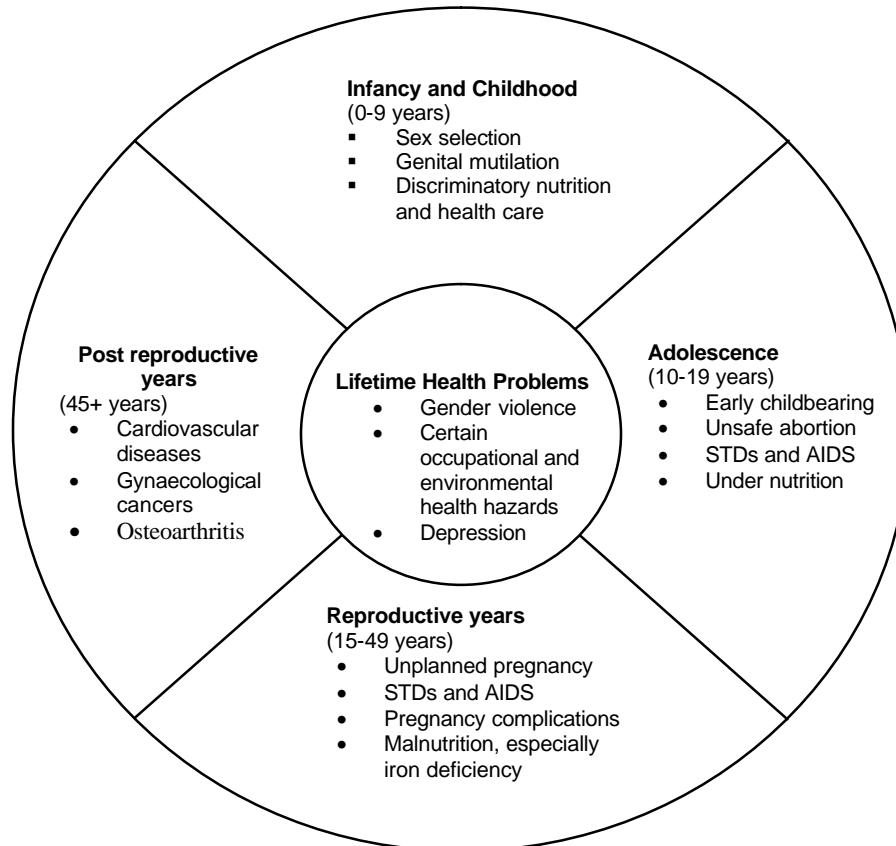
It adopts a life cycle approach to services where women are not the objectives of specific services but rather are



considered holistically (Chowdhury, 2002). The above strategy priorities remain unaffected in the reformulated national Health, Nutrition and Population Sector Programme (HNPS).

Figure 7.4

Health and Nutritional Problems Affecting Women The Life Cycle



Source: *Sexual and Reproductive Health – Family Care International, 1999.*

Impact of socio-economic status, education, health and nutrition on women during the life cycle:

Bangladesh is one of those countries whose economy is characterised by low growth, overpopulation, critical land-man ratio, acute joblessness and growing numbers of absolute poor. Women form a half of the population and their situation is worse than men. They live in abject poverty, suffering as poor and again because of gender disparity. Recent statistics in Bangladesh indicate that out of 50.2 million employed people, 40 percent are women and a significant portion of them (46 percent) are involved in agriculture (Salma, 2001). However in Bangladesh women’s involvement in the industrial sector has increased a great deal in recent years. A significant number of women (7.7 percent) are now employed in this sector.

About 60 percent of the total labour force employed in the ready-made garment industry are women. The average age of the garment workers is 19 years for women and 24 years for men. At the same time, in the private sector companies 3 percent of women are employed as managers and administrators and women hold about 5 percent of government posts (Shirin, M, 2002).

Majority of women workers (82 percent) in rural areas are unpaid family workers (Centre for Integrated Rural Development of Asia and Pacific: 1998). The rural poor women – while conforming to the established Bengali value system of performing their role within their family - have significantly contributed to the food production and also to the cash flow of their family resources by making traditional sellable items. Traditionally women have performed a good deal of productive activities, notably post-harvest operations and homestead gardening and attending the livestock, all of which add to family income. The women are in a subordinate position since birth. As girls, they are under the supervision of their fathers or brothers; when they marry, their husbands make decisions for them; in their old age, they become dependent on their sons. They are unable to come out of these systems of being dependent on the men in their lifetime.

Empowerment begins with poverty eradication. For women, the first hurdle has also been to access productive resources and social services. Microcredit has played a significant role in the achievement of economic self-sufficiency for women in Bangladesh. Microcredit is being utilized for the provision of shelter and livelihood, combining it with health care, education, nutrition, family welfare services and community development in a comprehensive anti-poverty initiative. The Grameen Bank has become one of the most well-known microcredit institutions in the world. Today there are over 2,200 telephone ladies employed by Grameen Telecom (a branch of Grameen phone) in Bangladesh and the number is growing. Grameen Telecom has set a goal of creating 40,000 village phone ladies. A 'telephone lady' earns an average of \$ 300 per year (Mohammad Yonus, 1997).

Despite these achievements, gender discrimination against girls and women, subordination and deprivation persist, as evidenced by relevant indicators. Inter and intra-border trafficking in children and women continues to be a serious problem. Every year more than one million children and women world-wide are believed to be trafficked and sold for sexual purposes. In Bangladesh, the number of children and women trafficked is estimated to range from 10,000 to 20,000 per year. From Bangladesh, most

Women's universal disadvantages:

- Lower social status than men
- Lower salary level than men in formal work forces
- Large proportion of women in informal sector of economy
- A rising number of female headed households
- Lack of enforcement of legislation protecting women's rights
- Under-representation of women in politics and decision making positions
- Culture has historically given men and boys preferential treatment in most aspects of life matters.

children and women are trafficked for prostitution, domestic work and industrial labour (textile factories), or to Arab states to become beggars or camel jockeys. Once oriented to the sex trade, a girl might find herself forced to service an average of ten clients a day (USAID, 2003).

Child labour is also one of the barriers for development. It is estimated that more than 6.3 million children in Bangladesh work full-time, most of them in the informal sector of the economy. Girls are often driven into 'invisible' child labour through domestic service and denied access to education (UNICEF, 2000).

Education and employment help to empower women. An educated woman is better able than an uneducated woman to make correct decisions about her and her children's health, education and life. In the past decade, Bangladesh has made great strides towards Education for All (EFA goals). Bangladesh is one of the few South Asian countries that can claim gender parity in enrolment in primary level, though gender equity remains a challenge in many fields. Despite this progress, around 10 percent of children (2 million) never enrol in primary schools, and at least one third (6 million) who enrol do not complete the primary cycle (UNICEF, 2000). Female students drop out from school mainly due to early marriage or social seclusion. The literacy rate obtained from 1991 census was 32.4 percent for population 7 years and above (BBS 2002).

Education gives women a sense of confidence and status to think, discuss and reach decisions on matters pertaining to themselves within the family. The BDHS 1999-2000 shows that women who have no formal education have an average of 4.1 children, while women with at least some secondary education have an average of 2.4 children (NIPORT, Mitra and Associates, and ORC Macro, 2001). According to the 'State of the World's Children 2003, UNICEF', adult literacy rate for male is 52 percent and for female is only 29 percent. Primary school enrolment ratio for male is 80 percent and for female is 83 percent whereas secondary school enrolment for male is 52 percent and for female is 56 percent (UNICEF, 2002). Recently The Government of Bangladesh has made female education free up to primary level, provides stipends to all rural girls from grades 6-12, and is recruiting more women to achieve the target of 60% of women teacher in primary school (UNICEF, 2000). In the higher Secondary Certificate and in all official documents, mother's name must also be mentioned side by side with the father's name, where necessary.

Adolescent girls are not informed about their rights, and have limited opportunity to meet and exchange ideas. Early marriage is a critical factor for dropping out of school. When an adolescent girl marries, she generally stops attending school and gives full time work in her husband's parental house (UNICEF, 2000). By the age of 17, approximately 70 percent of females in Bangladesh are married, nearly all of them by an arrangement between the parents of the bride and the groom - an arrangement aiming at strengthening social ties between families. A woman's productive value in society is equated primarily with the dowry she will bring to her husband's family. The payment of dowry, which often occurs over the course of several years, is a significant financial burden for most families. Inability to pay the dowry severely affects a young bride's treatment in her husband's family.

Most women in the rural areas are not allowed to buy or sell goods in the haats and bazars (village markets). Although women are not usually in control of their profits, their contribution to the products sold may serve to increase their household status and earn the respect of their husbands and his family (Jennifer Morris, 2003).

In the last decade, Bangladesh has made significant progress in the areas of maternal and child health as demonstrated by the fall in both the infant and child mortality rates and the dramatic rise in contraceptive use. Despite these achievements, maternal mortality has been poorly addressed and remains very high (320 per 100,000 live births). Pregnant women die during delivery mainly due to common, treatable obstetrical complications such as haemorrhage, abortion, eclampsia, puerperal sepsis and obstructed labour. Pregnancy is usually considered as a healthy state and cause of joy in the family. The expected outcome from each pregnancy is a healthy mother with a healthy baby. While most pregnancies take place without any problems, approximately 15 percent of pregnant women will develop life-threatening complications requiring Emergency Obstetric Care (EmOC) services. These complications often arise suddenly, requiring prompt action. Three fourths of the births are assisted by traditional birth attendants (TBAs), with 12 percent being assisted by trained dais and 64 percent by untrained dais. Unfortunately, there are many cultural taboos about acknowledging a 'pregnancy'. Certain cultural beliefs may result in delaying the use of antenatal care services until the third trimester, which makes planning for delivery more difficult and 67% of pregnant women receive no antenatal care (USAID, 2003).

Malnutrition is a very common problem in Bangladesh. The vicious cycle of malnutrition originates from the mother's poor health. In most cases, she herself is born with low birth weight, grows up in poverty and remains undernourished while developing as a child and adolescent; is neglected in health care and treatment during illness, and has an unfair share of the food in the family. Soon after reaching adolescence, upon menarche she is married off. Her early marriage is immediately followed by early childbearing with weak health, low body mass index and anaemia. Almost a half (49 percent) of the women are suffering from anaemia (MOHFW, May 2003). In case of breast feeding, the national cross sectional survey on infant feeding practices and child and maternal nutrition status shows that the prevalence of exclusive breast feeding in July 1998 was 58%, which rose to 85.1% in February 2001. The rate of continuation of breast feeding at one year was more than 96% and at 2 years more than 85% (UNICEF, 2000). Prevalence of night-blindness among women is very high at 2.2 percent and for pregnant and breast-feeding women it is even higher at 2.7 percent and 2.4 percent respectively. (HKI, 1998).

The economic consequences of Bangladesh's maternal malnutrition problem are profound, resulting in lost productivity and reduced intellectual and learning capacity. In addition to causing individual tragedies like maternal and child death, malnutrition exacts heavy costs from the health care system through excess morbidity, increased premature delivery, and elevated risks of heart disease and diabetes.

Male involvement

Reproductive Health issues in Bangladesh are mostly focused on the needs and problems of women only. The needs and problems of men are largely overlooked. The potential for involving men in family planning and RH in Bangladesh is substantial. In Bangladesh context like women, men also grow up as illiterate, poor, and hardly mobile who need education and motivation. Fortunately men in Bangladesh have a positive attitude towards family planning in general. Eighty two percent women reported that they and their husband together approved of the family planning (NIPORT, Mitra and Associates, and ORC Macro, 2001). Reported current use of male methods of contraceptive is low in Bangladesh despite their good knowledge and attitude – one reason for this is lack of adequate method choice and male providers.

In matters of RH, although men are the decision-makers, in most cases they are largely ignorant about the protection of themselves and their partners. In matters of antenatal

Role of men in eliminating gender disparities:

- Men can care women's domestic burden
- Take active part in all aspects of family life, such as, attending children's health, nutrition and education
- Provide economic support
- Care of their own as well as their partner's reproductive and sexual health

care, which is only 27% in Bangladesh; the mother-in-law is the decision maker and husband has less roles because of his ignorance about the requirements. Since the husband is not involved in arranging ANC for his pregnant wife he is also unaware of complication of his wife's health and as a result does not plan for delivery of the child (in hospital under care of a Doctor or Nurse. Involvement of the husbands in such crucial times of pregnancy and delivery will increase the frequency of ANC visits and subsequent skilled assistance during delivery.

National policies and objectives

The Bangladesh Government strives to ensure gender equity and empowerment of women, creation of income generating opportunities and child care support systems at work places as well as more active male involvement and responsibilities. The implementation strategy to achieve this major objective in the proposed policy is elimination of gender discriminatory practices and giving priority to the needs of poorer sections of the population, especially destitute women and children. Some strategies related to gender issues envisaged are to:

1. Improve participation of women in decision making roles at national and local levels as well as in income generating activities, including use of micro-credit, and vocational education to enable them to move beyond traditional roles and occupations;
2. Strengthen institutional capacity and resources of the women's development related institutions and mainstream gender concerns in all sectors;
3. Eliminate all forms of violence and sexual exploitation, including trafficking of women and children;
4. Promote male participation in household responsibilities and make them more responsive to reproductive health care needs of women.

The Government of Bangladesh also has enacted laws specifically prohibiting all forms of discrimination against women. The laws are:

- Dowry Prohibition Act (1980)
- Cruelty to Women Act (1983)
- Family Court Ordinance (1985)
- Child Marriage and Divorce Registration Act
- Women and Children Repression Prevention Act (1995)
- Acid Offenses Prevention Act (2002).

The Country Reports on Human Rights Practices – 2001 of Bangladesh states that enforcement of these laws is weak,

especially in rural areas, and those cases that are filed are hardly followed up. The number of protective custodies is inadequate to meet the needs of the victims of violence.

Challenges and opportunities

Huge challenges lie ahead for the program planners and policy makers in ensuring reproductive health care for the country's women. The distribution of costs and benefits of development, regardless of an individual member's sex, age and relationship with the household head is no easy task for Bangladesh.

Challenges lie everywhere during the life cycle of a woman – from adolescence to old age. These include lack of information or misinformation regarding puberty, early marriage and pregnancy, unsafe abortion, complications during childbirth, malnutrition, difficulty in accessing safe and effective family planning services and the like. These challenges are compounded by low literacy, gender disparity and low status of women in the family. In a society where women are yet to be empowered, gender violence is widespread. Women are subjected to violence, intimidation, abuse and trafficking. Increased incidence of STIs/RTIs and to some extent of HIV/AIDS among the women poses a serious challenge to all. The problem has become all the more formidable as in most cases women are the gullible recipients of the diseases.

The reproductive health challenges for the country's women can be effectively addressed only when the women are empowered through economic and social measures. Some challenges are esoteric to the health sector and can be addressed through increased allocation of resources. However, the life cycle approach transcends beyond the health field and needs a holistic approach for their solution and for ensuring the quality of life of the women.

Enacting and enforcing gender sensitive laws and policies in all sectors of the society remains a big challenge for all. This is especially daunting when it comes to improving existing laws to address violence against women and children. Experience from other countries indicate that gender equity can be effectively achieved only when women can become economically independent. This calls for increasing awareness among all segments of the population on the rights of women as well as their physical, emotional and economic security.

Chapter Eight

CHALLENGES AND FUTURE DIRECTIONS

The reproductive health of the population of Bangladesh stands at an important threshold as the tenth anniversary of the ICPD draws near. While some progress has been achieved in increasing the attention to and scope of women's health needs in the country, there is still a great deal that remains to be done.

Challenges and gaps

The disadvantaged “resource-population” equation in Bangladesh suggests that sustainable development cannot be achieved without targeted efforts in the population field. The hard fact of life in this country is that population pressure is creating additional demands on the already scarce land, water, and other non-renewable resources, thereby making it difficult to support the increasing number of human beings.

The high level of fertility will be a major contributor to the growth of population around 2005. After that population momentum will cause the growth of population at an increasingly rapid pace. If fertility of 2.2 is reached by 2005, the population will continue to grow and will stabilize at 211 million by 2059. And if replacement level of fertility is not reached by 2023, the population size will stabilize in 2109 at 300 million (MOHFW, February 1999). This is a real challenge for Bangladesh.

Some of the important challenges currently faced in the field of reproductive health in Bangladesh are:

- **Programmatic:** how to integrate health and family planning services;
- **Definitional:** lack of consensus about the definition of reproductive health and what is included in it;
- **Ethical:** how to address issues related to sexuality and reproductive rights in societies which are mostly conservative;
- **Policy related:** how to foster public-private relationships;
- **Political:** politicization of reproductive health issues such as abortion and reproductive rights;
- **Resource related:** decreasing resources both from the donors as well as from the Government making it difficult to ensure quality of care.

The term 'reproductive health' emerged from the 1994 United Nations International Conference on Population and Development (ICPD) held in Cairo. ICPD was a watershed event that significantly altered the policies and programs related to women's health around the world by broadening the more traditional women's health agenda of family planning and maternal and child health (MCH) to include issues like safe motherhood, STDs/HIV/AIDS, post-abortion care, adolescent health, violence against women and sexual and reproductive rights. ICPD presents major challenges and raises important questions for policy makes, program personnel and health care providers.

Specifically, at least five major challenges need consideration; (MOHFW 1999)

- Motivation of current non-users of contraceptive to become users; particularly those who have indicated that they intend to limit or space their children;
- Strengthening of the delivery system to provide quality services to increasing number of family planning users;
- Improvement of the quality of family planning services to meet the needs of increasing number of users;
- Efficient use of limited resources; and
- Improvement of the sustainability of the FP program, including financial, organizational and management sustainability.

Under the HPSP the major service delivery issue at the community level has been the shift away from domiciliary (doorstep) services to static clinic services. This mainly affected the functioning of the FWAs and HAs. Even where Community Clinics (CCs) were constructed, there was widespread uncertainty among the (FWA/HA) staff about their roles as service providers in the CCs versus households. Fears were expressed that such changes in the delivery system would adversely affect use of contraceptives and many women would drop out from home delivery to the private clinic (Khan M E et al., 2000).

The stalling of the declining TFR has proven such fears to be a reality. Establishing a community center is no guarantee with regard to its utilization. Bangladesh clearly demonstrates under utilization of various health facilities in rural areas and dependence of women on private sources for health care services (Population Council study). Therefore, unless the community clinics provide good quality integrated reproductive health services women may continue to depend on private sources and may not utilize the CCs for family planning services. Those unable to get services from the private sector may face difficulty in achieving their reproductive goals leading to unplanned pregnancies and demand for MR.

Upon assessing the perceived problems by women themselves, the BDH survey 1999-2000 showed that 80% of the women felt that lack of adequate healthcare facility nearby is an obstacle to accessing care. (NIPORT, Mitra and Associates, and ORC Macro, 2001). Half of the women mentioned that lack of confidence in the services and going to the health center as the main problems in accessing care. Another factor mentioned by about 70% women was arranging

the money required for treatment while 44% mentioned difficulty in getting permission to go to the facilities as the main problem. About two thirds said that their lack of knowledge about where to go is the major obstacle to accessing care.

The 'free' maternity care provided at urban hospitals involved considerable hidden costs that may have been a major contributor to low utilization (<15%) of maternity services among low income groups. The mean cost of normal delivery at these facilities was Tk.1275 (US\$ 31.9) and for caesarean section Tk. 4933 (US\$ 117.5) (Nahar S, Costello A, 1998).

Despite progress in many other areas, the maternal mortality and morbidity situation in the country is unacceptable. This is the main reason as to why the safe motherhood has been defined and accepted as the first of the seven sub-areas under the reproductive health care element of ESP. (Safe motherhood encompasses antenatal care including vaccination, detection and management of pregnancy complications and screening of high-risk pregnancies, attendance at normal delivery by trained personnel, obstetric first aid and referral services for complicated delivery by post-natal care).

GoB response to the situation

The reproductive health agenda is a multi-sectoral issue. Reducing maternal mortality, morbidity and violence against women cannot be achieved through health sector interventions alone. While this sector will concentrate on increasing availability and utilization of essential quality services, intense sectoral involvement will also be needed along with incorporation of different activities into existing programs (MOHFW, Oct 2001).

The government is fully aware of the fact that any further increment in the contraceptive use rate – in the short-run, and population stabilization-in the long-run, cannot be brought about by family planning program efforts alone. In this connection it is well recognized that investments in human capital, especially those which ensure equity, equality and empowerment of women and accelerate the process of mortality rate decline, especially infant and child mortality, are quite effective. These have been reflected in the official social investment policies, various legislation and newly created organizational structures.

Following the policy outlines of the ICPD reproductive agenda, the GoB had already taken a policy decision that family planning delivery systems at thana level will be restructured and services offered by them will be targeted with increased attention to maternal and adolescent health care provided as part of ESP.

Future directions

The GoB envisions fulfillment of every woman's right to safe motherhood. The mission is to nurture a socio-cultural movement that reduces mortality and morbidity as a woman's right as well as enhances her self-esteem and status. The experience in Bangladesh shows that reducing maternal mortality and morbidity is both an output and an entry point for addressing key strategic issues associated with women's rights, such as violence. Efforts will also reduce morbidity and the long-term suffering of the millions of women who survive obstetric complications. However, strategies and interventions will require focus on efforts to enhance women's status, dignity and self-esteem, if effective results are to be obtained (ibid.).

Besides the challenges that Bangladesh faces in the field of Sexual and Reproductive Health there are also some opportunities which could be explored and harnessed towards planning and implementations of future programs. Some of these opportunities identified by ICDDR,B in their strategic plan for 2010 are:

- Although deliveries generally take place at home, women are willing to use delivery facilities, especially for emergencies. ICDDR,B projects have demonstrated how to improve basic obstetric facilities and to make them acceptable and effective at low cost;
- Most families are now using contraceptives, but they need assistance in using them appropriately. There is opportunity for improving the method mix to more closely adapt to the changing needs of families (e.g., long acting methods for those who have completed their families);
- STI's will require behavior changes and increased use of condoms, but the treatment of current infections will also be required. Antenatal clinics will need to begin screening women for STI's in order to prevent complications (pelvic infections and transmission of infection to the newborn);
- Adolescents are eager to learn about reproductive health and the rising awareness of the need to educate the younger generation provides a new opportunity to improve the lives of the next generation.
- Regarding HIV/AIDS, Bangladesh has an opportunity to avoid the epidemic if the issue can be addressed rapidly. The nation already has a good surveillance system in place, and through coordinated interventions, the HIV epidemic might be avoided, but the window of opportunity is rapidly closing.

Development strategies

Based on the challenges and gaps that have been identified in the policies, programs and on-ground reality, strategies and priorities must address the reproductive health issues with major emphasis on safe motherhood, reduction in MMR, improvement in family planning acceptance and performance rate, and prevention and treatment of sexually transmitted infections. The major emphasis is given on including adolescents and men into reproductive health programs. Continued efforts to improve family planning programs with appropriate targeting of services are likely to be effective. The education level of both husband and wife has a direct impact on reproductive health. Research and studies have repeatedly identified educational background as a key determinant in issues like reproductive behavior, fertility, maternal mortality, infant and child mortality, etc.

The Government has made major strides in making primary education compulsory for girls and providing stipend at secondary and higher levels. These initiatives are also yielding tangible results in empowering women and in increasing the age of marriage and childbearing. The GoB has introduced a quota system in public administration under which 10% of gazette and 15% non-gazette posts are kept reserved for women. Sixty percent of the primary school teacher posts are reserved for women (Barkat, Abul, et al., 1999).

In the field of population control the main approaches and policies that will result in delaying marriage revolve around education and employment. Increase of average age at female marriage is likely to be the most productive intervention to reduce the future impact on population momentum. The issue of child survival also needs to be given a very high priority. The most immediate determinants of further fertility decline are contraceptive practice, abortion use, breastfeeding, and marriage or cohabitation patterns. Regarding contraceptive practice, a greater variety of methods are needed in Bangladesh, ideally with at least one long-term method and one short-term method being provided to at least half of the population. Furthermore, a better understanding of the reasons for reluctance of clients to use any clinical methods is needed.

In determining where their efforts should be focused, planners should make more use of information on the unmet need for and intention to use family planning. This should be seen not only in relation to the clients but also as a reflection of coverage and quality of family planning services. This would be a productive approach to bridging the gap between desired family size and actual fertility.

Education gives women a sense of confidence and status to think, discuss and reach decisions on matters pertaining to themselves within the family. The BDH Survey 1999-2000 shows that women who have no formal education have an average of 4.1 children, while women with at least some secondary education have an average of 2.4 children. Despite the modest achievements in the education sector, a big gap still remains between the number of educated males and females in this country. The BDH Survey also shows that a substantial gap exists between urban and rural education status. The proportion of urban men and women with some secondary education is almost twice that of rural men and women. However, it is encouraging to note that the male-female and urban-rural gap in school attendance of children (6-15) has become virtually non-existent.

As the plateauing TFR is a big concern for Bangladesh, the long term policy and strategy of HNPSP will emphasize a more appropriate method mix and increasing proportion of clinical and terminal methods. HNPSP also envisages to improve the quality of FP services through the revival of the doorstep services and increasing social awareness on FP services. HNPSP plans to improve access clinical services by offering high quality services in major hospitals in addition to Upazila, MCWC and UHFWC (MOHFW, May 2003).

Though much information is available on the experience and situation of maternal health in Bangladesh there is a need for some specific investigation. These will help in clarifying issues and contribute to policy and strategy implementation. Research is particularly needed (MOHFW, Oct 2001) to define:

- Modalities for improving Quality of Care and retention of trained personnel in the remote districts and in Upazila Health Complexes;
- Factors that will enhance utilization of antenatal care (ANC) and skilled attendance at delivery;
- Modalities for encouraging un-employed nurses to take up midwifery as a profession and link to referral facilities;
- Issues and options related to zero tolerance on VAW;
- The GoB has laid down matrices for strategy development with clear objectives up to 2010 and priority actions to strengthen the provision of essential (including emergency) obstetric care and improve utilization of services and ensure accessibility of appropriate and safe maternal health services by skilled providers at all levels of service delivery (ibid.) including the community/household level.

The priority action areas in the field of improving reproductive health as identified by ICDDR,B are:

- Improving emergency and essential obstetric care and ensuring safe motherhood;
- Improving family planning services including developing services for men as well as women;
- Meeting the needs of adolescent reproductive health;
- Prevention and treatment of STI/RTI/HIV/AIDS;
- Minimizing the need for and improving post-abortion care;

- Developing programs to increase male involvement in reproductive health;
- Improving newborn care;
- Understanding the issue of violence against women in the social context and developing public health strategies to reduce it.

To set priorities in addressing the population problem more research and investigations will be required along with a good understanding of issues that affect population science, i.e.:

- Investigations into fertility decline rate in Bangladesh, understanding how to reduce fertility rates to replacement level or below, and how to minimize the impact of population momentum through social interventions;
- Understanding adult health problems, including non-communicable diseases including how families provide the necessary resources, both in terms of financial and social support, to deal with the growing health demands of an ageing population;
- Understanding the economic and social forces motivating out-migration from rural areas. This understanding is linked to monitoring of changes in the family structure, especially in terms of social and financial support for family members remaining behind in the rural communities;
- Collaborating with other surveillance systems through a network to improve the capacity of such systems to develop and monitor interventions for better management of health and population challenges in other countries;
- Understanding the relation between family planning programs and abortion in order to minimize the latter;
- Understanding as well as developing tools for monitoring health equity, especially in relation to rapid population growth and urbanization.

As a multi-sectoral concern, population stabilization requires integration of population factors into the activities of health, education, women's development, urbanization, housing, environment, poverty alleviation, elimination of social and economic disparities, etc. Policies and strategies of these sectors have to be consistent with the goal of population stabilization and socio-economic development. GoB services need to integrate population variables in the development plans and policies of all relevant ministries in order to make public policies more population focused.

The population and development strategies will emphasize the following four areas:

- Migration and urbanization
- Coordinated collection and use of data
- Population and environment
- Welfare services for the elderly and poor

Policy Reforms

In the evaluation report of the MoHFW about HPSP 1998-2003 (Status of Performance Indicators 2002) published in January 2003, the GoB addressed the major policy issues with a view to decide the role of the Government as to whether it should primarily be a regulator and maker of policy, or mainly be a service provider. This issue is particularly relevant at the upazila level and below where many alternative service providers exist, and NGOs in particular collaborate with the Government in joint service delivery activities. This is happening without any formal GoB-NGO strategy or policy, although the development of such a strategy was anticipated under HPSP.

The Bangladesh Family Planning Program is at the initial stage of a big structural change. However, as policy decisions have not been implemented so far nor has the revised roles and responsibilities been clearly defined and communicated to all staff, certain amount of confusion and uncertainty prevails among the staff at thana level. This has led to a slowing down in promotional efforts and decline in program performances, particularly in clinical services.

Conclusion

Like most developing countries, Bangladesh faces difficult challenges caused by poverty, malnutrition, and poor health, poor performance of health system, and inadequate and/or unsustainable health care financing.

Bangladesh is the eighth most populous country in the world with a population of around 130 million and the highest population density in the world. It is one of poorest countries with a per capita income of around US\$380. The costs incurred by families in seeking critical health services acts as a deterrent to seeking care. As a result of overcrowding, poverty, and poor access to health services, infectious diseases and malnutrition are common (ICDDR,B., 2002).

Reproductive healthcare encompasses a wide variety of issues like safe motherhood, family planning, and adolescent health, STI/RTI, HIV/AIDS, maternal nutrition, abortion care and violence against women.

Unless a coordinated programmatic action is implemented and monitored for evaluation of the ground level success, no real achievement is possible in the field of reproductive health. While the country's achievement in this field has been reasonably successful against the backdrop of financial, social, bureaucratic and other constraints, previous programs have yielded visible results. Women's ability to come out of the home to avail services from community centers is quite encouraging.

A Population Council study (Khan M.E et al., 2000) indicates that Bangladeshi women are relatively more empowered today than 10 year ago and are in a better position to take decisions about their reproductive goals and contraception than their sisters in India or Pakistan. The study also indicates that discontinuation of home visits by FWAs could adversely affect motivation and provision of contraceptive services to younger couples (newly married and low parity women). Lack of access to contraceptive could become a serious bottleneck in the acceptance of contraception. The study also indicates that prevalence of domestic and sexual violence is of a fairly large magnitude. Such gender-based violence not only has serious consequences for women's health but also reduces their ability to avail services from clinics located outside the villages. With regard to family planning, the use of long acting, low cost clinical methods of contraception are declining, and temporary methods have high discontinuation rates. Better systems are needed to increase long acting methods and to improve continuation of temporary methods.

In the context of Bangladesh one negative aspect of service delivery in general is the growing inequality among certain important services. When the rich use these services more than the poor, it indicates that the system is not working as intended. This socio-economic inequity is particularly prominent where higher-level medical staffs are involved. Health and population activities have matured in Bangladesh and families are less reliant on household delivery of services. Increased mobility of women and greater awareness of available services has created a demand, and clients manage to obtain services from one source or another when their usual source is removed or restricted. Greater attention and research are required with regard to clients' needs in future programs. A number of examples of service delivery activities have continued to improve because of the existence of committed staff at the MOHFW, including at the Line Director level, and continued technical support from collaborating agencies.

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