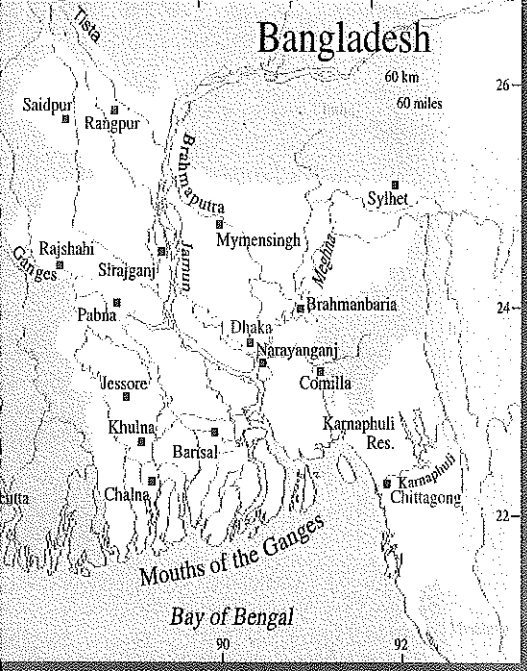

HEALTH GENDER SEXUALITY

BANGLADESH COUNTRY REPORT

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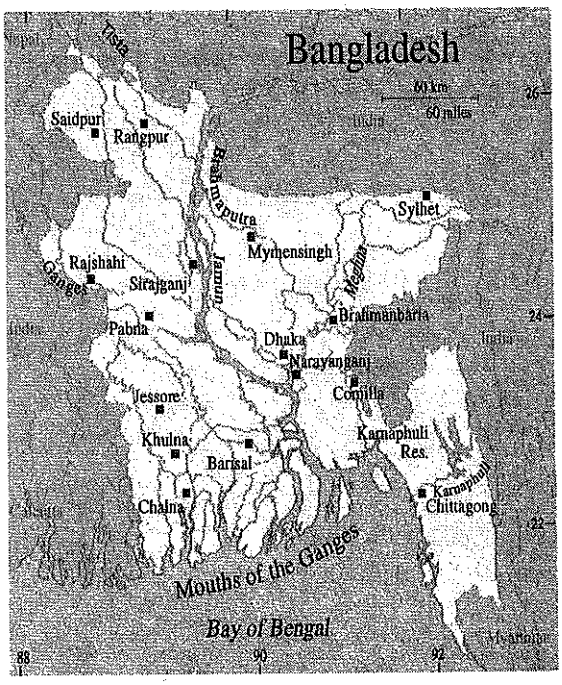

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Contents

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Glossary

ASHA	Association for Social and Human Advancement
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BDHS	Bangladesh Demographic and Health Survey
BIRPERHT	Bangladesh Institute of Research for Promotion of Essential and Reproductive Health and Technologies.
BRAC	Bangladesh Rural Advancement Committee
BWHC	Bangladesh Women Health Coalition
CBD	Community-based Distribution
CEDAW	Convention for Elimination of Discrimmination Against Women
CWFP	Concerned Women for Family Planning
DGHS	Director General of Health Services
EEC	European Economic Community
EPI	Expanded Programme of Immunization
FPMD	Family Planning Management Development
FP	Family Planning
FPHSP	Fourth Population and Health Services Project
FWV	Family Welfare Visitor
GDP	Gross Domestic Product
GNP	Gross National Product
GOB	Government of Bangladesh
GOBI-FP	Growth monitoring, Oral rehydration therapy, Breast feeding, Immunization, Family Planning, Female Literacy
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IEC	Imformation, Education and Communication
ILO	International Labour Organization
IUD	Intra-uterine Device
MCH	Maternal-Child Health
MOHFW	Ministry of Health and Family Welfare
MOLGRD	Ministry of Local Governmant, Rural Development and Cooperatives
MRTSP	Menstrual Regulation Training and Services Programme
MR	Menstrual Regulation
MTP	Medium-Term Plan
NAC	National AIDS Committee
NCWD	National Council for Women's Development
NGO	Non-Government Organization
NIPSOM	National Institute for Preventive and Social Medicine
NIPORT	National Institute of Population Research and Training
OB-UYN	Obstetric and Gynaecology
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
RTI/STD	Reproductive Tract Infection/Sexually Transmitted Diseases
STP	Short-Term Plan
TBA	Traditional Birth Attendant
TK	Taka (Bangladesh Currency)
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WID	Women in Development

Background

Tagore's lyrical references to a "Golden Bengal" seem more a lament than an exultation over a motherland now virtually synonymous with poverty and destitution for tens-of-millions of people. Today's Bangladesh, with a land mass of 144,000 square kilometers and a population of nearly 120 million in 1994, is the most densely populated country in the world (World Bank, 1995). This number will almost certainly double in another 30 years.

MOON IN THE SKY

... He saw that the green earth was beautiful
on the shore of the blue sea.
A farmer was reaping paddy in a golden field;
With sails raised, small boats moved along,
while the boatmen squatted and sang.
Bells were ringing in a far-off temple,
Women were going to the ghat to get water,
By village paths men were going to market.
Heaving a sigh, he said, with a heavy heart,
I don't want the moon
if I can get back this life...

Sonar Toree by Rabindranath Tagore (1891-1893); Translation by Brother James, 1986. University Press Ltd., Dhaka, Bangladesh.

With an estimated GDP per capita of US$ 220 in 1993, Bangladesh is also among the poorest nations of the world -- ranking 146th out of 174 countries (UNDP, 1995). Estimates of the rural population (83% of the total population) living in absolute poverty range from 60 to 85 percent. It is certain that at least a third of these, and perhaps more than half, constitute a hard core of extreme poverty that subsists on a per capita income and nutritional level less than half of those at the poverty line (Bangladesh Institute of Development Studies, 1990, 1992; Osmani, 1990; Lovell, 1992; World Bank, 1990). In other words, at least 70 million rural people live in absolute poverty, and of these, 35 to 50 million exist in extreme hard core poverty. This is more than the total population in all but 20 other countries in the entire world.

Bangladesh ranks 156th among 174 countries with an adult literacy rate of 36.4 percent in 1992. Over forty percent of primary-age children do not enroll in school at all; and, of those who do enroll, barely 20 percent complete the primary grades. Failure to enroll and dropout rates for girls are even higher (UNICEF, 1990). Over eighty percent of Bangladeshi women cannot read or write or understand numbers at a functional level. While 83 percent of the population resides in rural areas, 70 percent of the government investment in education goes to urban areas and post-secondary education. Bangladesh spends only 2.0 percent of its GNP on education (World Bank, 1995).

After a quarter-century of independence and the expenditure of hundreds of millions of dollars, the health of the nation, especially its most vulnerable, i.e. women, pregnant and nursing mothers, and children aged less than five years, is deplorable

by virtually any standard. Female life-expectancy in Bangladesh is lower than that of males, 58 years versus 57 years respectively. This is a dubious distinction characteristic of fewer than half-a-dozen other countries and speaks volumes with respect to the status of women in Bangladesh, ranked last among all the nations of the world in a Population Crisis Committee study (1988).

Women between the ages of fifteen and forty-nine years and children aged less than five years constitute a population of nearly 43 million people at risk in Bangladesh. Of the four million children born in the next twelve months, five hundred thousand will die within their first year, and another three hundred and fifty thousand will die before the age of five years. Of the approximately three million surviving beyond the age of five years, more than eighty percent will fail to realize their full growth potential. Over 65 percent of all children aged less than five years are moderately or severely malnourished by accepted international standards.

The median age at first marriage for all women is only seventeen and a half years (up from 14-15 years at the time of Independence in 1971), and compared to twenty-five years for men. If a woman survives to age forty-nine in a marital union she will, on average, experience almost five pregnancies. Over ninety-five percent of births will take place at home, the majority attended by untrained relatives and neighbours without even a rudimentary knowledge of hygiene and safe-delivery practices. A majority of women will experience significant morbidity associated with pregnancy and delivery, e.g. uterine prolapse, vesico vaginal fistula (Akhter, 1994, Goodburn *et al.*, 1994). As many as six of every hundred women (28,000 women annually) will die from pregnancy-related causes, a rate one hundred times greater than that in the developed world. This rate has remained virtually unchanged over the last two decades. Also unchanged is the fact that an estimated 25-30 percent of all maternal deaths are attributable to the consequences of septic abortions at the hands of untrained practitioners.

The Government of Bangladesh (GOB) spends only 1.5 percent of its GNP on health. With the exception of family planning services, perhaps as much as 70 percent of all health-related expenditures are urban-based, with a disproportionate amount allocated to the capital city's secondary and tertiary health systems. In rural areas, public sector services are essentially non-existent for many, particularly women. Seventy percent of the population are without access to any health services or proper sanitation. The population to provider ratio for physicians and nurses is 12,500 and 20,000 respectively (World Bank, 1995). These figures, alarming as they are, fail to convey the urban bias in the distribution of health manpower. In rural Bangladesh, a fully functional, i.e. staffed and equipped, health facility is a true exception.

The Bangladesh Government attempts to provide village health services to women and their children through Family Welfare Assistants (FWAs) and male Health Assistants (HAs). Male and female paramedics based at Union Health and Family Welfare Centres (UHFWCs) provide support to health workers in some 10-15

villages and provide backup services. Union health workers refer complicated cases to medical staff at the *thana* hospital which serves a population 200,000. The fact remains, however, that nearly three quarters of all rural families do not use government health facilities mainly because the service is poor, the facility is often some distance away, and when reached may not have the required medicines and supplies. For women unfamiliar with a medical setting and routine such clinics can be a difficult and unpleasant experience. Service used is also limited by the fact that the overwhelming majority of doctors are men, and it is culturally prohibited for a woman to be seen, let alone physically examined, by any male other than her husband except under dire circumstances, and by then it is often too late. Presently, the government and non-government primary health systems cover only thirty percent of the population. Still, government policies continue to place inordinate emphasis upon family planning, physical construction of urban-based facilities and the training of physicians.

Donor and GOB programmes which emphasize GOBI-FF reflect a prevailing view of health problems as being the result of inadequate technological inputs: contraceptives, vaccines, and personnel. There is no question that these strategies focus upon critical elements in the delivery of selected services, but these vertical initiatives do not acknowledge, let alone facilitate, the development of a comprehensive primary health care system. Government and bilateral programmes seldom specifically address the needs of adolescent and pregnant women, for example, which accounts for the preponderance of mortality among women of reproductive age. Maternal morbidity and reproductive health receives even less attention, and initiatives designed to address gender differentials in health status are conspicuous by their absence. This, then, is the basic context in which any consideration of gender, sexuality, and reproductive health must be embedded.

A. Basic Demographic and Health Information

In the absence of a national vital registration system, estimates of fertility and mortality in Bangladesh have historically come from two primary sources, i.e. surveys and sample vital registration surveillance systems.[1] Attempts to measure the size and growth of the population of the country since Independence through national census (1974, 1981, 1991) have been beset by considerable disagreement (Kantner and Noor, 1991). Still, there has been an increasing consensus regarding the national levels and trends in fertility and mortality in Bangladesh – all of which give some cause for cautious optimism. In other words, while various surveys

[1] The most recent national demographic information comes from Contraceptive Prevalence Surveys conducted periodically between 1979 and 1991, the 1989 Bangladesh Fertility Survey and the Bangladesh Bureau of Statistics Sample Vital Statistics Registration System, and the 1993-1994 Demographic and Health Survey. The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) has maintained an extensive surveillance and registration system on a population of approximately 200,000 persons for more than twenty years. These data are made available on a regular basis through the Centre; and, these are succinctly summarized and discussed in the recent volume by Fauveau (1994).

indicate progress has been made in the last twenty years toward achieving the goals of reducing fertility, increasing contraceptive use and reducing childhood mortality – they also demonstrate a great deal remains to be accomplished.

Table 1: Percentage of Population in Different Age Groups and Male:Female Ratios

Age Group	Percentage	Male:Female Ratio
0-4	17.0	101.4
5-9	16.3	102.9
10-14	13.4	114.8
15-24	17.4	97.6
25-34	13.1	101.5
35-44	9.3	111.0
45-59	8.2	120.9
60+	5.6	127.7

Source: Bangladesh Statistical Yearbook, 1991

Malnutrition is a major contributing factor to maternal and child mortality in Bangladesh (Rahman, 1989; UNICEF, 1990; Fauveau, 1994). Intra-uterine growth retardation is attributable to the poor nutritional status of mothers, itself the consequence of lifelong deprivation. Virtually, all poor mothers in rural areas weigh less than fifty kilograms, seventy percent of rural mothers from what is considered high-income households fall below this standard as well. Among the rural poor fifty-seven percent of all mothers are less than 147 centimetres in height, evidence of stunting as a result of chronic malnutrition. Half of all children weigh less than 2.5 kilograms at birth.

Table 2: Death Rates per 1000 by Age and Sex[2]

Age	Males	Females
Under 1 month	69.3	56.8
1-5 month(s)	38.5	31.8
6-11 months	14.8	18.1
1-4 year(s)	9.8	10.4
1 year	11.3	20.0
2 years	13.6	8.1
3 years	5.0	6.5
4 years	5.2	2.6
5-9 years	1.2	2.8
10-14 years	0.3	0.8
15-19 years	1.0	0.9
20-24 years	0.5	2.4
25-29 years	2.2	2.7
30-34 years	2.4	1.3
35-39 years	4.4	2.7
40-44 years	3.0	4.1
45-49 years	8.7	4.2
50-54 years	11.4	8.5

Source: ICDDR,B, DSS-Matlab Registration of Demographic Events, 1991

Sixty-seven percent of all rural children suffer from chronic malnutrition, and nearly ten percent from acute malnutrition, particularly in the 12-23 month-age group. Key nutrient deficiencies are common. Seventy percent of children and virtually all pregnant women are anaemic, thirty percent of the general population and eighty percent of pregnant and lactating women suffer from iodine deficiency, and perhaps as many as a million children suffer from some degree of vitamin A deficiency. Surveys reveal that the caloric intake of Bangladeshis has fallen over the last two decades. Given the rate of population growth and continued impoverishment of rural peasants, it is unlikely there will be a dramatic improvement in nutritional status in the near future.

[2]These figures represent rates in the comparison area of the ICDDR,B's surveillance system. These data are consistent with the estimates provided in the recent Bangladesh Demographic and Health Survey Report, 1994.

Aggregate statistics clearly document the poor health of the nation generally, and the risks to mothers and children specifically (Table 1 through 3). Within these cohorts, however, adolescents and newborns are at uncommon risk. While the overall maternal mortality rate in Bangladesh is estimated to be between 4.8 and 6.0 per 1000, for those under the age of nineteen years the rate exceeds 18 per 1000. In fact, twenty-five percent of all maternal deaths occur to women under the age of nineteen. A similar pattern is observed when maternal mortality rates in relation to numbers of pregnancies are examined. Among those experiencing their first pregnancy the mortality rate is 13 per 1000; for those experiencing their second pregnancy the rate is 2.4 per 1000. In Bangladesh 36 percent of all maternal deaths occur to women having a first pregnancy. Given patterns of marriage and family formation most deaths occur to adolescents.

Table 4: Cause of Death Among Women of 15-44 Years: Matlab 1976-1989

Cause	Percent	Rate
Infectious disease	**33.0**	**85**
Direct obstetric	**25.8**	**67**
Abortion	6.6	17
Postpartum sepsis	2.3	6
Postpartum hemorrhage	6.5	17
Toxaemia/eclampsia	4.2	11
Obstructed labour	2.0	5
Other obstetric	4.2	11
Injuries	**13.0**	**34**
Drowning/snake-bite	1.4	4
Other accident	4.6	12
Suicide	5.1	13
Homicide	1.9	5
Non-infectious disease	**7.9**	**20**
Iatrogenic	**2.2**	**6**
Unspecified	**18.0**	**47**

Source: Fauveau, 1994

Pregnant adolescents are subjected to risks other than those directly related to delivery. Among pregnant adolescents, regardless of marital status, at least 20 percent of all deaths are attributable to intentional injury. Of these, 62 percent are attributed to suicide, 16 percent to homicide, and 22 percent to septic abortion. It is estimated that among unmarried pregnant adolescents, suicide and septic abortion may account for as much as 90 percent of all deaths. In other words, the underlying causes of death among a significant proportion of pregnant adolescents are not biological, but social.

Table 3: Causes of Maternal Deaths: Matlab 1976-89

Cause	Percent	Rate (per 100,000)
Direct obstetric	**73.0**	**66.5**
Spontaneous abortion	2.8	2.5
Induced abortion	15.9	14.5
Obstetric complications	5.5	5.0
Toxaemia/eclampsia	12.0	10.9
Obstructed labour	5.7	5.2
Postpartum hemorrhage	18.3	16.7
Postpartum sepsis	6.5	5.9
Other postpartum	6.3	5.7
Concomitant	**22.8**	**20.8**
Digestive tract	11.2	10.2
Cardio respiratory	2.6	2.3
Injuries, violence	9.1	8.2
Unspecified	**4.1**	**3.8**

Source: Fauveau, 1994

While the infant mortality rate in Bangladesh, estimated to be between 81 and 130 per 1000, is among the highest in the world, neonatal mortality within the first

month accounts for nearly 60 percent of all infant deaths. Among neonates prematurity is perhaps the principal cause of death. Prematurity and low birth weight are directly related to the health status of the mothers, and children born to adolescents and first-time mothers are at significantly increased risk.

Table 5: Causes of Death Among Children of 1-4 Years: Matlab Comparison Area, 1986-1987

Cause	Percent	Rate per 1000
Diarrhoeal diseases	55.6	9.7
Acute respiratory infections	14.7	2.6
Other infectious disease	4.7	0.8
Severe malnutrition	6.0	1.1
Injuries/accidents	12.6	2.2
Unspecified	6.5	1.1

Source: Fauveau, 1994

Clearly, neonates and adolescents bear a disproportionate share of the burden among mothers and children at risk. Nevertheless, in Bangladesh there is virtually no programming directed specifically to them.

While these factors are important they should not be allowed to obfuscate the dramatic gender differentials in health status. In Bangladesh, this differential manifests itself in the first year of life, and continues unabated until death. There is little difference in the death rates for newborn boys and girls up to the age of one month. Subsequently, there is a higher female mortality rate in all age cohorts. Between one month and one year of age, the average death rate per thousand live-births in the Matlab between 1978 and 1984 was 48.8 for girls and 41.1 for boys. For children aged one to four years , the rates were 31.5 and 18.2 respectively. Within this age cohort, female mortality exceeded male mortality by sixty to almost eighty percent. Regardless of the indices employed (e.g. mortality, morbidity, weight-for-age), or of the comparison made (e.g. rural versus urban, low versus high income), females consistently fall below males with respect to health status. For example, in the 12-23 – month age group, 18.3 percent of the urban females versus 11 percent of the rural males exhibit acute malnutrition. This life-long differential is reflected in the fact that life expectancy at birth is greater for males.

Gender is not just a biological characteristic (Aziz and Maloney, 1985). Gender differentials in health, or the lack of health, overwhelmingly reflect the socio-cultural status of women in Bangladesh. Infections, for example, are oppor- tunistic and seldom sex-specific. Class, intergenerational relations and women's status account for the gender differentials in health. Females are four to five times more likely to suffer from severe and chronic malnutrition not because of biology, but because of socio-cultural values. Females are four to five times less likely than males to receive health services not because of biology, but because of sociocultural values. The lack of female health professionals and maternity care services is not because of biology, but because of socio-cultural values. One is left with a single overwhelming impression with respect to gender differentials in health -- women are significantly less valued then men. Malnutrition, stunting, morbidity and mortality in Bangladesh are all closely correlated with socioeconomic status. As a general rule rural populations are worse off than urban; low-income households are

subject to greater suffering than middle or high-income ones, and households where the mother has at least a primary education are inevitably better-off.

The prevailing patterns of morbidity and mortality among mothers and children in Bangladesh reveal the link to poverty as an underlying factor, as well as the fact that the greatest proportion of attributable causes are preventable through relatively simple interventions with existing technologies. It is also evident that Bangladesh remains at the earliest phases of the demographic and health transitions. Demographically, the country is characterized by early marriage for women, relatively high fertility and mortality, and relatively moderate levels of contraceptive use. Epidemiologically, the country is characterized by a preponderance of mortality among the youngest cohorts which is often attributable to preventable infectious diseases, exasperated by malnutrition, and ameliorable by proper case management.

The inexorable links between poverty, malnutrition, morbidity and maternal and child mortality could lead one to conclude that nothing will change as long as Bangladesh remains poor. There is reason for optimism, however. Perhaps half of all maternal and child deaths could be prevented by a series of interventions all well within reach. These include: quality pregnancy care; safe abortion; modern contraception; nutrition for high-risk mothers; improved infant feeding and weaning practices; treatment of diarrhoea and respiratory disease; and immunization. These represent supply-side technological interventions for the most part. They do not address many of the underlying causes of adolescent and neonatal mortality directly. These interventions discount the fact that the very socioeconomic and environmental factors determining the specific morbidity and mortality patterns, for example, also limit access to, availability and use of health services. Failure to take these factors into consideration will inevitably diminish the impact of such interventions.

In fact, many of these constituent elements currently exist in one form or another. They have had an impact. While maternal mortality has proven to be relatively intractable, progress has been made in other areas. Since the mid-1980s, there has been considerable improvement in child survival. Mortality in those aged less than five years has fallen from 180 deaths per 1000 to an estimated 133 per 1000 in the early 1990s -- a decline of over 25 percent. The infant mortality rate has declined by a similar extent, from approximately 120 to 87 per 1000 births (NIPORT, 1995). This trend is supported by numerous surveys, and by the surveillance systems of ICDDR,B (Fauveau, 1994). A major contributor to this pattern has been the success of various child survival strategies (GOBI-FF), and particularly to the Expanded Programme of Immunization (EPI). A recent survey indicates 60 percent of children aged 12-23 months are fully vaccinated -- a great increase from less than 20 percent five years ago. Still, as we have seen, much remains to be done, especially with regard to reducing gender differentials in health status.

During the International Conference on Population and Development (ICPD) in Cairo in September 1994, the Government of Bangladesh was acclaimed for the achievements of its family planning programme. ICDDR,B, the Centre for Health and Population Research, deservedly shared the recognition. Much of the government's success is directly attributable to the pioneering work of the Centre's Maternal and Child Health and Family Planning (MCH-FP) Programme introduced in Matlab in 1977. Contraceptive prevalence is now over 65 percent in the Matlab MCH-FP programme area, far above levels for other regions in Bangladesh. Since the mid-1980s, through the MCH-FP Extension project, the Centre has collaborated with the Government of Bangladesh (GOB) to transfer and scale-up the lessons learned in Matlab to the national family planning programme.

In many quarters, in fact, Bangladesh was being hailed as providing an overwhelming evidence of how much could be accomplished – in terms of fertility control – with political will and logistics in the presence of pervasive and persistent poverty. The total fertility rate in Bangladesh has declined from nearly 7.0 live-births per woman at the time of Independence (1971) to an estimated 3.4 births for the period 1991-1993. Since 1989, in fact, the most recent BDHS data indicate a reduction of 20 percent over a two-year period, the most dramatic decline in Bangladesh's history. While the rate of fertility decline has been relatively uniform across groups, significant differentials in levels still exist. Fertility is about 30 percent higher in rural (3.54) than in urban areas (2.69), for example. Differences also exist based on women's education. Those with no formal education average 3.8 children, compared to 2.6 for women with at least some secondary education. Although increased contraceptive use accounts for most of the fertility decline, there has been a trend, albeit slight, to attribute this decline to increased age-at-first birth. In 1975, the median age-at-first birth was 16.8 years; in 1993 this had risen to 18.3 years. Nevertheless, one in three Bangladeshi women between the age of 15 and 19 years is already a mother or pregnant with her first child. This represents a major challenge to policy-makers. The steady increase in contraceptive use over the last two decades has been remarkable. The contraceptive prevalence rate has almost increased six-fold since 1975, from 8 to 45 percent of married women. Use of modern methods has grown even faster. In terms of method mix, the dominant change since the late 1980s has been in the large number of couples using oral contraception. The proportion of women relying on the pill almost doubled between 1989 and 1993, from 9 to 17 percent. Use of male and female sterilization has stagnated or declined slightly since 1989 and now accounts for 10 percent of all contraceptive use. Aside from the pill and sterilization, use of

Table 6: Age-specific Fertility Rates

Age (in years)	Urban	Rural	Total
15-19	81	148	140
20-24	178	198	196
25-29	134	161	158
30-34	82	108	105
35-39	41	58	56
40-44	4	21	19
45-49	17	14	14
TFR 15-49	2.69	3.54	3.44

Source: BDHS, 1993-1994

injection, condoms, the IUD, rhythm and withdrawal have increased slightly since 1991, but none is used by more than 5 percent of married women. While the Government's family planning programme is being extolled as a success, the fact is, the dedication of disproportionate resources to population control has both inhibited the development of an integrated primary health care system and resulted in the near total neglect of other dimensions of reproductive health for women and men.

Table 7: Use of Contraception: Currently Married Women

Method	Percentage of currently married women using
Any method	**44.6**
Any modern method	**36.2**
Pill	17.4
IUD	2.2
Injection	4.5
Condom	3.0
Female sterilization	8.1
Male sterilization	1.1
Any traditional method	**8.4**
Periodic abstinence	4.8
Withdrawal	2.5
Other	1.1

Source: BDHS, 1993-1994

The Government's formal health care system consists of two parallel hierarchies: one for health and the other for family planning, both reporting to the Ministry of Health and Family Welfare (MOHFW). Government policy is to integrate services at the *thana* level and below, with the *Thana* Health and Family Planning Officer serving as the point of merger. The objective of the Government is to provide at least minimal access to health care services for all through a hierarchy beginning with the Union Health and Family Welfare Centre and Rural Dispensaries (UHFWC), proceeding up to the *Thana* Health Complex, on to the District Hospital, and to the urban and medical school-based tertiary centres.

Community-based services are offered by paramedical personnel who provide outreach from UHFWCs, covering ten to fifteen villages. Most personnel in the health system are male (Health Assistants), while those in the family planning system are both male (Family Planning Assistants) and female (Family Welfare Visitors). The prevailing health profile of the nation, and particularly of women and children, clearly indicates that much needs to be accomplished before there is "health for all."

The dual delivery system has a number of inherent weaknesses, not the least of which is the obfuscation of lines of responsibility and accountability. As a consequence, coordination -- let alone integration -- is seldom achieved, and the potential of personnel and facilities are unrealized. MCH services are divided between the two wings of the Ministry. The Health Wing provides immunization, ORT and distributes vitamin A. The Family Planning Wing is responsible for family planning, for ninety-three maternal and child care centres and for the training of paramedics and traditional birth attendants in safe delivery practices.

Presently, the government system covers approximately thirty percent of the population. There are fifty *thanas* where health complexes still remain to be constructed. Existing facilities are inadequately maintained, have generally poor sanitation and water sources, lack essential laboratory equipment, drugs and supplies, are inadequately staffed, managed and supervised. Under these circumstances, it should not be surprising that use levels are low. An effective system of referral as a function of primary care, for high-risk women and infants, for example, is defeated where the anticipated point of first contact cannot provide the required service, or where the population will not attempt to use the limited facilities.

There are also more than 250 non-government organizations (NGOs) with health-related programmes providing both community and clinic-based MCH services. Some focus on health education and motivation, while others seek to improve upon existing services by developing alternative delivery systems. The impact of NGO initiatives upon the health status of those served has not been well-documented beyond very basic service statistics.

The Government is cognizant of many of the limitations in the existing system. In the emerging Fifth Five-year Plan, greater emphasis is given on the training of nursing and paramedical personnel; developing a community-oriented curriculum for all health professionals; initiating greater efforts to integrate the two systems of delivery at all levels and improving management and supervision; and greater emphasis on MCH as an integral element of the primary health and family planning programme. Importantly, the Government has recognized the value of NGOs in the delivery of services and as an environment in which experimental and pilot initiatives may be evaluated prior to national implementation.

A greater commitment to participatory processes is required, especially enabling women to speak and act on their own behalf, their families, and their communities. With the ICPD consensus in Cairo, dictate became an operational directive. The challenge now is to transform common, but frequently hollow rhetoric, into a substantive reality for the reproductive health of both women and men.

B. Legislation and Policies

Traditional Law

Bangladesh is a multi-religious, nominally secular state (Muslim 90%, and the remainder divided among Hindu, Christians, Buddhists, and Animists). Its Constitution grants all citizens equal rights and speci- fically declares that the State shall not discri- minate against any citizen on grounds of religion, race, caste, sex or place of birth. It does, however, make provision for positive discrimination in

favour of disadvantaged groups, i.e. women, children, and the disabled.[3] Article 29 of the Constitution states: "Women shall have equal rights with men in all spheres of the State and public life." Conspicuous by its absence is the provision for equality in "private" or "personal" domains (Appendix 1). It is apparently presumed that private life is to be governed by the respective traditional laws of each religious community. This fact has been a major stumbling block to the promulgation of a uniform code of law which holds the promise of gender equity for Bangladeshi women. This is also apparently the underlying rationale for the government's reservations associated with its signing of the CEDAW convention.[4] By tradition, women are subordinate to men.

> The preamble to the Bangladeshi Constitution pledges, among other things, "...**that it shall be a fundamental aim of the state to realize through the democratic process a socialist society, free from exploitation, a society in which the rule of law, fundamental human rights and freedom, equality and justice- political, economic and social- will be secured to all citizens."**

The traditional Muslim code of "law" is derived from the Quran and the Hadiths, as interpreted by four principal schools of thought. Bangladeshis, in general, follow the Hanaafi school of jurisprudence.[5] Muslim marriage is a contract between two individuals. The minimum age for marriage is 18 for women, and 21 for men, but in practice the law is often ignored. Tradition also specifies a bride-price (Denmohor) which, in theory, can be claimed at any time following consummation or at the time of divorce. Provision is also allowed for the delegation of the right of divorce to the wife under exceptional circumstances –rights that are automatic for men. Men may have as many as four wives; and, although the law states that the prior wife(s) must give their consent, the requirement is most often ignored.

Islam recognizes the rights of women to own and inherit all types of property and assets. In the case of inheritance, women are entitled to half the share of a man on the presumption they will be supported by a male guardian or relative, i.e. husband, father or son. In rural areas, and in a majority of urban families, it is generally expected that women will not claim their entitlements, but exchange it for the right

[3] Other laws which have been promulgated to "protect" women include: The Muslim Marriages and Divorces (Registration) Act 1974; Dowry Prohibition Act of 1980; Cruelty to Women (Deterrent Punishment Act of 1983); Child Marriage Restraint Act (Amended Ordinance 1984); The Muslim Family Ordinance 1961 (Amended in 1985); The Penal Code (Second Amendment Ordinance); Family Court Ordinance 1985; Anti-terrorism Ordinance 1992; and, Women and Children Oppression (Special Provisions) Act 1995.

[4] Bangladesh's ratification of the Women's Convention is subject to reservations on Article 2, 13(a), and 16.1 (c) and (f) on the ground that these provisions are in "conflict with Sharia law based on the Holy Quran and Sunna." For a discussion of Bangladesh's reservations, see Sara Hossain, "Equality in the home: women's rights and personal laws in South Asia." *In: Human rights of women: national and international perspectives* (Rebecca Cook, ed.: University of Pennsylvania Press), 1994.

[5] Gender analysis of development issues in Bangladesh. Dhaka: Naripokkho Ms, 1992.

to visit the parental home several times a year. This right provides a measure of security in case of divorce or desertion.

Under Muslim law the legal guardian of a child is the father, and the mother is entitled to custody of the minor child only in case of divorce or separation – in the case of daughters, until they reach puberty; in the case of sons, up to the age of seven years.

Under customary Hindu law women do not own inherited property and cannot, therefore, pass it on to their descendants. Women may pass along purchased and gifted property called "stridhana." The rights of a widow to inherit have been ensured in the Hindu Women's Right to Property Act, 1937. Daughters inherit only if other eligible categories are absent, e.g. sons and other male lineage members.

Christian laws of inheritance are regulated by civil law. Under the Indian Succession Act of 1925 Christians may will all or any portion of their property to whomever they choose. The laws of the Act apply only when a Christian dies intestate, in which the widow(er) and all lineal descendants inherit.

In view of the inequities inherent in customary law, and more often than not in the application of the existing civil law, there is an increasing demand for a uniform civil code granting women and men equal rights. While efforts continue among the nation's feminists, the concept has yet to attain popular support. Other efforts of the government to "protect" women have suffered from the inadequacies of implementation and application. Some Acts, such as Dowry Prohibition and Child Marriage, are at such odds with social norms that they are blatantly ignored.

Some progress, albeit moderate perhaps, has been made with respect to women's participation in civic affairs. The Prime Minister is a woman, as is the leader of the major opposition party. The origins of women's action can be traced to the creation of the Bangladesh National Women's Rehabilitation and Welfare Foundation in 1972. In the mid-1970s, a Women's Affairs Cell was created in the President's Secretariat, and the Ministry of Women's Affairs established in 1978. At the same time 30 seats were reserved for women in the Parliament, representing ten percent of the total. In 1984, the Directorate of Women's Affairs was established as an implementing agency. Most recently, a 42-member National Council for Women's Development (NCWD), with the Prime Minister as Chairperson, has been created for policy formulation and WID oversight. WID focal points have been designated in virtually all ministries and agencies to ensure gender sensitivity in all sectors. Again, the difficulty arises in the application and implementation of the spirit of the initiative. Little, if any, substantive result has been realized to date.

"Protection" of Women and Children

Policies related to violence against women, incest, trafficking, harassment, etc. are reflected in the laws designed to "protect" women and children delineated previously. The recent Ordinance on the Oppression of Women and Children (1995) provides penalties ranging from rigorous imprisonment for 7-14 years with fine, to life in prison with fine, or even death depending on the nature of the crime -- for kidnapping for unlawful or immoral purpose, trafficking in women, causing death or grievous injury to a woman for dowry, for committing or attempting to commit rape.[6]

Women, in principle, have access to and protection under these laws. Only time will prove their worth. Experience shows that good intentions are insufficient. A ray of hope exists, however, among NGOs and feminist organizations. Many now offer legal literacy among their programmatic efforts in an attempt to raise women's consciousness and inform them of their rights.

Reproductive Health

Virtually no legislation has been promulgated with respect to either family planning or women's reproductive rights and health per se. In the sense that policies do reflect awareness, they have been derived from the basic premise that health and freedom from disease are basic needs.

The GOB declared population its number-one problem in the mid-1970s. It has not wavered from that position to this date. All family planning services are legal if they are not explicitly prohibited, e.g. abortion. The provision of services is determined by the Ministry of Health and Family Welfare. By consensus, contraception and related services are available only to married women.

The success of its efforts over the last two decades in addressing this issue is attributable in no small measure to political will, backed up by an elaborate family planning programme reaching the doorstep of virtually every house in the nation, a strong motivational campaign, and enormous external financial support. Contraceptives are available at no or nominal cost to men and women. Access is not generally a problem, and women in Dhaka have a greater choice of methods than women in Detroit. In fact, women's groups have been more often critical of the zeal of the family planning programme and its near total focus on increasing the contraceptive prevalence rate. The government efforts are often seen as coming at the expense of meeting a broader range of reproductive health needs through an integrated primary health care system. There have been relatively few attempts to articulate the right to reproductive health or freedom, including a woman's right to

[6] Since Colonial times prostitution as a trade has been given legal sanction. In urban areas a license may be issued for such trade by the responsible City Corporation. While considered immoral, it is not in the strict sense illegal. The law intervenes if someone is abducted for unlawful or immoral purpose.

reproductive self-determination in Bangladesh. Women's groups have also been conspicuously silent on the issues of human sexuality.[7]

Abortion, Menstrual Regulation

Abortion, except to save the life of a woman, is illegal in Bangladesh under the Penal Code of 1860. Nevertheless, first trimester termination of a possible pregnancy is widely practised under the name of Menstrual Regulation (MR). This practice has its legal basis in an interpretation by the Bangladesh Institute of Law and International Affairs that the procedure was "an interim method to establish non-pregnancy," thereby effectively removing it from the purview of the Penal Code when pregnancy is not established (Ali *et al.* 978; Dixon-Mueller, 1988).

Three inescapable facts about abortion make it a public health problem that must be addressed: (1) unsafe abortions are a major cause of mortality and morbidity among women; (2) the need for induced abortion is a reality; and, (3) women need not die or suffer from the consequences of unsafe pregnancy termination because, when performed correctly, the procedure is extremely safe.

Every year in Bangladesh, between eight hundred thousand and a million women attempt induced abortion, usually in clandestine circumstances without assistance of trained professionals in unsanitary conditions. Perhaps ten thousand women or more die (25-30% of all maternal deaths) as a consequence, while tens of thousands of others are rendered sterile or left with severe, chronic health problems.

As a public and reproductive health measure, in 1978, the Government of Bangladesh decided to provide menstrual regulation services throughout the health care system down to the *thana* level. Using a hand-held plastic syringe, MR can be provided safely by trained medical doctors and paramedics up to 12 weeks from the date of the last menstrual period. In other words, mortality and serious morbidity due to abortion are almost totally preventable.

The GOB has determined that..."MR is a means of ensuring that a woman at risk of pregnancy is not actually pregnant." As such, MR is not affected by laws restricting abortion, and GOB officials at the highest levels recognize MR as a life-saving intervention and an important health service for women. In 1979, the GOB stated unequivocally that MR services are to be available in all government hospitals and health and family planning facilities at the district and *thana* levels, under the supervision of the Director, MCH services.

Menstrual regulation was begun in Bangladesh in 1979 when ten MR Training and Service Centres were established nationwide. Since that time the number of

[7] Section 377 of the British Penal Code of the eighteen hundreds prohibits unnatural sex outside marriage. This law still prevails, and would, if enforced, prohibit same-sex practices. That it has not been used in this manner is probably attributable to the collective denial that homosexuality exists in Bangladesh.

procedures performed has steadily increased, from 4,400 in 1979 to an estimated high presently of almost 300,000 annually. To date more than 6,200 doctors and 4,900 Family Welfare Visitors have received formal training in MR procedures. Of these, approximately 3,800 FWVs and perhaps only several hundred trained doctors are actually in government posts where they would provide MR services. MR services are available in all upazilas and about two-thirds of the 4,500 unions in Bangladesh. Nevertheless, the vast majority of women continue to use unskilled abortionists to terminate unwanted pregnancies, and thereby expose themselves to increased risk of infection and death.

Abortions do not kill women; unsafe abortions kill women. Only a third of the abortions in Bangladesh is performed by trained health providers. Abortion-related deaths are likely to remain unreported, particularly in unmarried women, due to laws and religious prohibitions. Termination of unwanted pregnancy is particularly difficult for unmarried women. Although NGOs and government facilities offer menstrual regulation, these services are often avoided by unmarried pregnant women to conceal their pregnancy. Also, many MR providers only target married women and cannot provide services to unmarried women requesting termination of pregnancy. Morbidity and mortality associated with sepsis and hemorrhage due to unsafe abortion practices will continue to affect the reproductive health and lives of women in Bangladesh -- this is reality.

HIV/AIDS

To date no legislation has been promulgated in response to the HIV/AIDS pandemic. The HIV infection was first recognized in Bangladesh in 1989. To date 44 HIV-positive cases have been officially identified through sero-survey in selected groups. Despite the fact that the country exhibits all the potential risk factors for transmission of the virus, there is no surveillance mechanism to estimate the magnitude and spread of the epidemic. The governmental and institutional response to the epidemic has been slow and uneven.

RTIs/STDs

Reproductive tract infections (RTIs), including sexually transmitted diseases (STDs), have never been considered a significant public health problem, and therefore, have never received proper attention at the policy level. Very little is known about the magnitude of problems related to RTIs and STDs among the general population in Bangladesh. The main reasons for lack of information include:

1. Non-integration of RTI/STD issues into the existing health care system, especially, at the grass-root level;
2. Inability of health care providers (principally FWVs) at the grass-root level to diagnose RTIs/STDs;

3. Existing information systems are not designed to record RTIs/STDs;
4. RTI-related symptoms are often perceived as complications associated with family planning methods, and therefore, not reported separately as health problems;
5. A prevailing "Culture of Silence" prohibits women from seeking treatment for RTIs/STDs.

C. Programmes and Organization

Reproductive health is a relatively recent concept in Bangladesh. The current public sector programme is basically a MCH-FP initiative comprising safe-motherhood, child survival and family planning services. The current programme fails to address a number of essential elements, including adolescent health, sexual health, STD/HIV/AIDS, and infertility services.

There is no specific programme on gender and sexuality, and in various training programmes these issues are seldom addressed. In fact, most programmes can be characterized as being gender insensitive. Public programmes have targeted women as vectors for population control, virtually ignoring male responsibility and need for male involvement. The issue of sexuality is conspicuous by its absence. On the other hand, in the menstrual regulation programme for example, it is a rule that a husband or guardian of a woman must give consent before the procedure. This, in effect, may become an effective barrier to the use of services by women in need.

National MCH-FP Program

In Bangladesh, FP efforts began in the early 1950s with the voluntary efforts of a group of dedicated social and medical workers. The initiative was largely clinic-based with little government support. From 1960-1965 government health facilities began to provide services, and during the 1965-1970 period a large-scale, field-based FP programme was administered by an autonomous body. The objective was to control population growth as a strategy to economic development.

In 1976, the Government declared a national population policy along with a broad-based, multisectoral FP programme. The policy envisioned population control and FP as an integral part of a social mobilization and economic development effort. At present, integrated FP programmes consist of MCH, PHC, and FP. In addition, women's education, empowerment and employment are being promoted. The ultimate objective of these efforts, however, is fertility reduction.

The Ministry of Health and Family Welfare (MOHFW) is responsible for both health and family planning programmes, and comprises a Directorate for each. The National Institute of Population Research and Training (NIPORT) is meant to meet

the training needs of the programme. The Management Development Unit (MDU) and the Family Planning Clinical Supervision Team (FPCST) provide technical support to the implementation of the programme. The Ministry of LGRD has also become an important partner in the national family planning and health programmes, particularly in urban areas.

The administrative dichotomy in health and family planning service delivery is a barrier to the implementation of comprehensive, quality reproductive health care. An FP worker, for example, is unable to provide assistance to families for health problems, while health workers are unable to respond to concerns regarding family planning. Referral for MCH-FP complications up to the *thana* level is the responsibility of the FP sector, above that it falls under health. As a result, referral mechanisms are complicated and inefficient.

Services

The national programme is implemented through an extensive network of clinics and a programme of outreach activities in the villages. Three distinct but coordinated sectors, Government, NGOs, and the private sector, e.g. the Social Marketing Company, are involved in the implementation of the national family planning program. The private commercial sector also contributes to the efforts of the national programme.

Community-based distribution

Family planning field workers are responsible for the distribution of pills and condoms to eligible couples. Each FWA is responsible for 600 eligible couples. At present there are a total of 23,000 FWAs. NGOs also complement the CBD programme, and NGO field workers (12,000) account for 37% of the contraceptive distribution of modern methods. The private sector supplies two-thirds of all condoms, and 18% of oral pills are supplied through the networks of the social marketing company.

MCH-FP clinics

In both government and NGO sectors, fixed and satellite clinics provide clinic-based FP services, i.e. IUD, injectable, and norplant (4,000 government clinics, 173 NGO clinics). Menstrual regulation services are offered only through fixed clinics by trained doctors or FWVs. At the grass-root level, the public sector is the main service provider for MR services, as only a few selected NGOs provide such services.

Accessibility

House-to-house visit by female outreach workers is one of the key factors in the success of the family planning programme in Bangladesh. However, women's access to family planning and MCH services outside the home is limited because of the socio-cultural and physical situation of the country. Alternative service delivery approaches are currently under trial, such as the "Depot holder" approach. This is a GOB and NGO collaborative effort undertaken by FPMD. The initiative involves community leaders as a resource for the distribution of contraceptives. Other approaches involve part-time workers, unpaid community volunteers, community-based sale of contraceptives, use of trainees for contraceptive distribution, TBAs and commercial outlets. The Johns Hopkins University has undertaken a project called "Jiggasha," which is designed to evaluate how effectively IEC can be conducted through community women.

Affordability

All government family planning services are provided free of charge. A nominal price is charged for pills and condoms. In the private and NGO sectors, a service charge has been introduced on a sliding scale or fixed rate (BWHC, MI, CWFP, Radda Barnen, for example).

Quality of Care

Despite affordability and intense effort to increase accessibility, the Bangladesh MCH-FP programme is lacking in certain essential elements of quality of care, including:

> Poor follow-up and referral mechanisms;

> Poor knowledge and technical competence of staff, which itself is largely attributable to an overemphasis on theory and neglect of hands-on training;

> No organized staff development plan

> Lack of supervision and accountability.

Choice of Contraceptive Method

In Bangladesh, various family planning methods are available, including the pills, injectables, norplant, IUDs, condoms (male), as well as male and female sterilization. A cafeteria approach is adopted, which gives women an option to choose from a wide range of contraceptive methods.

Among hormonal contraceptives, the oral pill is by far the most widely used method. Though both standard and low-dose pills are available, the latter is limited to pilot project areas only. The injectable contraceptives Depoprovera and Noresterate are available at present, but the Government is giving consideration to the supply of only Depoprovera.

Norplant has been introduced both in the government and NGO programmes, but its accessibility is limited to pilot projects to date. As Government and donors are emphasizing long-acting methods, it is expected that the availability of Norplant will be increased in phases nationwide.

CU-T 380 and 220 are both currently available through government and NGO programmes. It has been found that CU-T 380 causes bleeding problem among Bangladeshi women, which resulted in a high removal rate. As a result, the Government and donors have decided to replace CU-T 380 with CU-T 220 by the end of 1997. Among barrier method, only (male) condom is available. No barrier method for women (female condom, diaphragm) is currently available in Bangladesh. Permanent family planning methods are available for both men and women. Minilaparatomy is widely available and laproscopic sterilizations are performed only at the FP model clinics and some NGO facilities. Procurement and distribution of contraceptives is controlled by the Family Planning wing of MOHFW.

Reproductive Health Care in Secondary and Tertiary Facilities

In these facilities reproductive health care is provided in a segmented fashion. OB-GYN departments deal only with pregnancy and gynaecological problems. MR and FP are offered through MRTSP and Model FP clinics. STD problems are dealt by the STD department. This department does not have any provision for examining women who are referred to GYN out-patient departments. Providers in this department often do not have the necessary skills to deal with RTIs/STDs. The element of counseling is missing in all aspects of reproductive health care.

Health Care for the Urban Poor

Urban areas, especially Dhaka city, experienced a high growth of slum settlements over the past ten years . More and more people are migrating to the city due to push factors, such as poverty, unemployment, landlessness and natural calamities, and thus giving rise to increasing number of slum settlements. The urban population of Dhaka city increases by seven percent per year.

Slum areas are characterized by very high population density, poor sanitation and water supply. The overall poor health conditions and practices in these areas are

poor, which seriously affect the health status of the most vulnerable groups, i.e. women and children. This, however, is not reflected in the national health statistics.

Although in all government planning and policy decisions the urban areas in Bangladesh are usually identified as areas of high availability and accessibility of health care services, the major focus of PHC service has been on the rural areas. Despite large numbers of government, private, and non-government facilities, there are no organized PHC services for the urban poor. Some basic health care is provided by the City Corporation, which falls under the MOLGRD. The MOHFW in urban areas is only responsible for secondary and tertiary care, and specialized vertical programs, e.g., TB control and prevention of night blindness. Use of these facilities for basic health care is very limited. A hospital-based study in Dhaka city showed that 39 percent of women never had any antenatal check-ups in their last pregnancy, 69 percent of all deliveries took place at home, and 43 percent of deliveries were conducted by untrained providers.

A Health Facility Survey in Selected Dhaka Slums, conducted by ICDDR,B (UHEP) revealed that 80 percent of the clusters reported pharmacies were the primary sources of treatment for minor illnesses. Government hospitals were used only in case of serious illnesses. Cost of health care in these facilities is high as patients are asked to purchase most of the medicines and supplies.

Health Care for Adolescents

Adolescents in Bangladesh (24% of the total population) can be considered a marginalized group, especially girls. Preference for a male child, low status of women, poverty, illiteracy, early marriage and child birth are the socio-cultural factors that affect the health status of adolescent girls. The health care system emphasizes programmes for less than five years old children and maternal health. Adolescents gain access to health care only when they are married and fall under the category of eligible couples. These services often do not meet the health needs (i.e.mental, social and physical) of an adolescent. Unmarried adolescents who do not fall under this category often have limited accessibility.

HIV/AIDS

In response to the rapid spread of HIV/AIDS in the South and South-East Asia region, the GOB has taken the initiative for a National STD/AIDS control programme. The GOB is a signatory to the World Health Assembly resolution for global action against AIDS, and also a signatory at the London Summit of 1988 on the AIDS Prevention Campaign.

A National AIDS Committee (NAC) was established in October 1985, and reconstituted in 1988. The NAC is an advisory body to the Ministry of Health and

Family Welfare on all aspects of HIV /AIDS, including legal, ethical, managerial, financial, and technical issues. The short-term plan (STP) of the Government was implemented in 1988. On the basis of the experience of STP, the Government formulated a medium-term plan with assistance from WHO/GPA. Difficulties in securing financial resources delayed the implementation of the MTP; however, activities continued under the interim plan funded by WHO/GPA.

In 1992, the Government raised the profile of the NAC by re-formulating it into a multi-sectoral body under the chairmanship of the deputy leader of the house. Nine ministries, NGOs, and community representatives are members of the present NAC. The Government is now in the process of formulating a Medium-term Plan II. Under the current plan the existing health infrastructure will be used for HIV/AIDS programmes; but realizing the priority and special need of the programme, the Government named a focal point, i.e. Directorate of STD/HIV/AIDS within the DGHS. The extent, composition and terms of reference of this directorate are yet to be confirmed. The GOB intends to make the composition of this directorate multi-sectoral and multi-dimensional. There is still a debate as to whether STDs should be separated from the AIDS initiative, or whether both should be under the same project.

Broad strategies for the programme are:

i. Prevention of sexual transmission
ii. Prevention of transmission through blood
iii. Prevention of perinatal transmission
iv. Reduction in the impact of HIV infection on individuals, groups and societies.

Role of NGOs in HIV-AIDS Programme

The NGO sector was the first to respond to the emerging threats of an AIDS epidemic in Bangladesh. The STD/AIDS network , a coalition of organizations working or planning STD/AIDS initiatives, was formed in the latter part of 1993. Currently, it is composed of 102 individuals from 72 organizations. The members are mostly from NGOs, but there are also members from government, donor ,UN and international agencies. The network functions as a coordinating body to better share information, facilitate coordination between organizations and individuals, advocacy, monitor STD/AIDS related statements and actions, and facilitate adequate and appropriate follow-up of these statements and actions, and act as a representative to the national decision-making process. The network will be organizing a national conference of the NGOs to arrive at a consensus regarding HIV/AIDS programming in Bangladesh which will be submitted to the Government for inclusion in the mid-term plan. Other national NGO initiatives on STDs/HIV/AIDS include the following:

VHSS

VHSS is an apex body of health care organizations and serves as a secretariat for the STD/AIDs network . It plays a very important role in advocacy on HIV/AIDs issues, human resource development on HIV/AIDS, mass awareness and campaign on HIV/AIDS, and development of IEC material.

BWHC

It is a national level NGO providing clinic-based reproductive health care and community-based social and health awareness programme in both urban and rural areas. BWHC runs integrated HIV/AIDS programme, and activities include staff education on HIV/AIDS, counseling, treatment and management of RTIs/STDs among men and women, and health education on STD/AIDS prevention. In addition, it provides brothel-based integrated reproductive and sexual health care service for CSWs.

CARE Bangladesh

CARE Bangladesh designed an HIV/AIDS prevention project called "Shakti" (Stopping HIV/AIDS through knowledge and training initiatives). Under Shakti, CARE will work with local NGOs to help them develop and implement staff education on HIV/AIDS. Shakti will directly provide service to the community to increase awareness of HIV/AIDS among populations with high-risk behaviour, and to promote the adoption of preventive behaviours, especially promotion of condom use. The project will include: intensive multi-media, multi-channel communication activities targeting men, specifically rickshaw pullers, truck drivers and clients of CSWs. A mobile clinic in the old Dhaka brothel will provide basic diagnosis.

Financing and Role of Donors

GOB and donors are important financiers for the MCH-FP programme;. the GOB shares 37%, whereas donors share about 63% annually. Total resource allocation for the current 5-year programme is US$ 430 million, which is about 3.05% of the national development programme. Moreover, the Government allocates funds to the family planning programme from its revenue sources. The revenue fund for the period 1993-1994 was about US$ 20 million.

Donor assistance includes foreign exchange spent directly for procurement of consultants, contraceptives, drugs supplies, and equipment, as well as local currency support for civil work, training, research, and workshops. The Government spends mostly on salaries, overheads, programme costs, taxes, duties and land cost.

The major donor agencies include:

1. World Bank and its co-financiers: Australia, Belgium, Canada (CIDA), EEC (EU), Germany (GTZ, KFW), Japan (JICA), Netherlands, Norway, Sweden (SIDA), and the United Kingdom (ODA).
2. USAID and its Contracting agencies(CAs): The Population Council, John Snow Inc. The Pathfinder Fund, The Asia Foundation, Management Sciences for Health (MSH), Family Health International, Johns Hopkins University, and Population Communication Services.
3. UN agencies: UNFPA, UNICEF, UNDP, WHO, WFP, ILO, and UNESCO
4. Asian Development Bank, Islamic Development Bank (IDB), and the Ford Foundation.

Major Donor Agency Programme

Among the donor agencies a selected group of donors have been played crucial roles in influencing the MCH - FP programme:

The World Bank and its co-financiers

This is a large-scale organized participation of the donors under the consortium umbrella of the World Bank. Currently, the World Bank is participating with twelve other co-financers and the GOB in implementing one of the largest population and health projects in the world. This is more comprehensive than the USAID-FPHP project,. The focus is not strictly on family planning, but also addresses key health issues. In terms of reproductive health, the major focus still remains on MCH-FP.

A recent review of the Fourth Population and Health Project has emphasized a shift toward more comprehensive health care. In the area of gender, this project had some influence on the public sector regarding gender sensitivities. Some minor efforts have been made by the Government to address gender issues. A separate unit in the MOHFW has been created, headed by a joint secretary, but much more needs to be done to address the gender disparities and its impact on sexuality and reproductive health.[8]

The NGO component of the Fourth Population and Health Project, which is implemented through BPHC, has addressed women's health in a more comprehensive manner . In addition, BPHC has developed a broad gender strategy in terms of programmes and policy, which will be introduced through its partner organizations during 1995-1997.

[8] Bangladesh Fourth Population and Health Project , Mid-term review, 1995

USAID

The Family Planning and Health Services Project of USAID is a 10-year (1987-1997) $300-million initiative. The purpose of the USAID-FPHSP is to improve access to and use of high quality, efficient and sustainable FP-MCH services. The overall goal of the project is to reduce current high levels of fertility and infant and child mortality.

For 18 years USAID has been a significant donor for the family planning programme, providing policy leadership and promoting private sector involvement. It supported a large network of NGOs providing family planning services to approximately 20 percent of all acceptors in the country. It also established the national Social Marketing Company. To strengthen the national family planning service delivery, USAID supports field research through the International Centre for Diarrhoeal Disease Research, Bangladesh.

USAID assistance to the Government focuses primarily on:

i. decentralized FP service delivery
ii. logistics management
iii. communications
iv. local initiatives project, training and technical assistance to teams of *thana*-level officials
v. urban immunization programme

Under USAID-funded projects, only certain elements of reproductive health care have been approached, and then in a segmented manner. Being a major donor, both in the government and NGO sectors, such a policy could be a barrier to both NGO and GOB in providing comprehensive reproductive health care, as both NGO and GOB programmes are donor-driven (e,g. USAID-funded NGOs cannot provide MR regulation service to women in case of contraceptive failure or non-use).

SIDA

In Bangladesh, SIDA has attempted to fill the gap of comprehensive reproductive health care by funding the MR programme. In 1989 SIDA signed a TAPP agreement with the GOB for MR equipment, technical assistance and programme services, and also supported MR by NGOs under individual project proposals. During 1991-1995, SIDA approved grants totalling SEK 27,120,000/- (approx. US$ 3.9 million)[9]. In addition, SIDA is a co-financier of the Fourth Population and Health Project.

[9] The Bangladesh National Menstrual Regulation Programme, IWHC, 1994

UNFPA

UNFPA-supported projects are mainly focused on IEM activities and training. Under these projects capacity building on IEC activities, and strong motivational campaigns on family planning, were undertaken to increase mass awareness, and to overcome religious and socio-cultural barriers. It also supports commodity assistance, including contraceptives and equipment, programmes on population education, rural cooperatives, and operation of the Bangladesh census.

UNICEF

UNICEF's mandate is primarily improving the health of mothers and children, including: broad-based MCH programmes, addressing the critical needs of reproductive health and MCH services. Bangladesh as a co-signatory to UNICEF's World Summit Declaration, an agendum for children of 1990, has been receiving support from UNICEF to improve the quality of life of mothers and the children. The specific major programme interventions of UNICEF in Bangladesh include : EPI, controlling vitamin A and iodine deficiency, launching nutrition programmes, campaign for breast feeding, emergency obstetric care, and water and sanitation.

WHO

WHO's participation is extensive, especially in developing the Primary Health Care programme. It also strengthened the MCH programme through the Fourth Population and Health Project. Currently, WHO is providing assistance to the GOB to develop the national STD/HIV/AIDS programme.

The Ford Foundation

The Ford Foundation has been a catalyst to the evolution of the population and health programmes in Bangladesh for more than forty years. Support of the Foundation, for example, in the mid-1980s for MR research, training and service delivery (following the loss of USAID support after Mexico City) was a turning point in the programmes history. MR was no longer perceived as a means of population control, rather, it became a woman's reproductive health measure. In the last decade, the Ford Foundation has consistently played a leadership role in establishing the sexual and reproductive health and rights of women as a priority issue in the public domain.

Research on Gender, Sexuality and Reproductive Health

Family Planning

Since the priority of the Government of Bangladesh has been to increase the contraceptive acceptance rate and to reduce fertility, research on family planning issues has also received a lot of attention. The contraceptive prevalence rate (CPR) has increased from 7.7% in 1975 to about 45% in 1994. During the same period, the total fertility rate (TFR) has declined from 6.3 to 3.4.

Numerous topics have been studied, widely publicized and disseminated. The Ministry of Health and Family Welfare has an organization, NIPORT (National Institute for Population Research and Training), which conducts research as needed by the government functionaries. In addition, there are international agencies like the International Centre for Diarrhoeal Disease Research, Bangladesh which have also done many studies on family planning. Non-government agencies, like BRAC, ASHA, are also conducting research in this area.

The research conducted and published in areas of family planning are too many to be summarized and discussed in this country paper. Previously, the research agenda included ways of increasing coverage of contraceptive use in different sub-sections of the population. While the priority now has shifted to issues of quality of care of service delivery mechanisms, continuation rate of contraceptive use, and management of side-effects. However, certain topics need to be addressed urgently, such as reaching young couples, and male involvement in family planning.

Adolescent sexuality and fertility

The adolescent group was never considered a research priority for studies in sexuality and fertility. Nevertheless, a few studies done in these two areas have generated some information. As the mean age of marriage in Bangladesh is 19 years, almost half of the adolescent girls would be married and appear in the fertility studies as eligible couples. Girls married during adolescent quickly find themselves as mothers.

Another noteworthy study has been conducted by Aziz and Maloney who published their work as "Life Stages, Gender and Fertility in Bangladesh" in 1985. The authors mention that with the onset of menarche a Bengali girl's domain is confined very much within the household. Restriction is imposed on talking freely with cousin-brothers. A girl is not expected even to be caressed by her father. Menstruation is a very private matter. Mother's often do not talk to their daughters about menstruation. It is generally considered to be a state of pollution. Girls at this stage are thought to be vulnerable to evil spirits. They are expected to modify their movements and behaviour during this time. At this time of menstrual cycle, women are expected to avoid sex, prayers and are forbidden to enter the cow shed, kitchen, and fields.

The same study mentions that adolescent boys and girls have fantasies about events related to sexual activity. Sexual intimacy between young people takes place entirely from personal initiative and is kept beyond the knowledge of guardians. Masturbation is frequently practised by males and females. It is thought of as a bad habit. Sexual play among adolescents of the same sex is relatively common and is a corollary of the heavy sexual restrictions on heterosexual mixing. However, it cannot be interpreted as homosexuality, but it is rather an isosexual activity, play and experimentation with the same sex. Such preferences for the same sex may not continue in later lives.

Male participation in family planning

This area is also one of the most neglected issues of family planning research. No research worth mentioning has been conducted on this topic.

Reproductive Tract Infections-HIV/AIDS-Sexuality of Other Age Groups

This area of research is a new agendum for researchers in Bangladesh. Not much work has been done previously. ICDDR,B has identified this area as an important topic, and plans are underway to address this issue.

National level statistics on STDs mainly focused on commercial sex workers and men attending STD clinics/hospitals. The most widely quoted study on RTIs in Bangladesh was conducted by Wasserheit in 1987 in Matlab among a rural family planning population. This study showed that 22 percent of women reported symptoms of RTIs and 68 percent of the symptomatic women had clinical/laboratory evidence of infection.

A recent clinic-based study done among women of reproductive age group in an urban area revealed a prevalence of RTIs to be 60 percent. Bacterial vaginosis was the most common type of infection (44 percent). The prevalence of syphilis was 0.5 percent, gonorrhoea 3.8 percent, and both gonorrhoea and syphilis 0.5 percent.

A study on STDs in relation to socioeconomic status conducted among patients attending skin/VD clinics showed gonorrhoea, non-gonococcal urethritis, and herpes progenitalis were prevalent among high-income group (> Tk 10,000/month); syphilis, gonorrhoea and chancroid were more prevalent among middle-income group (Tk 3,000-10,000/month); and in low-income group (< Tk 3,000) gonorrhoea and chancroid were more common.

Reproductive tract infections have profound impact on maternal health and health care initiatives. In addition, RTIs/STDs are risk factors for the spread of HIV infection. Women's health advocates, policy-makers and programme planners are giving considerable emphasis on prevention and control of STDs through existing

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APPENDIX-I

Gender Inequality in Existing Personal Laws of Bangladesh

	Muslim Law	Hindu Law	Christian Law
Age at Marriage	Women are younger (18 years) than men (21 years)	Women are younger than men (age is not mentioned)	Women are generally younger than men
Witness	Women have unequal right to witness, even though the Evidence Act of 1972 has provision for equal rights	No requirement	Women have equal right to witness (according to Canon Law of 1096)
Polygamy	Illegal for women to be polygamous; men have legal right to polygamy but a second marriage without the permission of the first wife is punishable under the Muslim Family Law Ordinance of 1961	Polygamy is legal for men; women cannot have a second marriage	Polygamy is illegal for both men and women
Marriage	Women have unequal right in choosing a partner from a different religious background	Inter-religious marriage is not recognized	Canon 1086 refuses to acknowledge the validity of marriage of a Catholic member with that of a non-Catholic
Divorce	Women have unequal right to divorce, and divorce right is also conditional for women	Women and men do not have equal right to judicial divorce	Women have unequal right to divorce
Custody	Women have unequal right to guardianship and custody	Women have unequal right	Women have unequal right

APPENDIX-II

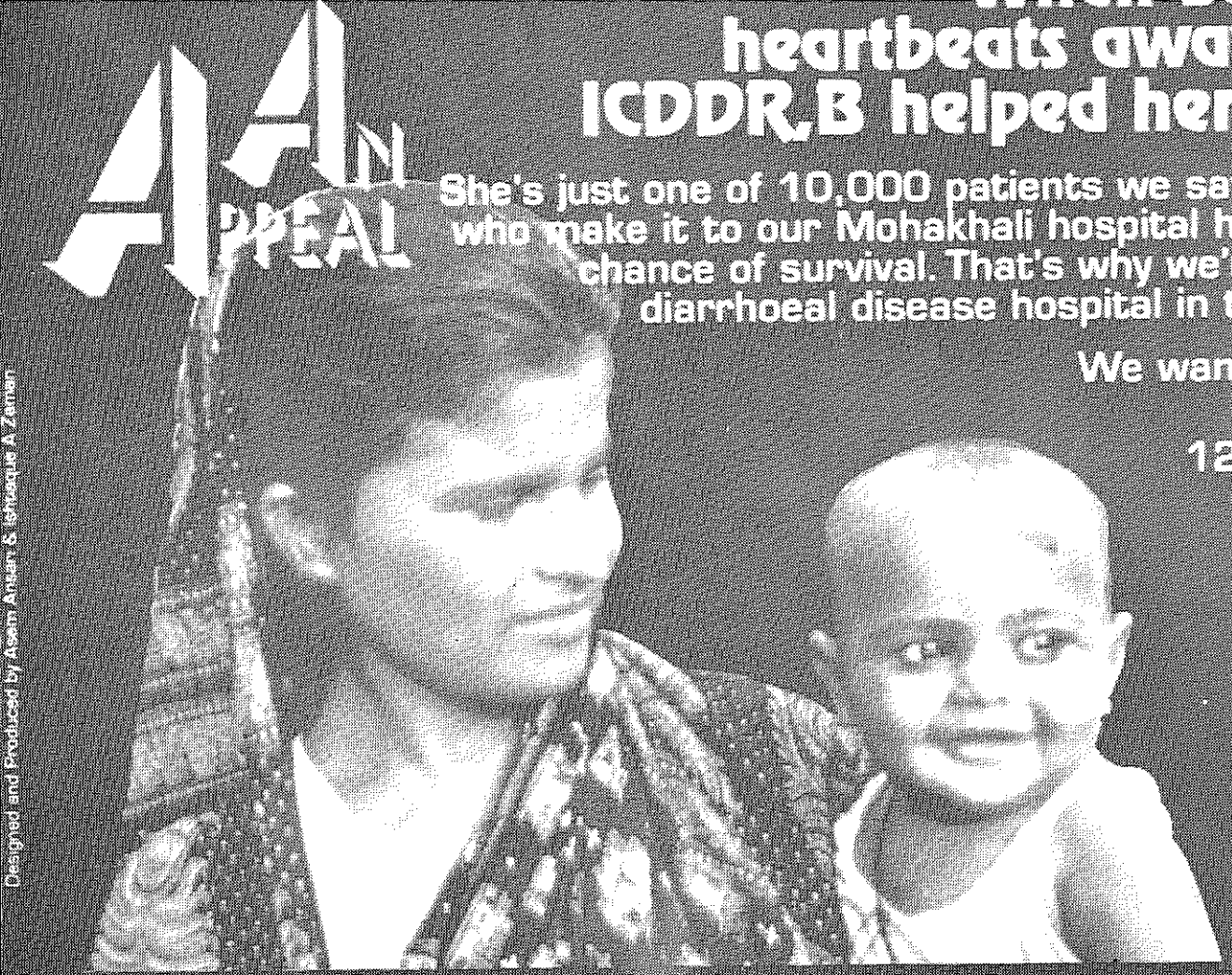
Bangladesh: The Facts

Population	: 1980: 89 million : 1995: 119.7 million
Sex ratio	: 105
Birth rate	: 29.1/1000
Death rate	: 11/1000
Rate natural increase	: 2.15% per annum
Doubling time	: 32 years
Estimated population	: 2000: 146 million : 2020: 206 million
GNP per capita (in US$)	: 1967: $ 80 : 1987: $160 : 1993: $220
Daily caloric supply per capita	: 1967: 2,300 : 1987: 1,927
Female median age at marriage	: 17.5 years
Proportion women married at <16 years of age	: 50%
Proportion of women married by 24 years	: 98%
Estimated number of married women by 2006	: 31 million
Life expectancy at birth	Male: 58.1 years Female: 57.6 years
Female literacy	: 26%
Proportion women using modern contraception	: 36%
Total fertility rate 1993-94	: 3.44
Number of births annually	: 4.3 million
Maternal mortality rate	: 4.8-6 per thousand
Neo-natal mortality rate	: 51/1000
Infant mortality rate	: 81.8/1000
Child mortality rate	: 100-122/1000
No. of women dying annually from pregnancy-related causes	: 24,000
Proportion of poor pregnant women weighing less than 50 kg	: 100%
Proportion of newborns weighing less than 2,500 grams	: 50%

heartbeats away from death, ICDDR,B helped her fight for life.

AN APPEAL

She's just one of 10,000 patients we save every month. Those who make it to our Mohakhali hospital have more than 99.5% chance of survival. That's why we're considered the best diarrhoeal disease hospital in the world.



We want to continue providing free treatment to over 120,000 patients a year - and saving almost as many lives.

SO PLEASE HELP, with an open heart, an open mind!

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Your gift to ICDDR,B's Hospital Endowment Fund is a gift of life that will be invested, not spent. Our goal is to raise $10 million by the year 2000. Your donation of Tk. 10,000 will save one life every year for *eternity*. Tk. 100,000 will do the same for 10 lives. And so on. *So how many lives will you save today?*

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