

CALL FOR ACTION:

IN THE POST-2015 **SEXUAL AND REPRODUCTIVE**
HEALTH
RIGHTS
FOR WOMEN AND GIRLS **DEVELOPMENT AGENDA**



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INTRODUCTION

Through the ratification of several international treaties, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC), endorsement of the International Conference on Population and Development (ICPD) Programme of Action, and the Beijing Platform for Action (BPFA) and commitment to the Millennium Development Goals (MDGs), Bangladesh has declared her commitment to the promotion of gender equality and non-discrimination, the advancement of reproductive health and rights, and addressing gender-based violence and enhancing accountability. However, much remains to be done to achieve sexual and reproductive health for all.

Bangladesh has a long way to go with regards to the recognition of sexual & reproductive rights as human rights. Women's sexual and reproductive health is invariably linked to multiple human rights, including the right to life, the right to be free from torture, freedom of choice, the right to health, the right to privacy, the right to education, and the prohibition of discrimination etc. Furthermore, the gap between policy and practice especially with regard to service delivery on the ground is evident from the poor sexual and reproductive health outcomes. In addition, there is still a lag in the use and access to family planning. The total use of modern contraceptives increased from 56 to 62.4 percent between 2007 and 2014¹.

A key concern regarding family planning is the high percentage of women who discontinue use or switch to less-safe or less-effective methods, resulting in unintended pregnancies.² Although the Government of Bangladesh provides Menstrual Regulation (MR) services for women until the 12th week of their pregnancy³, abortion itself remains illegal and a social taboo which eventually hinders universal access to reproductive health services, especially for adolescents.

The performance of the Government of Bangladesh in terms of reducing the maternal mortality rate is noteworthy, however due to the absence of gynaecologists and anaesthetists especially as a pair in rural hospitals and health facilities, Comprehensive Emergency Obstetric Care (EmOC) is yet to be ensured. There is an urgent need to synchronize policies and laws to safeguard the rights of women, young people and adolescents in accessing SRHR information and services. *“Addressing reproductive health issues of women is now on the global social agenda in the new millennium. Maternal mortality has long been the only indicator of women's health even though reproductive morbidity occurs far more frequently and seriously affects women's lives”*.⁴

¹ Bangladesh Demographic Health Survey (BDHS 2014)

² *Understanding Unintended Pregnancy in Bangladesh: Country Profile Report*, http://www.popcouncil.org/uploads/pdfs/2012STEPUP_BangladeshCountryProfile_icddr.pdf, ICDDB'R (2013),

³ <http://www.popcouncil.org/uploads/pdfs/banglapolicydialogue9.pdf>

⁴ <http://www.ncbi.nlm.nih.gov/pubmed/15455609>

“Cancer is predicted to be an increasingly important cause of morbidity and mortality in Bangladesh in the next few decades. According to the Bangladesh Bureau of Statistics, cancer is the sixth leading cause of death. International Agency for Research on Cancer has estimated cancer-related death rates in Bangladesh to be 7.5% in 2005 and 13% in 2030. The two leading causes are in females are breast cancer and cervical cancer. Bangladesh is now in severe shortage of radiation therapy machines, hospital bed, trained oncologists, medical radiation physicists and technologists⁵.”

“Children in Bangladesh are vulnerable to being trafficked into bonded labour or brothels; being sexually abused in the home, the workplace, community and at school; and being sexually exploited. There are few protections in place for children such as these. In a country where less than 10 per cent of children are registered at birth, it is difficult to track whether children's rights are being protected. Those who are abused, trafficked or exploited are explicitly denied their rights to be safe from these practices under the Convention on the Rights of the Child (CRC). They are also more vulnerable to HIV/AIDS, drug abuse, more likely to not finish - or begin - their education, or realize their right to be brought up with their family⁶.”

Every week, somewhere in Bangladesh, a woman's life is changed forever when she is doused with acid and disfigured. Love proposal rejection, gang rivalry, dowry solicitation, misogyny, prejudice – these are some of the horrendous reasons behind a painful form of violence many women around the world face: acid attacks. Acid violence is global, but a significant number of attacks are concentrated in South Asia, particularly in Bangladesh. According to the Acid Survivors Foundation (ASF) of Bangladesh, there have been 3,303 reported incidents in the country since 1999 to 2015 and over 80 percent of the victims are female⁷. Naripokkho has been working with survivors of acid attacks since 1995. They try to help by providing medical and psychological support to the survivors and facilitate the police case as well as the treatment of the survivors⁸. Naripokkho found most of the attacks are aimed at women and young girls, and the face is targeted in particular. To destroy a woman's face is to ruin her potentials for marriage and to ensure that no one else will want her as a romantic partner (Combating Acid Violence 1997, Naripokkho, Bangladesh.)

“Bangladesh being a developing country, in the economic sector, the newly emerged garments industries have been creating job opportunities to a large number of people in the cities. It now ranks among the largest garments exporters of the world which accounts for 75% of the foreign currency and 25% of GDP of Bangladesh. Most of the garments workers are female and majority of them are adolescent and unmarried. The literacy rate being low, these workers are not

⁵ <http://www.ncbi.nlm.nih.gov/pubmed/24163419>

⁶ http://www.unicef.org/bangladesh/Child_Abuse_Exploitation_and_Trafficking.pdf

⁷ <http://www.acidsurvivors.org/Statistics/1>

⁸ *Combating Acid Violence 1997, Naripokkho, Bangladesh*

informed about menstruation, safe sex, contraceptive methods, STDs, and HIV infection. As there is large scale of social insecurity, adolescent garments workers are often victims of terrible sexual abuse. So, the adolescent garments workers are a vulnerable group for HIV infection⁹.”

“Domestic workers from Bangladesh are mostly rural women and even children, many with dependents back home. The difficulty in calculating protective measures for domestic workers lies in the fact that they are severely isolated in the homes of the employers. For example, while many migrant labourers have the ability to live with fellow workers from their industry, domestic workers are far singular and divided. They are subject to double discrimination, first for their gender and then for their immigrant status directly linked to employers whom they are dangerously dependent on for all aspects of their livelihood¹⁰.”

“To identify critical issues concerning female migrant domestic workers and to determine the extent of their vulnerability, the International Labour Organization (ILO) analyzed their working and living conditions in several countries of the region. Studies of four Arab states – Bahrain, Kuwait, Lebanon, and the United Arab Emirates (UAE) – reveal practices and patterns that make women domestic migrant workers vulnerable. On work-related problems, domestic workers most frequently cited the presence of physical (including sexual), psychological and verbal abuse; over 50 percent of those surveyed in Kuwait reported this concern. Most workers mentioned vulnerability to sexual abuse by their male employers, who are often also their visa sponsors, as well as by the sponsors' sons or other men visiting the home where they work. The situation in Bahrain and the UAE was also similar¹¹.”

According to ‘Situation Analysis of Obstetric Fistula in Bangladesh’, a 2003 survey, over 71,000 women in Bangladesh suffer from fistula. The survey was carried out by the NGO, Engender Health in cooperation with UNFPA¹².

“Genital prolapse is a very common gynaecological disorder in Bangladesh. But women do not admit this problem due to shame, ignorance, social taboo and insolvency. The rural scenario is much more disastrous”. According to the study by S. Kishwara (2010), only 9 among 200 women reported to have the complaints of a genital prolapse. The study revealed that respondents’ age had no association with the incidence of genital prolapse ($p>0.05$). But strong association was found between number of child and genital prolapse ($p<0.05$)¹³.

The Child Marriage Restraint Act 1929, it was evident that about 64% of all women aged 20-24 were married before the age of 18¹⁴ in Bangladesh. Due to early marriage about 45% pregnant women delivered low birth weight and stunted

⁹ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3661035/>

¹⁰ <http://archive.thedailystar.net/forum/2011/December/recognition.htm>

¹¹ <http://www.migrationpolicy.org/article/domestic-workers-little-protection-underpaid>

¹² <http://www.dhakatribune.com/obstetric-fistula/2013/may/27/international-day-end-obstetric-fistula#sthash.OqYvK9Rx.dpuf>

¹³ <http://banglajol.info/index.php/JDMC/article/view/7082>

¹⁴ icddr”B & Plan International Bangladesh research Findings

babies and during delivery about 5% of these groups of adolescent pregnant mother's life become vulnerable and have a death risk.¹⁵

Furthermore, the syllabus and curricula for secondary and higher secondary schools in Bangladesh do not include comprehensive sexuality education and teaching methods are non-pedagogical and not student-friendly. Additionally a large number of young adolescents are either school dropouts or never went to school and have therefore remained completely outside formal education.

The media did broadly cover the prominent daily events concerning children and children's issues. What was lacking was focused, planned, proactive, and in-depth reporting. One of the cornerstones of ethics in journalism is to represent all sections of society. Fair coverage of all groups and the issues that are important to them is essential for raising public awareness, stimulating public debate, and addressing injustices. Media content analysis shows that important issues relating to children, such as government policies or child-specific vulnerabilities are largely ignored by the media. This absence was more pronounced on TV than in Newspapers. On a positive note, the media prioritized two important rights-based sectors; education and healthcare. However, the coverage of these issues was almost always in conjunction with an event or was given special coverage on a day of international focus on these issues. Another area of concern is that a considerable proportion of news reports disclosed the identities of victims of sexual abuse and of children in conflict with the law. This not only violates journalistic ethics of protection to children in vulnerable situations, it also goes against legal provisions for children. The questionnaire surveys of journalists and editors indicated a lack of comprehensive knowledge on laws for the protection of children. Selected cases studies revealed great insensitivities as well¹⁶.

The level of awareness on SRHR is uneven and extremely low. Lack of concern and involvement of policy makers and the conservatism of community gatekeepers is a reason for the poor SRHR situation. Bangladesh's commitment to international conventions and agreements requires government to ensure better implementation of these agreements and enforcement of all the legal provisions.

GOALS, INDICATORS AND TARGETS

The right over one's body is a basic right. Women suffer a whole range of restrictions and ailments arising out of the denial of this basic right. Furthermore, women and girls are especially vulnerable to human rights violations regarding their sexual and reproductive health.

Prior to the Fourth World Conference on Women held in Beijing in September 1995, Naripokkho organised six regional workshops on key topics related to women's rights and gender equality. Analysis of the workshops proceedings helped to

¹⁵ UNICEF, State of the world's Children, 2011

¹⁶ http://www.unicef.org/bangladesh/BS_on_ethical_reporting.pdf

identify the barriers to women's autonomy and ultimately formed the basis for the monitoring of key institutions dealing with women's sexual and reproductive health and the consequences of violence against women. These findings continue to inform the analysis of goals, indicators and targets, which are most relevant to Bangladesh today as laid out in the 7th Five Year Plan 2016-2020¹⁷.

- Under these goals, indicators and targets, policies and programmes have been designed
- The government has already committed to many of the issues identified
- Various oversight committees have committed themselves to ensuring the implementation of SRH services from the local to the national level.
- Naripokkho conducted the first pilot study in Bangladesh on Violence against Women (VAW) during 1996-99
- Naripokkho has provided much explanatory information and data regarding questions related to SRHR

Naripokkho, as a women rights activist organization, along with its partners in the Women's Health Rights Advocacy Partnership project calls for the full integration of all targets including target 3.1 to reduce the maternal mortality ratio to less than 70/100,000 live births; target 3.7 on universal access to sexual and reproductive health services; target 5.6 on universal access to sexual and reproductive health and reproductive rights into the national development plan. We welcome calls for global indicators to be disaggregated to allow targets to be measured in various dimensions, such as by geographical location, gender, education, marital status, age, etc. All efforts should be made to ensure that government will commit to implement the targets, goals and indicators agreed by global, regional and national consensus.

In order to fully integrate targets 3.1, 3.7, and 5.6, the government has to provide quality, comprehensive and accessible services to meet the SRH needs of Bangladesh. Commitment to goal 4, indicator 4.7 on assuring access to information on human rights and gender equality should be expanded in order to integrate sexuality, sexual rights and sexual health by providing comprehensive sexuality education through Bangla, English and Madrassa curricula .

Like any other crisis or disaster women, especially adolescent girls, older women and women with disabilities, become the more vulnerable because they remain invisible to researchers and information collected is not disaggregated for ability.

Menstrual hygiene management at home and in schools and beliefs that menstruation is polluting and disabling limits regular activities affecting girls' school attendance and education attainment.¹⁸ 40% report having missed school due to menstruation, 19% still a significant number of adolescent girls are

¹⁷ <http://www.plancomm.gov.bd/7th-five-year-plan-draft/>

¹⁸ Bangladesh National Hygiene Baseline Survey, (Preliminary Report) June 2014,

¹⁹ http://icuh2015.org/wp-content/uploads/2015/07/Hasin%20Jahan%20and%20Shahrukh%20Mirza_Menstruation%20and%20Menarche%20in%20Urban%20Slums.pdf

dropping from school due to the challenges in maintaining menstrual hygiene. Water and sanitation, ecological justice and poverty alleviation are core factors and enablers that will also further advance SRHR status of Bangladesh, especially relating to women and girls as amongst the poor, coastal women form the ‘poorest of the poor’ due to unequal and inequitable gender relations in the social, economic, physical, and political spheres of Bangladesh²⁰.

A list of rights based indicators proposed by ARROW and Naripokkho is listed in the table below for inclusion in the Bangladesh development plans post-2015.

GOALS AND TARGETS	INDICATORS
Goal 3: Ensure healthy lives and promote well-being for all at all ages	
<p>3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births</p>	<p>3.1.1. Maternal mortality per 100,000 live births disaggregated by causes of death (including unsafe abortion, pre-eclampsia and eclampsia, haemorrhage, sepsis, hypertensive disorders, HIV related, haemorrhagic, and prolonged or obstructed labour) and further disaggregated by age, income, disability, geographic location, race and ethnicity</p> <p>3.1.2 Skilled birth attendance</p> <p>3.1.3 Coverage of Post-partum/Post-natal Care both at home & at hospital within 48 hours/2 days of delivery by a skilled health provider (At least one visit within 48 hours)</p> <p>3.1.4 Antenatal Care Coverage (at least four visits)</p> <p>3.1.5 Maternal Death audit at all level</p>
<p>3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes</p>	<p>3.7.1 Availability of sexual and reproductive health services at community, union, sub-district, district at tertiary level including: gynaecological services; maternal health care including access to EmOC; contraception; HIV/STI prevention; screening for cervical and breast cancer; safe menstruation regulation services and One Stop crisis services for indications permitted by law</p> <p>3.7.2 Adolescent birth rate (10-14, 15-19)</p>

²⁰ http://bangladesh.nlembassy.org/binaries/content/assets/postenweb/b/bangladesh/netherlands-embassy-in-dhaka/import/water-management/project-documents/gender-and-water-program/gwapb_proposal_bangladesh_010713.pdf

	<p>3.7.3 Proportion of family planning demand met with modern contraceptives (benchmark: 75%) and disaggregated by age, geographic location, ethnicity, race, disability, health status, and educational level</p> <p>3.7.4 Proportion of women using contraception who were informed about side effects of their method and how to deal with them, were informed about other contraceptive options, and who participated in the decision to use contraception</p> <p>3.7.5 Proportion of adolescent girls who have received the HIPV vaccine according to current guidelines. (The HIPV vaccine itself is controversial.)</p>
<p>Goal 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all</p>	
<p>4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among other, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and nonviolence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development</p>	<p>4.7.1 Comprehensive sexuality education (CSE)/basic knowledge about sexual and reproductive health at secondary and higher secondary level in Bangla medium and Madrassa medium is available as a percentage of all schools</p>
<p>Goal 5: Achieve gender equality and empower all women and girls</p>	
<p>5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome of documents of their review conferences</p>	<p>5.6.1 Active and effective complaint mechanisms for universal access to sexual and reproductive health services at sub-district, district and tertiary levels</p> <p>5.6.2 Local policies and programmes recognise adolescent and young people's rights to access SRH services</p> <p>5.6.3 Evidence of women seeking redress for incidences of sexual violence within marriage</p> <p>5.6.2 Women decision making power to choose the facilities, services and methods related to pregnancy, child birth and contraception.</p>

Table 2- Targets and indicators to be adopted by the Government of Bangladesh

FINANCING FOR DEVELOPMENT

Bangladesh is a developing and populous country of 160 million people and is undergoing rapid urbanisation. The Gross Domestic Product of Bangladesh grew by 6.1% in 2011 and poverty declined during the last decade by 1% per year²¹. However, high levels of inequalities persist: 50% of the people live on less than \$1.25 per day and 81% on less than \$2.00²². Bangladesh is projected to have an estimated 220 million population by 2050 (UNFPA, 2014, BBS, 2014; Bertelsmann Stiftung, BTI 2014, World Bank 2014, UNDP 2014).²³ Although more than half of GDP is generated through the service sector, almost half of Bangladeshis are employed in the agriculture sector.

In Bangladesh, the health sector is among the most neglected ones in terms of government fund allocation and at the same time gripped by widespread corruption and irregularities. There is no denying that the government allocation for the health sector is inadequate. Poor coordination among the relevant ministries and departments jeopardises the situation further. Additionally, the allocation for the health sector continues to decrease every year. Tk 12,726 crore has been allocated for the health sector in the country's proposed budget for the fiscal year 2015-16, which is only 4.3 percent of the national budget whereas, in 2009-2010 fiscal year, the allocation for the health sector was 6.18 percent of the total budget.²⁴ This drastic fall in allocation is surprising and disappointing in view of the fact that the country's population and the cost of medical services are rising every year. The allocation for the health sector is the lowest in Bangladesh among the SAARC countries. Bangladesh is allocating less than one per cent of the GDP for the health sector while WHO guideline suggests allocation of 4-5 per cent of the GDP.²⁵

According to the publication '*Cost Effectiveness and Resource Allocation*', (2005)²⁶, a significant amount of healthcare costs (over 60%) are paid out-of-pocket towards maternity patient expenditures. For the 2015-16 budget the allocation for education dropped from 13.1% for the 2014-15 fiscal year to 11.6% of the Tk 2.95

²¹ <http://data.worldbank.org/country/bangladesh>

²² <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CDMQFjACahUKEwiY47vA06jIAhUCWo4KHdacD14&url=http%3A%2F%2Fwww.nwo.nl%2Fbinaries%2Fcontent%2Fdocuments%2Fen-en%2Fcommon%2Fdocumentation%2Fapplication%2Fwotro%2Fsrhr--share-net-bangladesh&usg=AFQjCNFsR0WA1VFZn-rkAXG8UMZODkzziQ&sig2=KZS-YZUVWINBLbnFF5HmUw>

²³ UNFPA, 2014 <http://unfpa.org/index.php?option=page&id=49&Itemid=4>

<http://www.bbs.gov.bd/Home.aspx>

Bertelsmann Stiftung, BTI-2014- Bangladesh Country Report, Gütersloh: Bertelsmann Stiftung, 2014.

<http://www.worldbank.org/en/country/bangladesh/overview>

<https://www.un-bd.org/bgd/>

Bangladesh Country Report: GDP data and GDP forecasts

<http://www.gfmag.com/gdp-data-country-reports/321-bangladesh-gdp-country-report.html#axzz28cLo41Om>

²⁴ <http://www.daily-sun.com/printversion/details/49882/Health-sector-needs-increased-allocation>

²⁵ <http://www.daily-sun.com/printversion/details/49882/Health-sector-needs-increased-allocation>

²⁶ Khan, S.H. (2005) Free does not mean affordable: maternity patient expenditures in a public hospital in Bangladesh. *Cost Effectiveness and Resource Allocation*, 2005, 3:1 doi: 10.1186/1478-7547-3-1

trillion budget.²⁷ Such figures demonstrate the need for advances to be made in the domestic resource allocation to achieve the SDG goals and targets in order to further advance the progress of SRHR in Bangladesh. Adequate spending is needed to implement comprehensive sexuality education, maternal health services, the meeting of contraceptive needs, as well as the full architecture of SRHR services.

Moreover, high levels of workers' remittances contributing to the economy of Bangladesh, (constituting the country's second largest source of foreign exchange)²⁸, contribute to money growth volatility in the economy of Bangladesh, often fluctuating sharply and responding to shocks of both foreign and domestic origin. Efforts should be made on the part of the government to better monitor these flows in order to more effectively allocate this substantial source of income, with particular regard to the areas concerning women's health including SRHR highlighted in the SDGs.

Due to the substantial engagement of women (either for migration of male member or meeting the family demand) in the economic development both in the formal and informal sector again increases the risk of triple load which eventually increases their SRH needs and concerns further. In addition, the country like Bangladesh where women's household core's activity was not acknowledged or recognized and the practice of sharing the workload is not practiced among the partners/spouse.

Steady rise in the external debt owed as reported by the Bangladesh Bank²⁹ jeopardise long-term sustainability, and the capacity of the government to maximise resource allocation in favour of pressing SRHR needs. In order to fully commit to the SDG targets and goals, the government of Bangladesh needs to abide by the Paris Declaration concerning aid effectiveness and its impact on development. In this respect we acknowledge the impressive record of Bangladesh in key social indicators, such as fertility reduction, life expectancy, increased in school enrolment for girls and child immunisation (Table 3). Nonetheless, allocation should be oriented towards financing women's and adolescents' health and rights, including SRHR.³⁰ Nevertheless, we call upon the Government to implement systems of accountability in order to monitor the funds and resources provided by the private sector in financing the development agenda. Such contributions should be made in alignment with development priorities and not in the profit interests of the private sector. Economic development should at all times encompass the matrix of social indicators and ensure social wellbeing.

²⁷ 'Bangladesh cuts spending on education, technology in new budget', bdnews24.com

²⁸ Ghosh Palash, 'Taka to Dhaka: Cash Remittances From Bangladeshi Migrant Workers Keep Declining', *International Business Times* (February 18 2014)

²⁹ Bangladesh External Debt, www.tradingeconomics.com, Bangladesh Bank

³⁰ Projects & Operations, BD Private Sector Development, www.worldbank.org/projects/P120843/bd-private-sector-development?lang=en

MEANS OF IMPLEMENTATION

Goal 17 of the SDGs articulates the need for effective means of implementation (MoI) in order to address the social, economic and environmental dimensions of the SDGs in an integrated manner. Goal 17 is essential in assuring global justice including managing the dynamics between North-South and South-South partnerships.

Finance

We would like to applaud the government of Bangladesh in its strengthening of the means of implementation for the former MDGs, of which they adapted to meet local needs by setting new targets and indicators for promoting women in local government bodies, as well as separate targets on access to reproductive health services.³¹

Given the high level of remittance income in Bangladesh, focus should centre on finance from internal sources, particularly sources of domestic revenue. Improving taxation capacities and harnessing revenues from natural resources including natural gas will boost the development finance flow in Bangladesh. While enhancing the tax-GDP ratio, it would be pertinent to address the low levels of revenue mobilisation in Bangladesh as well as the high degree of tax evasion. The tax revenue to GDP ratio of Bangladesh is still low in comparison with South Asian countries (about 12% in South Asia).³²

In this regard, the mobilisation of internal financial resources should at all times take a gendered perspective, taking into account the disproportionate number of women in Bangladesh in menial work alongside the recent rise in the tax-free income limit for women.³³

Human resource

Bangladesh suffers from both a shortage of and geographic mal-distribution of HRH. There are an estimated 3.05 physicians per 10,000 population and 1.07 nurses per 10,000 populations (estimates based on MoHFW HRD 2011). There is a severe gap between sanctioned and filled health worker positions: 36% vacancy in sanctioned health worker positions and only 32% of facilities have 75% or more of the sanctioned staff working in the facilities (World Bank, 2009). 28% of treatment provided in government health facilities is through alternative medicine (Ayurveda, Unani, and Homeopathy), yet as of June 2011, there was a 50% vacancy rate for alternative medicine providers (MoHFW AMC 2011).

³¹ Government of Bangladesh Planning Commission(2013). *The Millennium Development Goals: Bangladesh Progress Report 2012*

³² Policy Research Institute of Bangladesh, 'A Review of Bangladesh's Tax System', International Growth Centre, 2014-08

³³ Staff Correspondent, 'Tax-free income limit for women raised', www.newagebd.net/18303/tax-free-income-limit-for-women-raised/#sthash.hZVdYs6E.dpbs

Health workers are concentrated in urban secondary and tertiary hospitals, although 70% of the population lives in rural areas (Country Case study (GHWA, 2008). Major challenges include: an overly- centralized health system, weak governance structure and regulatory framework, weak management and institutional capacity in the Ministry of Health and Family Welfare (MoHFW), fragmented public service delivery, inefficient allocation of public resources, lack of regulation of the private sector – which employs 58% of all physicians, shortage of HRH, high turnover and absenteeism of health workers, and poor maintenance of health facilities and medical equipment.

Despite these challenges and the fact that HRH was not considered a priority in the current sector program, there have been recent successes including: increase in the number of graduates and health worker training facilities, and an increased number of rural health facilities. The MoHFW prepared its new sector program - the Health, Population and Nutrition Sector Development Program (HPNSDP) and is revising its draft National Health Policy, based on lessons learned from previous programs. Goals include: developing an HRH plan, creating a functional HRH Information System (HRIS), scaling up the production of critical health workers, introducing incentive packages to deploy and retain critical health workers in remote and rural areas, addressing the challenge of skilled birth attendance by training community-based SBAs and/or nurse-midwives and family welfare visitors, and streamlining the recruitment and promotion of nurses (PID, World Bank, 2011) .³⁴

Technology

Bridging the technology divide is one of the main challenges in implementing the post-2015 agenda. With this in mind it is advisable to proceed with establishing a technology bank and supporting mechanism for Bangladesh, as has already been promised under the Istanbul Programme of Actions for the LDCs (2011), but has not been extended to include LMICs.³⁵ The provision of E-service centres, r vital for access to public services, information, results of public examinations and government forms could benefit from greater integration of the technology services of developed countries.

Further, measures such as providing access to information and communications technology and other life-saving technologies could also be critical in strengthening the transformative services to the wellbeing of women and girl's lives in Bangladesh.

³⁴ <http://www.who.int/workforcealliance/countries/bgd/en/>

³⁵ 'Secretary-General Appoints High-Level Panel on Technology Bank for Least Developed Countries', Note no.6431, 26 November 2014, www.un.org/press/en/2014/note6431.doc.htm

³⁶ Unpublished report by Naripokkho: Religious extremism and comprehensive SRHR in secondary and

Capacity Building

Currently, the Bangladesh government has made significant strides in effective policies and programmes like National Population Policy 2012, National Nutrition Policy 2014, Menstrual Regulation (MR) Policy 1979 amended in 2015 focusing on certain aspects of SRH, in particular, through efficient collaboration with a number of NGOs, UN agencies and international organizations.

However, the issue of SRHR in Bangladesh remains a difficult issue to address openly due to socio-cultural barrier and to some extent the religious extremism which hinders the process of getting information in the community about SRHR³⁶, particularly among adolescents despite its significance for this vulnerable age group.

There is a need for capacity building, particularly in the follow-up stages of training, in order to ensure quality provision throughout the process of engagement with health service providers. Indeed, health care providers at all levels must receive regular training in order to ensure the highest standard of health care provision in the areas concerning SRHR and updating the MIS system accordingly. It is also important that the government continues to engage in global partnership mechanisms in order to reach the grassroots level and facilitate effective collaboration.

Trade

The need to provide affordable and essential medicines can be understood in terms of the Global Partnership for Effective Development Cooperation (GPEDC). The global partnership is principally between governments of developed and developing countries, where the developed countries often play the dominant role. The means of implementation can be either global or national. Moreover, South-South relations in the recent past have strengthened the global arenas of trade and investment, with shares of larger Southern countries gradually increasing their role as non-traditional donors.

The pharmaceutical sector in Bangladesh is a highly developed sector, catering to about 97% of the internal demand³⁷. Nonetheless, despite the expansion of available and affordable contraceptives and services, gaps persist for example; unmet contraceptive need is still 12%³⁸.

higher secondary education: Bangladesh Perspective 2015

³⁷ <https://donttradeourlivesaway.wordpress.com/2011/12/20/success-story-of-generic-pharmaceutical-industry-in-bangladesh/>

³⁸ Bangladesh Demographic Health Survey 2014

³⁹ http://www.wpro.who.int/asia_pacific_observatory/hits/series/bgd_health_system_review.pdf

Monitoring mechanism

Over 43 years after independence in 1971 the health system of Bangladesh has gone through a number of reforms and established an extensive health infrastructure in the public and private sectors. Bangladesh has achieved impressive improvements in population health status by achieving MDG 4 by reducing child death before the 2015 target, and rapidly improving on other key indicators including maternal death, immunization coverage, and survival from some infectious diseases including malaria, tuberculosis, and diarrhoea. However, some challenges for the health system remain critical. First, lack of coordination across two different ministries for implementing primary health-care service delivery in rural and urban areas; second, critical shortage of trained health providers with appropriate skill-mix in the public sector and widespread increase in unregulated informal providers for an alternative source of care; third, low annual allocation to health in the government budget and high out-of-pocket payments by households; and finally, inequitable access to health services between urban and rural areas including variable health financing mechanisms, which have slowed achieving universal health coverage. Mobilizing the private sector to increase the production of health work force and bringing informal health-care providers within the mainstream health system may facilitate reducing the gap in human resources in a relatively shorter time period. There is an urgent need for more investment of public funds and stronger local accountability to improve the quality of public services, and monitoring the quality of care provided by the private and informal sectors³⁹.

ACCOUNTABILITY

Lack of adequate accountability mechanisms are some of the most pressing concerns affecting the protection of women in Bangladesh today. In alignment with the unmet MDG targets of increasing primary school completion, adult literacy rates, and the creation of decent wage for women, robust efforts from government are needed to advance the success in achieving the SDGs. The Right to Information Act (RTI) came relatively late in Bangladesh (2009), and even among civil society activists, there is little awareness of this issue. People in Bangladesh face great difficulties in accessing information from public authorities.

There is a need to engage with civil society organisations in establishing direct and indirect dialogues between the government and public at large about the tracking of effective implementation of various levels and the service delivery outcomes. In order to open up this dialogue and make the private sector organisations more accountable, civil society groups working to promote democratic governance through training, parliamentary training and election monitoring must be sustained in order to maintain step with reality.

Furthermore, accountability mechanisms that already exist that of hospital management committee, Parliamentarian standing committee, committees at upazial and district level on Violence against women etc should be regularised, active and effective. Civil Society Organisations should be part of carry out planning, implementation and oversight at the all level. Compliance with the RTI Act, 2009 must also be strictly enforced for development projects, and detailed guidelines should be developed as to what specific kinds of information are to be disclosed proactively. Clearly defined strategies and procedures of grievance redressal must be made easily available for all; in order to ensure social accountability tools are disseminated throughout society.

RECOMMENDATIONS

We strongly urge to need fulfil the goals are ensure healthy lives and promote well-being for all at all ages; ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; achieve gender equality and empower all women and girls by 2030 to consider this recommendations for this goals. In spite of successes against health indicators, challenges remain in achieving universal access to reproductive health, maternal mortality rates, morbidity rates, neonatal mortality, sexual abuse, sexually diverse group (LGBTQI), in part because of the persistent unmet need for family planning, especially among unmarried adolescents still now. More broadly, the agenda for health is changing in a number of important ways that have a bearing on priorities for development. Gender-based violence, which was not addressed in the MDGs, also is emerging as a basic health issue. To improve the SRH situation government, national and international organization needs to work more closely. Media has a role to play to inform and aware on rights and ways to avail services. Human rights organizations, researcher and civil society should work together to attain and improve the following SRHR issues.

In addition the following recommendations should be addressed:

- o Ensure universal access to sexual and reproductive health services and overall quality of care. Special emphasis should be given to marginalised groups e.g., poor and rural women and adolescents and excluded groups e.g., sex workers, sexually diverse group or Lesbian, Gay, Bisexual, Transgender, Queer & Intersex (LGBTQI) groups and women with disability, Domestic workers (in Bangladesh and foreign), Garments workers.
- o Recognition of LGBTQI through amends of existing laws and enacts new law and policy for this group and initiates adequate appropriate services for them.
- o Ensure that sexual and reproductive health as fundamental rights and women and girls are rights holder. .

⁴⁰ http://www.dshe.gov.bd/images/female_stipend.html

- o Establish strong referral system to ensure emergency obstetric care and essential newborn care services.
- o Ensure adequate budget allocation for essential expenditure in sexual and reproductive health services.
- o Special attention should be given to implementation of the existing laws and policies as well as review periodically for necessary amendment such as The Nationwide Female Stipend Program 1994⁴⁰, Child Marriage Restraint Act 1929⁴¹, and Amended in 1984 to reduce maternal and prenatal mortality-. Effective enforcement of Births and Deaths Registration Act 2004⁴², the Children Act 2013⁴³ across the country, Initiate intervention to eliminate “son” preference which often causes polygamy, divorce and violence on women. Ensure universal access to comprehensive sexuality education in the schools and colleges. Family members and the elderly groups should also know the existing services to get information and services of SRH issues.
- o Improve skilled birth attendance during delivery
- o Strengthen 24/7 safe delivery & essential newborn care services by SBA with properly linked by TBAs.
- o Improve ANC in & out of health centre as well as quality of antenatal care especially among rural women.
- o Validation of the recording process for accurate maternal deaths audit.
- o Ensure demand of family planning method (modern contraceptives) and appropriate use family planning method.
- o Ensure media coverage to inform and aware on rights and ways to avail services in the local and national level.

CONCLUSION

Sustainable Development Goals are rights based action and to achieve these goals Bangladesh should have appropriate policy and plan and its effective implementation at the national level. Bangladesh has made outstanding progress in MDGs achievement and has already met several targets of the MDGs like reducing headcount poverty and poverty gap ratio, reducing the prevalence of underweight children, still birth, attaining gender parity at primary and secondary education, under-five mortality rate reduction, containing HIV infection with access to antiretroviral drugs, children under five sleeping under insecticide treated bed nets, cure rate of TB under DOTS and others. In addition,

⁴¹ http://bdlaws.minlaw.gov.bd/print_sections_all.php?id=149

⁴² http://www.unicef.org/bangladesh/Birth_Registration%281%29.pdf

⁴³ <http://www.blast.org.bd/content/report/06-09-2014-jfc-and-law.pdf>

Bangladesh has made remarkable progress in, increasing enrolment at primary schools, lowering the infant mortality rate and maternal mortality ratio, improving immunization coverage and reducing the incidence of communicable diseases. On the other hand in our advocacy need greater attention to reduce the maternal mortality ratio, to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and to the integration of reproductive health into national strategies and programmes, to improve quality education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and nonviolence, and to ensure universal access to sexual and reproductive health and reproductive rights. In above, we try to address in these targets related present situation in our country and to fulfil these targets to address indicators and recommendations in our national level.

About Naripokkho

Naripokkho is a membership-based, women's activist organisation working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice. Since its founding in 1983, Naripokkho has met every Tuesday to discuss problems, issues and strategies related to these concerns. These discussions form the basis for Naripokkho's programmes and activities, which include campaigns, cultural events, training, research, lobbying and advocacy, and the maintenance of a regular participatory discussion forum. Occasionally this leads to a specific project, which is carried out with grant funding. However, most of Naripokkho's activities are voluntary and financed through resources contributed by the membership. Naripokkho's work is focused on the following five inter-related thematic areas:

- Equality and the Political Empowerment of Women
- Violence Against Women (VAW) and Women's Human Rights
- Women's Health and Reproductive Rights
- Communal Harmony
- Women's Economic Rights

Naripokkho has extensive experience in developing sustainable networks and alliances as well as in conducting research, workshops, seminars, training and national level conferences.

Naripokkho's campaigns, projects and advocacy interventions are conducted by members with the support of full-time staff. Naripokkho has through the collective knowledge and experience of its membership and the engagement of individual members in various movement-based and advocacy roles, has achieved a strong reputation of expertise in gender and rights issues.

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