Share-Net International
The Knowledge Platform on Sexual and Reproductive Health & Rights

AOC ARCHITECTS OF CHANGE

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GAP ANALYSIS

BRIDGING THE GAP BETWEEN SRHR AND MENTAL HEALTH

2020

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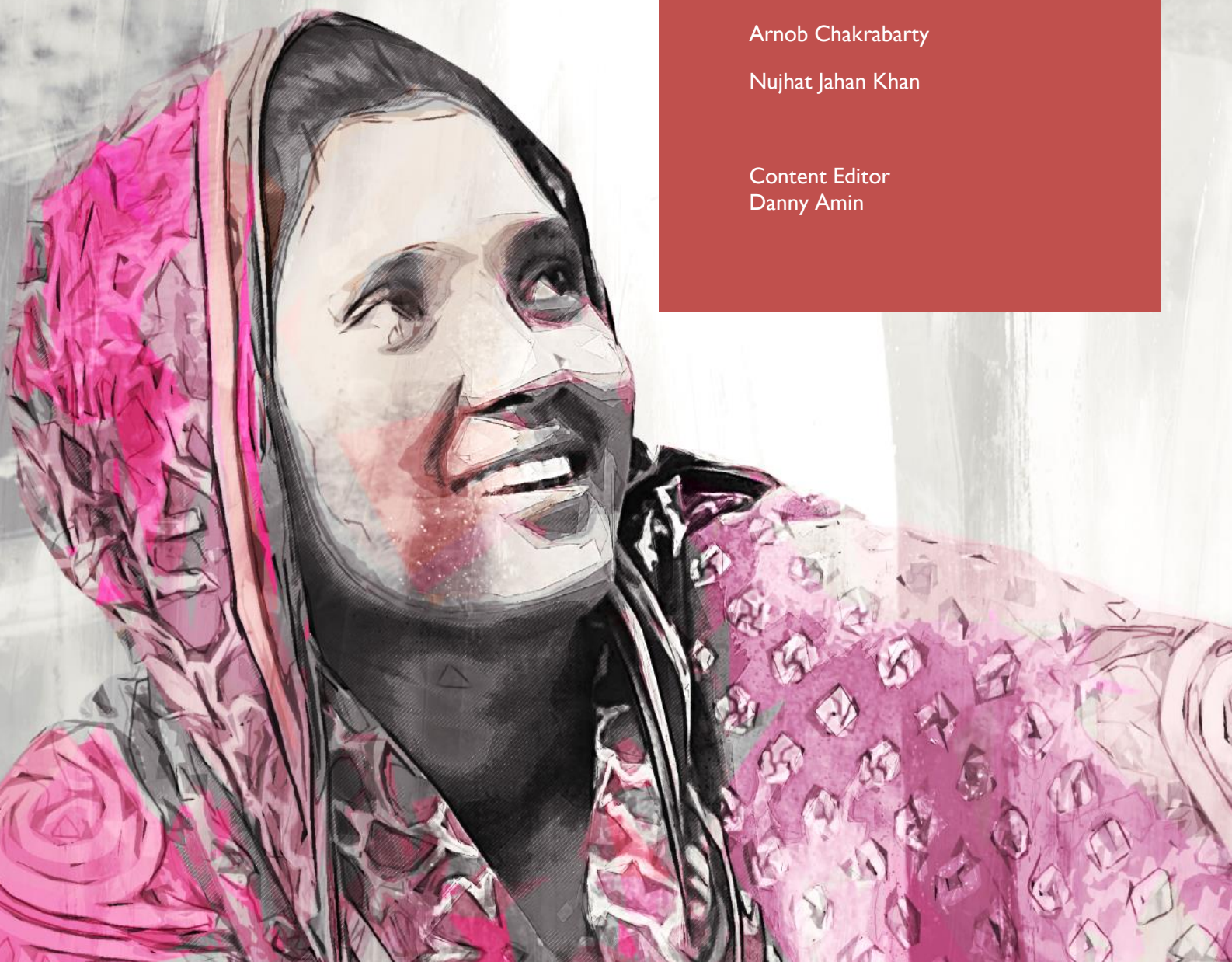

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ACRONYMS

ASRH:	Adolescent Sexual and Reproductive Health
BDHS:	Bangladesh Demographic and Health Survey
Beijing Platform for Action:	The Beijing Declaration and the Platform for Action
CEDAW:	Convention on the Elimination of all forms of Discrimination Against Women
CMRA:	Child Marriage Restraint Act-2017
DGHS:	Director General of Health Services
DGFP:	Director General of Family Planning
FP:	Family Planning
FWV:	Family Welfare Visitors
FYP:	Five Year Plan
GBV:	Gender Based Violence
GoB:	Government of Bangladesh
GRM:	Grievance Redress Mechanism
HCTT:	Humanitarian Coordination Task Team
ICCPR:	International Covenant on Civil and Political Rights
ICESCR:	International Covenant on Economic, Social and Cultural Rights
ICPD:	International Conference on Population and Development
ICT:	Information and Communications Technology
IPPF:	International Planned Parenthood Federation
LMIC:	Low-to-Middle-Income Country Membership
LMP:	Last Menstrual Period
MOHFW:	Ministry of Health and Family Welfare
MR:	Menstrual Regulation
NAWG:	Needs Assessment Working Group
NIMH:	National Institute of Mental Health
NYP:	National Youth Policy
OCC:	One-Stop Crisis Center
PMDD:	Premenstrual Dysphoric Disorder
PTSD:	Post-Traumatic Stress Disorder

PSC:	Psychiatric Sex Clinic
SRH:	Sexual and Reproductive Health
SRHR:	Sexual and Reproductive Health and Rights
STI:	Sexually Transmitted Infections
SV:	Sexual Violence
UNHRC:	United Nations Human Rights Council
UNICEF:	United Nations Children's Fund
Upazila:	Sub-unit of district
WHO:	World Health Organisation
YFSRH:	Youth-Friendly Sexual and Reproductive Health
7th FYP	Sevent Five Year Plan

EXECUTIVE SUMMARY

The study explores the connection between Sexual and Reproductive Health and Rights (SRHR) and mental health in Bangladesh. It also aims to identify and bridge the knowledge gap between mental health and SRHR in policies and practice. We briefly cover the historical journey towards establishing SRHR in the global human development agenda and examine the progress of SRHR and mental health in Bangladesh. The literature review was done in two parts. The first part includes an overview of the current situation in Bangladesh by analyzing published literature and news articles. The second part of the review highlights the gaps in the current policies, laws, strategies and agreements in Bangladesh. Furthermore, we conducted expert interviews to capture their experience and to translate their tacit knowledge to explicit knowledge. This further allowed us to validate the findings from our literature review. Based on our findings we present recommendations. Firstly, our analyses show that there is a limited link between SRHR and mental health in the current policies and strategies. The Government of Bangladesh (GoB) has expanded its commitment to address SRHR, and in some cases these commitments are reflected in the current policies and strategies, there is very limited focus given on addressing the quality of the services. Our analyses show that the SRHR services are often not accessible for unmarried young people, Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) community, people with disabilities and older persons. The study reveals lack of coordination between the inter-ministries and the development partners. While some efforts have been made to address the mental health issue in the country, it is a multifaceted problem which requires coordinated solutions that appear to be missing. The experts stressed to include psychologists as they could play a role in designing and developing policies and programs related to SRHR and mental health. They also suggested that we need to foster a stigma-free environment to accept mental health as a serious issue through creating awareness and strengthening the capacity of service providers. We need to recognize that SRHR and mental health are linked. It requires innovative approaches to reach out to everyone by introducing a model of service delivery and addressing sensitive issues. Furthermore, the new approach can include the grassroots stakeholders to bring their local knowledge to respond and meet the SRHR and mental health needs of the local community. Moreover, the government should allocate their budget to ensure stigma-free, discrimination-free and quality SRHR and mental health services.

ACKNOWLEDGEMENT

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We would like to acknowledge the contribution of participants who shared their knowledge, opinions and recommendations with us through online interviews.

ABOUT SHARE-NET

Share-Net International, the Knowledge Platform on Sexual and Reproductive Health and Rights based in the Netherlands, funded a project conducting a study titled 'Bridging the Gap between Mental Health and SRHR', conducted by Architects of Change and RedOrange Media and Communications. The objective of this project is to identify, analyze and investigate gaps between SRHR and mental health in national policies; and to highlight opinions and perspectives of experts on mental health and SRHR. With this project we intend to create evidence that can be shared with stakeholders of government and non-government sectors so that they may look at SRHR as an essential component of mental health. The study will generate knowledge that can be used as evidence to prove that SRHR and mental health are closely connected to each other, and that one can achieve a healthy mental state only when their sexual and reproductive health and rights are properly addressed.

Share-Net Bangladesh is a comprehensive knowledge platform focusing on SRHR in Bangladesh. Share-Net Bangladesh is the first of three national knowledge hubs outside the Netherlands supported by Share-Net International. Share-Net International and the country hubs aim to create a safe space for national and global practitioners, researchers and policy makers in SRHR to generate, share and translate their knowledge and experiences, and drive the SRHR agenda forward at the policy level.

In Bangladesh, Share-Net serves as an overarching knowledge network, bringing key practitioners, researchers, field officers, academics, and relevant stakeholders working in various fields of SRHR under one umbrella, encouraging them to share information and experiences. Along with creating communities of practice, Share-Net Bangladesh offers a range of digital services to the registered users including access to e-library and tools, and other resources on SRHR.

INTRODUCTION

The introduction chapter provides a global perspective on SRHR and the progress that has been made since its inception. SRHR's historical background shows the long struggle of bringing SRHR and mental health into prominence. The discussion then gradually moves towards the progress of SRHR and mental health in Bangladesh.

Photo 1 RedOrange Media and Communications

Sexual and Reproductive Health and Rights (SRHR) is one of the essential components of human rights (Liliane Foundation, 2019). SRHR is an umbrella term for a variety of issues that affect all individuals. It represents four separate but intrinsically interlinked fields: sexual health, sexual rights, reproductive health, and reproductive rights. As part of human rights, individuals reserve the right to make their own decisions and to be treated with respect and dignity - particularly with regard to SRHR. This includes the recognition of overall well-being which is heavily dependent on sexual/reproductive health as well as mental health. Sexual health and reproductive health are often used interchangeably, as are sexual rights and reproductive rights. In some cases, sexual rights are included in the term sexual health, or vice versa (International Planned Parenthood Federation, 2003).

The historical evolution of SRHR allows us to understand the past trends as well as its global development. In 1994, the International Conference on Population and Development (ICPD) in Cairo, Egypt marked a significant shift in perspective in regards to reproductive health and is considered to be the birth of the modern SRHR movement (Fincher, 1994). At the time, the increase in HIV/AIDS cases brought out the importance of sexual health. It was also considered important for population control through contraception. While this focus on the population was no doubt important, it lacked an emphasis on the individual's sexual health and rights. In 2002, the World Health Organization (WHO) held a technical consultation meeting which brought out a

working definition of sexual rights, sexual health and sexuality. From then on there has been a gradual endorsement of SRHR among the global community (Cottingham, 2019).

Building on numerous international and regional agreements as well as international human rights treaties and principles, the new definition reflects an emerging consensus on the services and interventions which needed to address the sexual and reproductive health needs of all individuals. This definition offers a universal framework to guide stakeholders in developing policies, services and programs that address all aspects of SRHR effectively and equitably (Guttmacher Institute, 2018). According to Guttmacher Institute's new definition 'sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity' (Guttmacher Institute, 2018). It further adds, 'All individuals have a right to make decisions governing their bodies and to access services that support that right' (ibid). This new positive approach to sexuality and reproduction recognized the importance of pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being.

The Beijing Platform for Action recognizes that women's human rights include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (Naripokkho, 2017).

One of the first reports to focus explicitly on the intersection between mental health and development was published by the WHO in 2010 (Chan, 2010). In 2015, mental health was included in the Sustainable Development Goals. SDG 3 aspires to ensure healthy lives and promote well-being for all at all ages and target 3.4 specifically aims to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being (WHO, 2020). Mental health appears in Article 26 of the declaration, which states that 'to promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care' (United Nations General Assembly, 2015). Historical absence of mental health on the development agenda has been a major obstacle towards development. This concern has led to its recent inclusion in the UN Sustainable Development Goals (Mills, 2018). Following the inclusion of mental health in the SDGs, the World Bank and the International Monetary Fund (IMF) began taking mental health more seriously as a development issue. In April 2016, the World Bank together with the WHO hosted an event called 'Out of the Shadows: Making Mental Health a Global Development Priority', which aimed 'to move mental health from the margins to the mainstream of the global development agenda' and to build a 'collaborative response to tackle mental health as a development challenge' (World Bank, 2016). This further shows that perceptions regarding the importance of mental health began to shift globally.

SRHR and Mental Health in Bangladesh

The SDGs include ambitious global targets for health, including universal health coverage (target 3.8) and universal access to sexual and reproductive health care services (target 3.7). Each country makes its own decision about what services are included in universal health coverage (UHC) benefit packages, but WHO is committed to making sure that SRHR are prioritized. Women's involvement, SRHR and gender equality must be part of the equation (Tedros, Adhanom, Ghebreyesus, Director General, WHO, 2018). According to the report of the Bangladesh budget allocation discussion-2019, six members of parliament, including the Honorable Speaker, strongly advocated for population control. In 2019, UNFPA interventions focused on providing mental health support integrated with SRHR services for Rohingya refugees and host communities to prevent GBV and harmful social practices. Development partners of Bangladesh strongly proposed to include SRHR as part of the Universal Health Coverage in the National 8th Five-Year Plan (FYP) (UNFPA, 2019). Bangladesh is going through the final stages of forming their 8th FYP and has requested technical and financial support from the development partners to secure existing growth. The GoB has also formed a committee which regularly monitors the countries progress against the target. The GoB has

identified three priority areas: job creation, GDP (Gross Domestic Product) growth, equal opportunities for all and tackling the adverse effects of COVID-19 and climate change (Daily Star, 24 July, 2020).

The country has a high prevalence of sexual harassment and child marriage; this has severe repercussions on mental health (Human Rights Watch, 2020). To establish and implement the SRHR agenda committed by the GoB, it is important to focus on mental health. The overview of the current situation in Bangladesh further highlights the recent increase in sexual harassment cases, gender based violence cases and child abuse. These issues no doubt have a negative influence on mental health; however, the research is limited. There are other issues concerning mental health in the country, covering not only the aspect of mental health itself but also the social stigma, lack of resources and accessibility.

1.1 OBJECTIVES

The objectives of the study are stated below:

- To identify, analyze and investigate the gaps between SRHR and mental health in the national policies of Bangladesh.
- To highlight the perspectives of academicians, researchers, practitioners and policy makers towards mental health and SRHR.

To prevent bias and to ensure validity, we have adopted different strategies which target our aims. To analyze the limitations in the national policies we have identified government policies and documents that target young people and adolescents. The knowledge and experience of the experts help us understand the status quo of SRHR in Bangladesh. In addition, they provide recommendations for integrating mental health and SRHR in the future. In addition to our main objectives we aim to show that SRHR and mental health are intertwined. Therefore, policies should be designed and adapted in line with what we expect to find and the gaps plugged through necessary intervention.

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1.2 METHODOLOGY

This research was done in two parts. Firstly, we have reviewed research and news articles to present an overview of the current situation of SRHR and mental health in Bangladesh. The study identifies relevant literature on mental health and SRHR from a global as well as local (Bangladesh) level. The dates of the literature range between January 2000 and October 2020 and were systematically selected.

This was followed by analyzing the national policies, strategies, laws and agreement. Number of policies, laws and commitments were identified and analyzed such as Bangladesh Mental Health Act 2018, National Strategy for Adolescent Health 2017-2030, National 7th Five-year Plan, Education Policy 2010, COVID-19 Bangladesh Multi-Sectoral Anticipatory Impact and Needs Analysis, COVID-19 Response Family Planning-2020 and other UN policy briefs on Bangladesh related to SRHR and mental health. A list of reviewed policy documents is presented in Table 1. The policy section also included GoB and UN policy briefs and actions to address SRHR and mental health support systems.

Bangladesh Government's Policies and Strategies Regarding SRHR and Mental Health Reviewed
National Strategy for Adolescent Health 2017-2030
Bangladesh National Development Policy 2017
Seventh Five Year Plan
Mental Health Act 2018
Education Policy 2010
Family Planning Policy 2020
Child Marriage Restraint Act 2017
National Health Policy 2011
National Population Policy 2012
Bangladesh Government Needs Assessment COVID 19

Table 1: The reviewed policies, strategies and needs assessments

The search strategy identifies policies, studies, reports, and evaluations of initiatives in Bangladesh that include components of SRHR and mental health. The search engine includes Google Scholar and databases, government website, and IUB (Independent University, Bangladesh) library.

In order to fill the gap in the literature, the study applies a Critical Interpretive Synthesis (CIS) approach. The CIS encompasses gap analysis of Bangladesh relevant national policies and peer reviewed research studies, UN policy documents and government documents. It also includes key findings from academic and grey literature especially on LGBTQ community which are very difficult to come by.

Secondly, four SRHR practitioners and two mental health experts were identified and interviewed. To ensure representation from the Government of Bangladesh, the study also includes an interview of a high government official of the Ministry of Women and Children Affairs (MoWCA). Due to COVID-19, all expert interviews, including semi-structured in-depth interviews were conducted virtually. The study also briefly reflects on the UN and GoB's response towards COVID-19 concerning SRHR and Mental Health.

We prepared a semi-structured questionnaire, and conducted interviews with all the respondents using the same questionnaire to achieve validity and reliability of the results. All the interviews took place online, via Zoom. Six practitioners/experts were interviewed. The interview consisted of 11 questions focusing on the gaps between SRHR and mental health and their implementation in Bangladesh.

Each interview summary was divided into three major parts:

- Experts' reflection on SRHR and mental health in the Bangladeshi context
- Reflection on national policies related to SRHR and mental health
- Highlights on expert's recommendation

Furthermore, these experts shared relevant documents and studies to address the gap between mental health and SRHR.

Photo 3 RedOrange Media and Communications

2 LITERATURE REVIEW

The literature review chapter is divided into two parts. The first part provides an overview of the current situation and actions from the GoB and development partners on the phases of development of SRHR practices in Bangladesh during 2020. The second part of the review covers existing policies, laws and agreements, the implementation progress and the impact of COVID-19 on SRHR and mental health services in Bangladesh.

OVERVIEW OF THE CURRENT SITUATION IN BANGLADESH

After Bangladesh's independence in 1971 until the mid-1990s, Bangladesh mainly invested in child survival and family planning services targeting women (World Bank, 1990). Since 1994, Bangladesh has made a major paradigm shift in health policy and programs, which were influenced by the ICPD.

Its priorities, investment and commitment shifted from a narrow focus on family planning to reproductive health. The GoB has committed to include SRHR under the Universal Health Coverage (UHC) and state the following:

'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 programs' (WHO, 2016).

Furthermore, the GoB has begun to acknowledge the issue of sexual harassment which is an important component of SRHR. The National Review focuses on sexual harassment, to strengthen Government's effort to address this issue (Bangladesh National Reviews, 2020). In addition, it acknowledges that suicide rate among women is high, and emphasizes to improve mental health services in the country (ibid).

While the GoB has extended its focus on mental health, there is still very limited focus on sex and sexuality. To date, the Psychiatric Sex Clinic (PSC) is the only clinic which is specialized in providing psychiatric service-based sex in the country. This clinic only has the capacity to provide service to 15-20 patients once a week (Arafat and Ahmed, 2017).

Most patients in Bangladesh with sexual issues tend to visit a dermatologist or a venereologist. Accessing a specialized sex clinic is not common, mainly due to lack of information and limited referral provided by the physicians they visit. Most referrals are made by the Psychiatry Outpatient Department (OPD) of Bangabandhu Sheikh Mujib Medical University (Arafat and Ahmed, 2017).

2.1.1 SEXUAL VIOLENCE AND MENTAL HEALTH IN GLOBAL TO LOCAL PERSPECTIVE:

Globally, 35% of women have either experienced sexual violence and/or physical abuse by their intimate partner or non-partner (WHO, 2017). Worldwide, 38 % of women get murdered by their intimate partner (WHO, 2017). Studies show that victims of GBV have a negative impact on their mental health and in many cases develop depression (UN Women, 2019). In Bangladesh, GBV is widely prevalent, which limits freedom of choice and decision-making autonomy among those who experience it. It also limits their access to SRHR for a lifetime (Arrow, 2011).

Many adult survivors of physical, sexual or severe emotional abuse show symptoms of Post-Traumatic Stress Disorder (PTSD). Emotions such as fear, shame, humiliation, guilt, and self–blame are common and lead to depression and anxiety (Moffitt and Klaus-Grawe, 2013). Through various case studies, it is evident that most sexual assaults are carried out by known perpetrators in their own home and not in a secluded place by a stranger (The Daily Star, 2020). This is problematic as the perpetrator can repeatedly offend without fear of any repercussions (Tarzia et. al, 2018). In many developing countries, girls experience more violence and sexual harassment and they are expected to work long hours on domestic chores, limiting their ability to study (Plan UK, 2013). Recent news highlighted that men and boys getting raped has serious implications on mental health, leading them to suicide. However, there is a limited number of studies on male rape survivors (Ahmed, 2020). The UN Multi-Country Study on Men and Violence shows that 3.7% of men are raped by another man in rural areas (UNDP, UN WOMEN, UN Volunteers, 2013). It highlights that sexual abuse is highly faced by boys in Madrasas (Islamic schools) by their male teacher (ibid).

2.1.2 SEXUAL HARASSMENT IN BANGLADESH

Ain O Salish Kendra (a legal aid and human rights organization) reported that an average of four women were raped every day in Bangladesh amid the COVID-19 pandemic during 2020 (Rabbi, 2020).The Daily Star (2019) reported that 5.17% girls are sexually abused before reaching the age 10 (Khatun, 2019). In an another article, the newspaper reported that 1 out of 10 boys encounter sexual harassment and do not report the case due to social norms (Nasreen, 2019). The

transgender (hijra) community is the subject of sexual abuse and harassment in the country (Bintey Ali, 2020).

BBC (2020) reported that in 2020, for the first time in Bangladesh, several large-scale protests against rape have been organized by various human rights activists, students, youth, and various political parties. The protests are demanding expedited police investigations and trials of rapists to ensure justice for victims and amend the Evidence Act to end victim-blaming. An article by the Guardian (2020) further discussed that Jatiya Ganatantrik Front, a political group, released a statement that from 2001 to 2020, only 3.56% of the filed cases received a verdict, whereas only 0.37% of these filed cases received punishment.

Across the country, the students' coalition demanded fixing a 15-day time limit for investigation and completing trials within 60 days. In an article, Al Jazeera (2020) reported that Bangladesh High Court ordered the Law Ministry to form a commission within 30 days to address the sexual assault cases and submit a report by June 2020. Taqbir Huda, a research specialist at Bangladesh Legal Aid and Services Trust (BLAST) told Al Jazeera that loopholes in the legal process meant that only 3 percent of rape cases tried in court resulted in convictions (ibid). On 12th October 2020, Bangladesh's government has approved an amendment that would allow for the death penalty in rape cases (Al Jazeera, 2020).

The issue of male rape started to get media attention in 2019, when a 45-year-old man hanged himself after getting raped by 10 men (Dhaka Tribune, 2019). The story draws attentions of the media and the development partners further stressing the issue that current law does not have any provision to address the male rape cases (ibid). The discussion started to advocate for justice for male rape through policy and law reform (ibid).

As the country has an increased sexual abuse rate, studies further demonstrate the direct relationship between childhood sexual abuse and the development of depression in adult women (Hossain, 2014). Bangladesh does not have any specific law or policy addressing Grievance Redress Mechanisms (GRM) for sexual rights and reproductive health rights. Such grievances are addressed in medical cases only. Any negligence in services is addressed by the General Medical Negligence Act (The Consumer Rights Protection Ordinance, 2008).

However, the grievance readiness system governs by Citizen Charter and Policies. Any case related to SRHR is addressed by the General Medical Negligence Act (The Consumer Rights Protection Ordinance, 2008; The Bangladesh Medical and Dental Council Act, 2010). In addition to these laws, the connection between mental health and SRHR is still not understood and reflected in the policy documents or in any intervention.

Table: 1

MJF : May 2020 record Total of 53,340 women and children from its project areas. 36,434 women and 15,908 children					
Domestic violence face by women and children	Became victims for the first time.	Abused children/adolescents	Child marriage	Rape	Domestic violence face by women and children
13,494 31% increase	Children/teenager: 1219 81% percent Women 2641 are 25 %	1477 68 % girls 694 32 % boys	170	19 raped 18 attempted rape	13,494 31% increase
Ain O Salish Kendra (ASK) collects figures based on reports of sexual violence in newspapers (January –September - 2020)					
Domestic violence – women murdered by husband	Tortured by husband	Child killed	Torture by own family & Murdered by own family	Sexual Harassment on women	Rape cases
115 Cases filed: 89	29 Cases filed: 21	375 Cases filed: 174	24 tortured Cases filed: 1036 Cases filed: 17	130	975 Case filed: 450 (38 died after rape)
Violence against children	Victim under 9-12	victims aged below 6	Sexual hassment on boy	attempted to rape	Gang Rape
1078	242	108	20	204	142

2.1.3 THE ISSUE OF CHILD MARRIAGE IN BANGLADESH

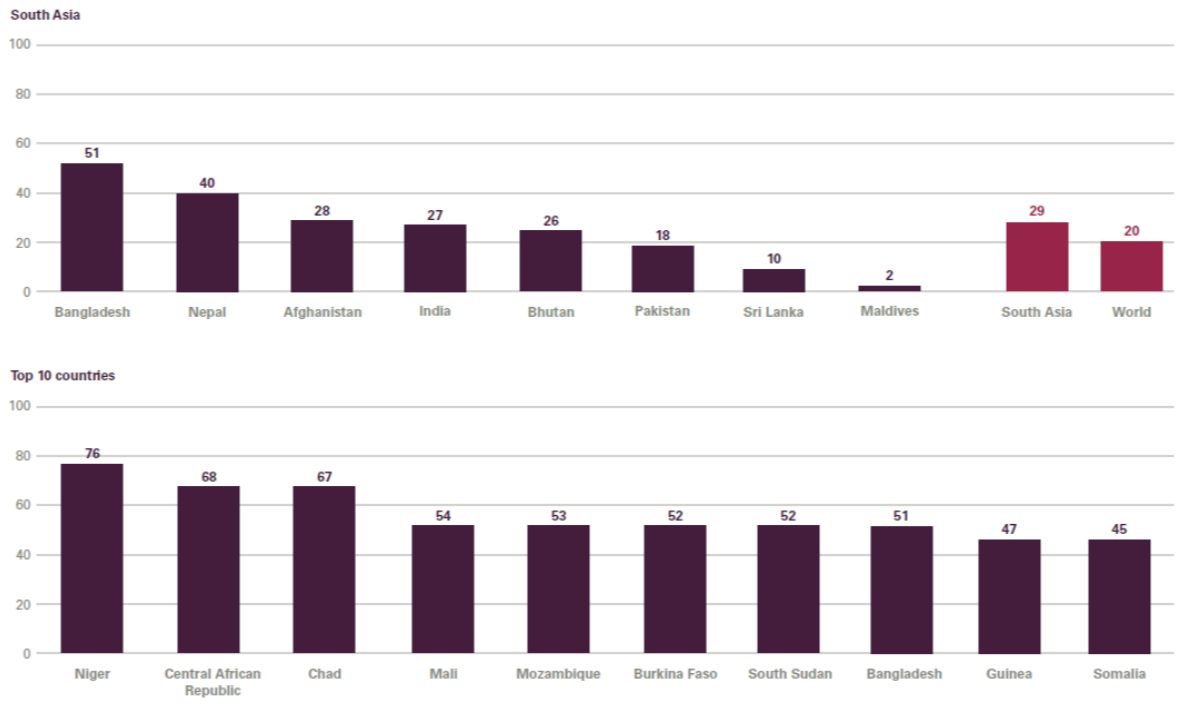
Child marriage is another form of gender-based violence that is practiced in Bangladesh which directly affects SRH and mental health (UNICEF, 2020). Child marriage has been illegal in Bangladesh since 1929, and the minimum age of marriage is 18 for women and 21 for men since the 1980s. Despite the law in place to protect the young girls in particular, Bangladesh has 38 million child brides (ibid). UNICEF and the Ministry of Women and Children Affairs jointly launched a report on ending child marriage which shared 30 years systematic collected data on prevalence of child marriage. According to the study, Bangladesh has the highest child marriage in South Asia as well as ranked among the top 10 nations in the world with the highest numbers (ibid) (See Table 2). Even though, the study highlighted that child marriage has decreased by 90% since 1970, there are still 38 million child brides who were married before the age of 18, including 13 million who were married before their 15th birthday. UNICEF collected and analysed this data from the Demographic and Health Surveys (DHS) 1993-1994, 1996-1997, 1999-2000, 2004, 2007, 2011 and 2014, and the MICS 2006, 2012-2013 and 2019.

The study finding shows that improvement needs to be minimum of 8 times faster than the rate of the efforts made in past 10 years to reach the national targets, and 17 times faster to reach the target of SDG. It also shares evidence that girls who could finish secondary education are the least likely to be victims of child marriage, regardless of where they live or their family's economic condition (UNICEF, 2020).

Table: 2

Bangladesh has the highest prevalence of child marriage in South Asia, and is among the 10 countries worldwide with the highest levels

FIG. 4 Percentage of women aged 20 to 24 years who were first married or in union before age 18



Notes: The standard measure of child marriage refers to both formal marriage and informal unions. Data for Bangladesh refer to marriage only, as information on informal unions was not collected, but data for other countries shown in this figure use the standard definition, which refers to both types of unions.

The reasons for high levels of child marriage are manifold including religious beliefs, social norms, poverty and social impacts. (Sadaf Ahmed, Saima Khan, Malka Alia, Shamoon Noushad, 2013). Child marriage is a driver for early pregnancy and pregnancy-related mortality and morbidity thereby causing major physiological and psychological health issues in adolescent girls (Ram, 2005 & Puri,

2003). This results in lack of confidence in the relationship, distrust and detachment. For girls who are young, sexual intercourse and unavoidable sexual relations with their husbands can be traumatic (ibid). Sex in such type of relationships, that involves young girls, is usually not built upon consent rather enforced upon them despite their reservation (CHANGE, 1999 & Ram, 2005).

This type of physical emotional and social torture leads to greater psychological traumas such as toxic immobility which refers to a set of involuntary motor responses elicited under conditions of extreme fear and perceived inescapability, and it is one type of pre-traumatic distress reported by survivors of childhood sexual abuse. Experiencing toxic immobility during childhood is associated with increased risk of developing symptoms of post- traumatic stress disorder (Buren & Weierich, 2016).

Furthermore, victims of child marriage suffer from loss of self-confidence and those attending school forced to abandon their education. Bangladesh is still behind in exploring and understanding the long term impact of child abuse and mental health outcome during adulthood. As a result, severe depression combined with inferiority complex is witnessed, particularly seeing other girls having good educational background and career opportunities which they couldn't pursue. (Singh, 1996). There is some evidence of greater difficulties in interpersonal and particularly intimate relationships among adults who were sexually abused during childhood. Guilt, shame, and blame are some of the attributes that they feel. They might feel guilty about not having been able to stop the abuse, or even blame themselves for experiencing sexual/physical pleasure (Child Family Community Australia, 2013).

Furthermore, young people in Bangladesh have limited access to quality information on sexual and reproductive health rights (SRHR) and quality youth-friendly sexual and reproductive health (YFSRH) services. This is due to a multitude of factors including poverty, socio-cultural beliefs and norms, and weak policy formulation and implementation. Many cases of sexual violence particularly among young women go unreported because of lack information as to where to avail such services combined with the fear that their complaint will not be treated in confidence. The other factors range from fear of repercussions, repeated violence and stigmatization (UNFPA, 2019).

2.1.4 ADOLESCENTS' MENTAL HEALTH AND SEXUAL HEALTH

SRHR is a cultural taboo in Bangladesh. Despite its importance and relevance, most adolescents in Bangladesh enter their reproductive years poorly informed about protection from pregnancy and infection and their reproductive choices (IPPF, 2009). There's limited research on the subject of sexual satisfaction in adolescents and young adults' mental health. Nonetheless, most research has indicated that those who are in romantic relationships tend to exhibit better mental health than those who are not (Viejo and Ruiz, 2019). Hormonal fluctuations combined with Premenstrual Dysphoric Disorder (PMDD) play a significant role in triggering depression, anxiety and extreme irritability, which in turn affects their daily lives as well as their relationships (Taylor Francis 2015).

Adolescents often face difficulty getting information and guidance regarding these issues, and their access to SRHR-related services is even more limited (Nahar et al., 1999). There are limited SRHR programs solely focused on either adolescents or the aging population (Ainul, Bajracharya and Reichenbach, 2017). A study reviewed 32 SRHR programs among which only 16 programs were exclusively targeted towards adolescents ages 10-19 (ibid). The rest of the programs included adolescents not by design, but through their coverage of a wider age range of beneficiaries e.g. women of reproductive age (15-49), and did not include interventions tailored towards adolescents' specific needs (ibid). Younger adolescents were especially neglected- only two of the 32 programs reviewed had a tailored strategy for 10-14-year-olds (ibid). Since this is the stage when gender and sexual norms, values, and attitudes start forming, it is important to establish positive and responsible SRHR attitudes and behaviors at this age (ibid).

In the absence of SRHR, adolescent sexual and reproductive health is often geared towards family planning, which under the conservative Bangladesh context, is only permissible for married young couples due to cultural acceptance (ibid). The systematic exclusion of unmarried adolescents from SRHR services makes them vulnerable to health risks and discriminatory treatment (Citizen's Platform for SDGs, 2018). Furthermore, girls and boys have very different experiences in adolescence, particularly related to expectations around marriage and childbearing (Amin, Mahmud, and Huq 2002; Amin, Selim, and Waiz 2006). Besides, social and cultural factors such as social insecurity (fears of being harassed or labeled as "bad"), social norms regarding age and girls' marriageability, and dowries create pressure on girls to marry and bear children at a young age (ibid). Lack of knowledge and access to SRHR services as well as no decision-making autonomy further force these girls to early pregnancy which contributes to negative health outcomes for them (Shahabuddin et al., 2016).

2.1.5 SOCIAL STIGMA, MENTAL HEALTH AND SRHR

Mental health challenges, such as depression are also observed during the end of reproductive years and perimenopause. This is the time when the body makes a natural transition to menopause marking the end of the reproductive years. The naturally caused chemical reaction in the body diminishes sex drive and takes its toll on mental health (Dalal and Agarwal). Another reproductive disorder, Endometriosis, is a painful medical condition affecting millions of women and girls worldwide. This medical condition occurs when tissue that normally lines the inside of the uterus – the endometrium - grows outside instead. As a result, it causes severe pelvic pain, cramps, heavy periods and even infertility (Action Canada for Sexual Health and Rights, 2019). The severity of the pain has an adverse impact on the quality of life and may lead to depression and mental illness (Taylor & Francis 2015). Mental health is further affected when there is difficulty in receiving a professional diagnosis, despite there being several symptoms present (Guardian readers, 2015). There is a limited number of studies on the effect of menopause and endometriosis on mental health. These are still emerging issues for Bangladesh.

A wide range of awareness programs on mental health at community level are being introduced in Bangladesh. For example, BRAC, icddr,b (International Centre for Diarrhoeal Disease Research, Bangladesh), Moner Bondhu and Bot Tola have taken online initiatives to support and raise awareness on children's mental health. Other online agencies like Hello Doctor, Moner Daktar, Athena, Pulse healthcare, and Olwel have started online video consultation services by specialist doctors (Syed, 2020).

Since March 29, 2020, the Ministry of Primary and Mass Education (MOPME) and Ministry of Education (MOE) with the technical support from Access to Information (a2i) have launched various platforms (TV, internet, mobile phones and radio) to facilitate virtual learning for children during the current pandemic (UNICEF, 2020). Since August, UNDP has been running a project on psychosocial support, partnering with "Moner Bondhu" on resilient community building. This project is titled, "COVID-19 Response" which focuses on providing online psychosocial counselling services. This also includes the development of information, education and communication materials, live discussions and discussion on mental health on TV, pledges for TV and social media, online training courses etc. The project not only has a special focus on women and adolescents considering their traditionally restricted access to availing psychological help, but it also hopes to de-stigmatize the topic of mental health and sensitize people to psychosocial counselling, capacity building, policy advocacy, knowledge management, reporting and documentation are also key tasks of the project (UNDP, 2020).

Although some initiatives have been taken to create awareness on mental health, still a negative attitude towards treatment prevails. Moreover, referrals of patients to mental health specialists by the general practitioners or other health care providers are almost non-existent (Ahmed, Alam, Niessen, 2014). There are also superstitious beliefs linked with psychiatric disorders. These are seen as evil influences and patients often seek remedies from traditional and religious healers. These

potentially harmful practices can be minimized through increased mass awareness as well as the development and implementation of mental health guidelines (Hossain, Ahmed, Alam, Niessen, 2014). In Bangladesh, systematically-collected data on mental disorders is very limited which doesn't help to paint a clear picture of the existing scenario. For example, statistics shows that the prevalence of mental disorders ranges from 6.5 to 31% among adults and 13.4 to 22% among children (Hossain, Ahmed, Chowdhury, 2014). These figures are extremely varied and it is difficult to draw any evidence-based conclusions (ibid).

While mental health is a stigmatized topic in the country, sexuality is another topic which is not discussed openly. Given the importance of sexuality in one's life, the attention garnered is not reflected accordingly across all ages. Older people generally find it hard to express themselves sexually due to ageist attitudes and perceptions that act as a hindrance. Older people are often stereotyped as non-sexual beings, having no sexual needs, thus no importance is given to their sexual relationships (Ayalon, Tesch-Romer, 2018). Engaging in sexual activity as an older generation is frowned upon and rather seen as a sign of immorality and perversion. Pre- conceived notion about an older person's sexuality with regards to physical attraction and association of sex with reproduction also plays a role in limiting their sexual activity (ibid).

These attitudes towards older people shape their own views in a direction where sexuality is seen in a negative light and avoidance is practiced. This predicament is further exacerbated due to their reluctance to discuss sexual issues with their physician because of fear of being judged and stigmatized (Gott and Hinchliff, 2003).

3 EXISTING POLICIES, LAWS, AGREEMENT IN PLACE TO ENSURE SRHR AND MENTAL HEALTH

The second part of literature review critically analyzes and investigates the relevant policies, laws and commitments on SRHR and mental health, as Bangladesh does not have any separate policy on SRHR. In order to understand the progress and gaps in the policies in SRHR and mental health, refer to annex 1.

Photo 4 redorange Media and Communications

3.1.1 NATIONAL STRATEGY FOR ADOLESCENT HEALTH

The National Strategy for Adolescent Health (NSAH) acknowledged that the needs of adolescents are multidimensional. It also highlighted that there is limited access to information regarding SRHR among boys and girls (National Strategy for Adolescent Health 2017-2030, 2017). To understand the policy context for adolescent health, well-being and bodily integrity, the study reviewed the National Adolescent Health Strategy 2017-2030. The strategy surrounding adolescents' sexual and reproductive health (SRH) aimed to control population growth and reduce maternal and child mortality.

The strategy further highlighted that adolescents were particularly vulnerable to violence in a range of settings, from their homes and schools to the workplace and other public spaces. The gap in service delivery for vulnerable groups such as adolescents with disabilities, those living in urban slums and in remote areas were also expressed as a key concern. Under such circumstances, it makes perfect sense to raise awareness and advance the knowledge base through improved education curricula where SRHR is taught as a matter of course and is an integral part of their educational program. Other key areas of focus are capacity building and improving health service delivery. It differs from the previous policy in that it includes specific objectives to improve adolescent nutrition and mental health, as well as adolescents' SRH (National Strategy for Adolescent Health 2017-2030, 2017).

The current strategy has four Strategic Directions (SD):

1. All aspects of adolescent SRH;
2. Violence against adolescents;
3. Adolescent nutrition ; and
4. Mental health.

Each SD first outlines a brief problem statement, followed by a description of the problem, then identifying key objectives and key strategies to achieve them. The NSAH also has two cross-cutting issues, focusing on social and behavior change communication (SBCC) and health systems strengthening. The policy objective focuses on improving adolescents' knowledge of reproductive health issues to delay pregnancy and reduce prevalence of Sexually Transmitted Infections (STIs). The Youth Policy-2017, advocates on developing a mental health support system for students. Moreover, the policy focuses on including age appropriate information on sexual and reproductive health and rights in the academic curriculum.

Commitment No.5 of the National Strategy for Adolescent Health 2017-2030 includes a wide range of initiatives such as ending child marriage, addressing the family planning needs and promoting rights of all adolescents. Efforts will be made to track adolescent health data and introduce the widest range of family planning methods possible.

The existing policy highlights arranging programs to focus strongly on changing the attitudes and behaviors of gatekeepers, including parents, family members, teachers and service providers to respect adolescents' opinions, needs and interests. It strongly recommends capacity development of respective institutions and systems to design, plan, implement and monitor the SBCC interventions (National Adolescent Reproductive Health Strategy, 2013). It also acknowledged that adolescent boys also face the pressure to conform to the prevailing hegemonic masculinity ideal, which can then drive them to perpetrate violence. The strategic objectives include promoting positive social norms to eradicate discrimination, mental health, develop capacity of the health experts to address mental health issues. For example, the primary health professionals should be able to screen anxiety, stress, depression and suicidal tendencies. The strategy further recommended integrating the mental health agenda within primary health care and in educational institutions (National Adolescent Reproductive Health Strategy, 2013).

3.1.2 COSTED IMPLEMENTATION PLAN FOR NATIONAL FAMILY PLANNING PROGRAM IN BANGLADESH 2020-2022

The Family Planning (FP) Policy has provided significant importance to reproductive health. The GoB has mobilized USD $615 million for the family planning implementation of the national action plan for postpartum family planning, which is a 67% increase from the previous program (Family Planning Policy Guideline, 2020). Commitment no. 5 of the policy focuses on fully operationalizing the National Strategy for Adolescent Health 2017-2030 with special attention on addressing the family planning needs and promoting rights of all adolescents.

Adolescents will have access to the widest range of family planning methods possible and special efforts will be made to track adolescent health data. The policy also highlights the SRHR needs of different age groups, especially unmarried girls. The policy strongly advocates on tackling child marriage to ensure delay in family planning (Costed Implementation Plan for National Family Planning Program in Bangladesh 2020-2022, 2020). Abortion is illegal in Bangladesh despite a circular issued in 2015 by the Director General of Family Planning (DGFP) of the Bangladesh Government, where it was decided that Menstrual Regulation (MR) is allowed within 10 weeks of pregnancy when conducted by paramedics, and by a medical doctor when it is 12 weeks of pregnancy (Akhter Huda, Afrin, 2017). MR has long been included in the official policy and that the necessary support for MR services and training is to be provided by the DGFP. In Bangladesh, seven in ten ever-married women know about MR. Among those aware of MR, 9 percent of previously-married and currently married women have gone through the procedure (BDHS, 2011). In 2010, an estimated 653,000 women obtained MR in Bangladesh (Guttmacher Institute, 2017).

The GoB recently allocated a budget of $2,500,000 to develop an effective sexual education guideline. SRH services are also included in it. Out of this budget 1.70 million USD was spent on communication materials and health services. Another USD 1.40 million was spent on training for the providers of adolescent friendly health services. The above funding made significant commitments for family planning by fully implementing its National Postpartum Family Planning Action Plan by training doctors, midwives, nurses and, in part by placing Family Welfare Visitors in each of the 64 district hospitals.

3.1.3 NATIONAL POLICY ON OLDER PERSON:

For the first time in the history of human society, senior citizens (aged 60 or older) will outnumber children in 2050 which has been projected in many research on global population (Mohammad Didar Hossain, 2018). In Bangladesh, as in other regions of the world, the population aged 60 years and older is growing faster than the total population. (Kabir, Khan, Mohammad, 2013). According to World Health Organization (WHO), Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (WHO, 2017).

In Bangladesh, the first National Policy on Older Persons was developed in 2013. It focused on the development and wellbeing of the older person and advancing health and wellbeing through insurance scheme, social assistance schemes and enhancing the mental health services for older persons. Similar to other policies, the National Policy on Older Persons- 2013 also does not take into the account of sexual and reproductive health. The SRHR needs of the aging population are not acknowledged in the national policy documents. Senior citizens have been left in the dark with no access to information on SRHR. In 2015, the International Planned Parenthood Federation (IPPF), which is a global non-governmental organization, acknowledged the SRHR needs of the ageing population (IPPF, 2018). Regrettably, Bangladesh has not given due importance to the same.

3.1.4 SEXUALITY EDUCATION

There is no sexuality education policy, however, according to 2009 High Court directive, every academic institution needs to have anti-sexual harassment committee. The Strategy for Adolescent Health Strategy 2017-2030 and Family Planning 2020 recommend the inclusion of comprehensive sexuality education in the school curriculum, with special provisions for out-of-school and married adolescent girls. However, the Education Policy 2010 has not included it. It has, however, committed to developing student counseling support systems in the academic sector.

The Government is going to appoint a child psychologist in each Upazila to support and supply counseling services to students. In accordance with the education minister's statement, every district will appoint a child psychologist within the initial stage. Subsequently, the psychologist will in turn train a male and a female teacher in each school on psychological issues, so the teachers can support students with various mental health issues through counseling (Daily Star, 2020).

The National Women Development Policy underscores its objective of eliminating all forms of violence including mental and physical abuse. Objective no. 20 focuses on women and girls' development through education by creating access to education and providing different incentives such as stipends to keep girls in school. However, the National Women Development Policy did not reflect on the access to information on SRHR through educational institutions.

The Seventh Five Year Plan (7th FYP) is committed to providing gender sensitive quality education through capacity development and training for teachers and improvement of curriculum. It further emphasizes on institutional commitment to promoting equality, equity and extracurricular activities to build girls' confidence through sports (The Seventh Five Year Plan, 2017). The 7th FYP covers reproductive health and sexual health with a wide range of objectives such as delaying first birth among young mothers and reducing STI and HIV infections.

Creating access to SRHR information is only focused on newly-wed couples. The subject of counseling has been mentioned in the context of population control as to where newlywed couples will avail information on contraception and family planning. Mental health, sexual health or correlation between SRHR and mental health has not been covered. Furthermore, the complications, such as vulvovaginal atrophy, painful intercourse or mood swings related to menopause appeared only once in the whole policy without any activity or intervention to address the problem later

The Ministry of Health and Family Welfare (MoH&FW) is tasked to reduce unplanned pregnancy and create awareness on reproductive health. Unfortunately, the lack of comprehensive sexuality education is increasing the risk of unplanned pregnancies, STI and the chance of getting abused (Bangladesh Country Advocacy Brief, 2017). The Education Policy 2010, has not covered comprehensive sexuality education agenda but several other policies mentioned the need for age – appropriate comprehensive sexuality education provided at school. The Population Policy (2012) includes among its objectives to build awareness among adolescents on family planning, reproductive health, reproductive tract infections and HIV/AIDS. Strategies include educating adolescents on health and life skills, building awareness among parents, teachers and service providers, ensuring marriage registration and making registrars aware of their responsibilities.

3.1.5 ENDING VIOLENCE AGAINST WOMEN

A wide range of policies and laws are addressing the issue of violence against women such as Prevention of Women and Child Repression Act 2000. This act was later amended in 2003 where it addressed rape. In this Act, rape is defined as vaginal penetration only by the penis, where the burden of proof lies on the complainant. Laws against sexual abuse and harassment also exist. Later

in 2011, the High Court ordered to use the term 'sexual harassment' instead of 'eve teasing'. The other laws to prohibit violence against women are The Dowry Prohibition Act 1980, Bangladesh Acid Crime Prevention Act 2002, Acid Control Act 2002 and Domestic Violence (Prevention and Protection) Act 2010.

Some of these laws call for harsh punishments. For example, the Prevention of Women and Child Repression Act 2000 (Amendment 2003) stipulate capital punishment or life imprisonment and financial penalty to a husband or any of his relatives who cause or attempt to cause death or grievous injury to a wife on account of dowry extraction.

While the current laws and policies are aimed to protect women and prevent violence against them, these laws are often ineffective. This is due to various reasons such as women and girls have very limited knowledge about their rights and limited access to avail the services. Furthermore, lack of skilled, motivated, gender sensitive health care providers, weak referral links and travel arrangement from home to facilities, all result in poor quality of the services.

National Women Development Policy 2011 includes necessary measures to protect females and children from sexual harassment, pornography, physical and mental abuse in public places such as in educational institutions. In this light, the executive magistrate has been given power to take steps by linking Section 509 of the Bangladesh Penal Code in the schedule of Mobile Court Act to resist and prevent eve teasing and sexual harassment of the girls and women.

Table: 4

Quick Reflection on Laws

Laws on Rape Substantive Laws and Penal Code, 1860 Section 375
Section 16, Sections 18 - 34 which provides for a sentence of death or life imprisonment and financial penalty to a husband or any of his relatives who cause or attempt to cause death or grievous injury to a wife on account of dowry; this act also penalises other forms of gender based violence including rape, acid violence
Section 376 Nari O Shishu Nirjaton Daman Ain, 2000 [Suppression of Violence against Women and Children Act, 2000], as amended 2003
Laws against Domestic Violence Paribarik Shohings hota (Protirodh O Shurokha) Ain, 2010 [Domestic Violence (Prevention and Protection) Act, 2010] which enables any victim to lodge comlaint with a judicial or metropolitan magistrate seeking protection from such violence; Paribarik Shohingshota (Protirodh O Shurokha) Bidhimala, 2013 [Domestic Violence (Prevention and Protection) Rules, 2013]
Dowry Prohibition Act, 1980 made the taking and giving of dowry an offence punishable by fine and imprisonment Penal COde, 1860 (Sections 312 - 314) permits abortions only for saving the life of the pregnant woman. Nari O Shishu Nirjaton Doman Ain (NSNDA), 2000 (Suppression of Violence against Women and Children Act, 2000], as amended in 2003
Laws Against Acid Violence and Acid Niyontron Ain, 2002 (Acid Control Act (ACA), 2002] Acid Oporadh Niyontron Ain 2002 [Acid Crime Suppressioin Act, 2002]

Nari O Shishi Nirjaton Domon Ain (NSNDA), 2000 [Suppression of Violence against Women and Children Act, 2000], as amended in 2003
Laws Against Human Trafficking Penal Code, 1860 Children Act, 1974 Manob Pachar (Protirodh O Daman) Ain 2012 [Human Trafficking Prevention and Suppression]

3.1.6 MENTAL HEALTH ACT

Bangladesh passed a new Mental Health Act in 2018, which replaced the out-of-date 105 years old Lunacy Act, 1912. The country has a high number of population, suffering from various forms of mental health disorders. The nationwide survey accounts for a very few mental health services. A systematic review revealed the prevalence of mental disorders as 22•9% in children and 31•0% in adults in Bangladesh. Many studies have confirmed and National polices have acknowledged that violence and persistent socio-economic pressures are key trigger risks to mental health. (Bangladesh National Adolescent Health Strategy, 2017). The Mental Health Act-2018, majorly focuses around dealing with the "mental illness" not achieving overall "mental wellness" of the population. The policy did not included correlation between poor mental health result from sexual abuse. Although, the Mental Health Act-2018 is recently developed, but still the connection between SRHR with mental health lead to ultimate wellbeing is completely missing.

The national adolescent strategy recognizes that reproductive health problems and sexual abuse were associated with depressive symptoms for girls. The policy also highlights that exposure to violence leads to poor mental health and resulting in low self-esteem, depression along with economic cost.The policy recommends giving necessary support and assistance through the one-stop crisis centers (OCC) at the divisional towns and through women support centers in prevention of abuse of women and to take necessary steps to expand OCC at the district level. To increase activity of National Trauma Counseling Centers to give the women victim of abuse mental support and assistance. To extend necessary assistance through the Ministry of Women and Children Affairs, National Women Organization and Department of Women Affairs.

During the National 7th FYP -2016-2020, MOHFW have adopted to promote mental health and well-being including access to essential care. The priority areas to be addressed include: depression, psychosis, bipolar disorders, epilepsy, developmental and behavioral disorders in children and adolescents, dementia, drug use disorders, self-harm/suicide, etc.

The 7th FYP further commits to raising awareness through establishment of clubs for the adolescents all over the country to prevent sexual harassment, child marriage, and other gender based violence. Reproductive and sexual health care services include provision for counselling to be expanded. Moreover, commitment made on expansion of women friendly hospitals in all districts by enhancing services in all Sadar hospitals and medical college hospitals including out-patients' department for reproductive health care. (National Seventh -Five Year Plan, 2016). Counseling has been given importance for population control, as a result reproductive health related initiatives continued to expand in health care centres. It also includes steps to be taken to ensure women's decision making over reproductive health through proper education and information. It gives focus on services for women beyond reproductive age will be addressed to ensure a more equitable and gender-friendly access to health services.

3.1.7 LEGISLATION AND POLICIES ON SEXUAL ORIENTATION AND GENDER IDENTITY INCLUDING LGBT COMMUNITY, AND UNMARRIED GIRLS

In Bangladesh, same-sex sexual activity, whether in public or private, is illegal and punishable. According to the Penal Code, 1860 Section 377 "Unnatural Offences," "Whoever voluntarily has carnal intercourse against the order of nature with man, woman, or animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years, and shall also be liable to fine." (Law of Bangladesh, 1860). This is in conflict with the anti-discrimination clause and the right to equality before the law guaranteed by the constitution of Bangladesh.

A mapping exercise on HIV/AIDS law, ethics and human rights" published by the Bangladesh Ministry of Law, Justice and Parliamentary Affairs in 2002 states that Section 377 "violates the constitutionally protected right to privacy under the expanded definition of right to life and personal liberty." (Human Rights Watch 2003). Therefore, it is imperative to include Sexual and Reproductive Health and Rights related issues in training according to the commitments of ICPD and CEDAW Council (UNHRC), where in 2009, based on reports prepared by local rights groups of Chile and the Czech Republic. Three recommendations were made to the Government of Bangladesh which, if implemented, would improve the legal status of lesbian, gay, bisexual, and transgender (LGBT) persons in Bangladesh. These were:

1. To decriminalize same-sex relationships by abolishing Section 377 of the Bangladesh Penal Code,
2. To educate law enforcers and judicial officers about LGBT issues, and
3. To adopt further measures to ensure the protection of LGBT persons against violence and abuse.

The government, accepted the recommendation of training law enforcers to protect sexual and gender minorities. The first two recommendations were rejected on the basis that "Bangladesh is a society with strong traditional and cultural values. Same-sex activity is not an acceptable norm to any community in the country." The Government of Bangladesh has recognized transgender persons as a third gender. This has been approved in Cabinet meeting of GoB on 11 November 2013 and Gazetted, recognizing Hijras as a separate identity within the population in order to ensure they receive equal rights like other citizens of the country (Naripokkho, 2017).

National 7th FYP, 2016-2020 recognizes that transgenders face systematic discrimination at every stage of their lives. It also highlighted that transgender and sex workers cannot seek health insurance. The combination of incorrect and misleading information, religious condemnation and lack of knowledge lead to confusion, guilt, suicidal thoughts, lower self-esteem and poor mental health. But, this discussion has not followed later in the plan, as no activity, performance indicator or particular intervention was proposed in the plan.

3.1.8 NATIONAL HEALTH POLICY 2011

The National Health Policy 2011 guides the government to prioritize health needs of the nation so that citizens can get access to quality and affordable health services. However, there are 3.6 physicians per 10,000 populations and 2.2 nurses and midwives per 10,000 populations (HRH Data Sheet, 2014). This shows that there is still a long way to go for proper implementation of the policy. The country's health and family welfare services are managed by the MoHFW through the Directorate General of Health Services (DGHS) and DGFP.

The aims of the policy are:

a. To ensure that everyone has access to primary health care and emergency care,
b. To ensure equity-based quality healthcare for everyone,
c. To use a rights-based approach for increasing community demand for health care.

The policy mentions the relationship between physical and mental health of women and gender equality. It emphasizes the need to reduce maternal and child mortality rate. It mentions the importance of contraception as part of family planning services. Inclusivity is ensured by providing accessibility to health care in both the urban and rural areas, focusing on poor and disadvantaged populations. The policy does not mention how the absence of comprehensive SRHR services can take a toll on one's mental health.

3.1.9 NATIONAL YOUTH POLICY 2017

The National Youth Policy of 2017 replaced the National Youth Policy 2003. The policy suggests creating specific action plans for unemployed youths, young females, young entrepreneurs, expatriate youths, rural youths, school dropout youths, illiterate youths, unskilled youths, youths with special needs, drug addict youths, transgender youths, homeless youths and youths suffering from epidemics. The policy addresses empowerment via education, and mentions the inclusion of SRHR in the curriculum (8.1.24). It does not address the need of a mental health counselor at schools to help children and adolescents cope with their mental health or emotional issues. It mentions the importance of Information and Communications Technology (ICT), science, debate and extra-curricular activities, but does not touch upon the need of comprehensive sexuality education.

The policy emphasizes on making the youth aware of mental health and suggests the expansion of medical treatment and counseling services to support youth with mental health problems. The issues of frustration and depression are mentioned as mental health problems. It also suggests building awareness among youth reproductive health, rights to reproductive health and sexual health. It also includes creating awareness on STDs. It emphasizes conducting awareness programs for mothers, including young mothers in the age range that is considered to be unsafe for motherhood. The policy emphasizes building awareness programs for the prevention of health problems, but does not mention the steps that should be taken for people who are already suffering from sexual and reproductive health issues or STDs. The curing measures are only mentioned for people who are suffering from mental health problems.

3.2 IMPLEMENTATION PROGRESS

The Implementation progress chapter highlights budget allocation, budget depletion and progress on implementing policies and action plans. This section focuses on identifying institutional capacity gaps, shortage of experts and human resource working to establish an effective mental health support system and SRHR. Also included are important decisions and actions taken during COVID-19 crisis relating to SRHR and mental health.

Photo 5 RedOrange Media and Communications

The Seventh Five Year Plan makes the commitment to monitor the performance of its health programs that also focus on reproductive health and family planning. The performance indicators under education include only increasing literacy, enrollment, providing special incentives to people with disabilities and girls. It also focuses on ensuring women's decision-making agency about their reproductive health through proper education and information. However, the policy does not specify sexuality and reproductive information in the academic curriculum.

Family Planning 2020 goals are established after consulting with both national and international stakeholders and policy makers through workshops, meetings and reviews. The study discusses some key strategies that are required for achieving FP2020 goals. These strategies are:

- Improving and strengthening service delivery provision in existing facilities (service coverage, current and new FP commodities, HR);
- Increasing acceptability of Long Acting Reversible Contraception (LARC) and Permanent Methods (PM) through skilled HR and engaging males;
- Promoting interval and postpartum contraception;
- Giving special focus on hard to reach and urban areas and other low performing areas;
- Increasing Monitoring & Evaluation (M&E) and research;
- Targeting adolescents especially married adolescents;
- Targeting males who are currently uncovered.

SRHR needs are not included in the strategic directions and it has limited focus on unmarried girls and their SRHR needs. While the guideline addresses that social and cultural norms create barriers to access and avail family planning information and services, there is no mention of SRHR. On the basis of the policy document, the government exhibits a strong political commitment to achieving its FP2020 goals; however, that has not necessarily translated to the budget allocation and/or priority settings. Since there are high vacancy rates in family planning jobs and an inadequate number of trained workers, there appears to be little progress in achieving the FP2020 goals.

Young unmarried people in Bangladesh struggle to access sexual and reproductive health information and services. Two out of five mothers under the age of 25 in Bangladesh report that their last pregnancy was unintended. Government facilities are only required to provide sexual and reproductive health information and services to married couples. 71% of the marriages happened because educational institutions were closed while 62% happened because potential grooms had lost their jobs overseas and returned to their home villages (Suraiya and Saltmarsh, 2020). The National Youth Policy (NYP) does not specify any implementation or monitoring plan to implement the Youth Policy. The policy intends to create provision for sport facilities for transgender youth and youth with special needs. However, it is rather fruitless if there is no implementation plan. The policy does not include the needs of the urban youth population which comprises approximately 36.63 percent of the total population (Youth Policy 2017, 2017). There is no data provided, therefore no analysis can take place. The policy also does not specify measurable indicators or goals. As a result, when the NYP will be reviewed after a few years, as is planned (Ministry of Youth and Sports, 2017), there will be no scope for an objective evaluation of the success matrix of the policy.

The National Development Policy advocates media to play an active role in promoting gender-based issues to change mindsets. Active engagement is encouraged to remove discriminatory and harmful social practices. The Ministry/DGFP and other development partners started drafting the successor strategy early enough for the implementation plan to be formulated with sufficient time. Although ample policies exist both by the Government institutions and different United Nations (UN) agencies, a lack of coordination between them impedes the full potential of the program. Lack of coordination among the GoB's own agencies also hampers implementation, for example, a lack of coordination between the Health and Education Ministry on reproductive health. The latter exhibits fear of a backlash from religious quarters. Furthermore, the Ministry of Health does not have a mandate to implement programs in urban areas as this falls under the Local Government Division, who in any case are supposed to adopt Ministry of Health policies.

In understanding contemporary adolescent social movements, social media has helped in reshaping political participation and bringing like-minded individuals together to take a stand towards ending sexual violence. Social media has created new opportunities for young feminists to organize and mobilize through blogs, sharing of stories, and Twitter campaigns (eg, #BlackLivesMatter, #MeToo, #TimesUp). At the same time, women's movements in several countries are facing backlash even though there is greater access to information and awareness about sexuality and reproduction (Kimball, 2019).

According to the WHO report, mental health expenditures from the government health department is very insignificant and equated to less than 0.5 percent of the total national health expenditures in 2007. There is no national health coverage, insurance or reimbursement scheme for mental health treatment of people with major disorders such as bipolar disorder, psychosis and depression. There is no dedicated authority to assess compliance of mental legislation with international human right standards (WHO, 2017). The mental health policy does not contain any specified indicator against the implementation of committed activities (Mental Health Act-2017).

Table: 5

Mental health workforce (rate per 100'000 population)	Update
The government's total expenditure on mental health as % of total government health expenditure	0.50%
Child psychiatrists	0.00
Suicide mortality rate	5.9

Mental health workforce (rate per 100'000 population)	Update
Mental health nurses	0.87
Psychiatrists	0.13
Psychologists	0.12
Social workers	0.00
Total number of mental health professionals (gov. and non-gov.)1,893	1,893
Occupational therapists 0.00Total mental health workers per 100,000 population	1.17
Treated cases of severe mental disorder	621,094

Source: WHO, 2017

Table: 6

Resource allocation for mental health	
Speech therapists **Total number of child psychiatrist (gov. and non-gov.)- 4** **Other paid mental health worker -0.03**	0.00
Mental health services available	
Treated cases of severe mental disorder---------	385.29

Source: WHO, 2017

All of these findings from the WHO highlight how disconnected Bangladeshi doctors are from the mental healthcare needs of their patients. The country is facing a mental health care crisis (Hossain 2017). According to Golam Rabbani, Chief researcher of The National institute of Mental health, successive governments have failed to address the issue of mental health both in terms of raising awareness and financial investment (The new Humanitarian, 2011). To address the aforementioned failure, it is vital that the state and donors coordinate with each other and extend their efforts in developing a comprehensive strategy for adolescent health. This was the reason for engaging the United Nations Children's Fund (UNICEF), the WHO and UNFPA from the beginning, as well as the DGFP and the DGHS. UNICEF focused on rights-based issues, UNFPA provided technical advice on reproductive health, and the WHO focused on providing strategic and financial support. The NSAH was formulated to be aligned with the timeline (up to 2030) for the SDGs. The policy provided a thorough implementation plan which majorly focused on reproductive health to ensure family planning services reached the target group, however it still omitted the needs of sexual health. Around 70% of the total cost will be spent at the Upazila level, 17.32% and 7.37% of the total cost will be spent at the union and national level respectively. Ward/ community level and district level will each see around 3% of the total cost. There is a glaring lack of coordination between these two divisions (DGFP and DGHS) of MOHFW which may limit the possibility of increased service

coverage and quality service provision (Policy Guideline, Costed Implementation Plan for National Family Planning Program in Bangladesh, 2020).

3.3 COVID-19-IMPACT ON SRHR AND MENTAL HEALTH SERVICES IN BANGLADESH

This chapter highlights SRHR and mental health support systems in Bangladesh pre-COVID and post-COVID. The GoB and UN have conducted a number of assessments including COVID-19-Bangladesh Rapid Gender Analysis, The Needs Assessment Working Group (NAWG) and UN Women policy brief.The chapter highlights the important findings and gaps in addressing SRHR and mental health needs for the Bangladeshi population prior to the emergence of COVID-19. Statistics on mental health conditions (including neurological disorders and substance use, suicide risk and associated psychosocial and intellectual disabilities) were already stark.

Photo 6 RedOrange Media and Communications

The world is going through a global crisis, as the Coronavirus pandemic is tearing apart nations; including Bangladesh. To address the current context of SRHR and mental health in Bangladesh it is also important to cover the impact of COVID-19. Even before COVID-19, it took many years of effort to break the taboo of discussing the importance of SRHR, but the impact of the pandemic could be a major setback for many of these efforts. The growing number of gender-based violence cases including child marriage is evidence of how vital SRHR is both pre and post COVID-19. Melinda Gates from the Bill & Melinda Gates Foundation, has taken a positive approach towards the pandemic, seeing it as an opportunity to redesign our economy. SRHR advocates could take a similar approach, turning the challenges into opportunities to create strong government advocacy to ensure adolescent mental and physical wellbeing.

On 28th September 2020, UN Women and UNDP confirmed that most of the world's nations are not doing enough to protect women and girls from the economic and social fallout caused by the COVID-19 (UNDP & UN Women, 2020).

Around half of all mental health conditions start by age 14, and suicide is the second leading cause of death in young people aged 15-29. In low- and middle- income countries between 76% and 85% of people with mental health conditions receive no treatment for their condition. This is despite the evidence that effective interventions can be delivered in any resource context with a positive outcome. It is vital that due priority is given to prevent the issues surrounding SRHR exacerbated by COVID-19-affect (UNFPA, 2020). Deliberation about what counts as "essential" SRH services reveal and perpetuate deep-rooted political and ideological rifts about sex, reproduction, and sexualities. When SRHR is deemed non-essential, health systems may be unable to fulfill these rights, and communities will end up losing access and awareness (Schaaf, Boydell, Belle 2020).

According to UNICEF, an estimated 2.4 million babies will be born during the COVID-19 pandemic in Bangladesh. Moreover, the country ranks 9th in terms of the highest expected number of births during this period **(**Mohammad Mainul Islam, 2020). Adolescents and young people are also at risk in the present crisis; as most mental health conditions develop during puberty. Mental health will remain a core concern as countries emerge from the pandemic and embark on social and economic recovery. (United Nation, 2020).

Bangladesh conducted a COVID-19-Bangladesh Rapid Gender Analysis where SRHR was loosely addressed. The analysis acknowledged that there was limited data reflecting on the impact of COVID-19 on women, girls and LGBTIQ+ persons in Bangladesh. The analysis also flagged protection concerns related to the multiple layers of discrimination due to gender inequality, social exclusion, stigma and social attitudes which further prevented access to information, health services and response facilities.

It also highlighted, approximately 3,350 Hijra community members and 8,533 floating Hijra were affected by COVID-19. This marginalized community earns a living on the streets and has due to the pandemic experienced acute food shortages. A small rapid impact assessment survey by Innovision on the third gender community in Bangladesh, found that 82% of the 51 persons surveyed had not earned a single penny in the past two weeks of the survey taking place. Women and adolescent girls' access to sexual and reproductive health services were also affected by the COVID-19 lockdown and reallocation of health care resources (COVID-19 Bangladesh Rapid Gender Analysis, UN Women, 2020).

The Needs Assessment Working Group (NAWG) is the platform for government and non-government humanitarian agencies under Humanitarian Coordination Task Team (HCTT). The NAWG prepared a document for Bangladesh concerning the crisis of the pandemic. It focuses on effective and coordinated humanitarian response to be provided to the most vulnerable communities in Bangladesh. Under the section SRHR, the main focus is on the impact of COVID-19 on maternal health. It mentions the shortage of personal protective equipment (PPE) which imposes a direct risk for midwives and other health care staff. Currently, the Ministry of Health and Family Welfare (MoH&FW) has been implementing adolescent-friendly health services through two wings – the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). GoB allocated $8.5 billion as an emergency stimulus package to fight COVID-19 but no amount had been explicitly allocated as emergency support to the victims of domestic violence or to meet SRHR needs (World Economic Forum, 2020). The assessment has also taken mental health support systems into consideration especially for the protection of children from violence. The recommendation highlights creating access to multi-sectoral services for GBV survivors including psychosocial support, and GBV risk mitigation for most vulnerable groups. It also integrated GBV response services in priority sectors and committed to supporting the national government in case management and psychosocial support. However, no evidence has been found for connecting sexual and reproductive health impact on mental health. Moreover, the priority areas include food security and nutrition, hygiene, sanitation, income and employment, health care, including reproductive health, education and child protection (Multi-Sectoral Anticipatory Impact and Needs Analysis, 2020).

The UN policy brief on mental health (2020) recommended mental health actions should integrate with the national COVID-19 response. It has recommended setting up mental health interventions through tele-counseling. In Bangladesh, a recent meeting of the subcommittee for mental health of the national technical committee was held on 25th April 2020 at The National Institute of Mental Health (MIMH), Sher e Bangla Nagar, Dhaka to develop COVID-19 response for mental health. It suggested providing psychological treatment related responses for people who already have mental health conditions along with recommendations for self-care. The committee proposed referral for COVID-19 patients who expressed suicidal thoughts, violent/aggressive behavior, uncontrolled use of alcohol/drugs, crying or expressing uncontrollable distress, unexplained bizarre behavior like talking or smiling to self and significant deterioration in occupational functioning (Dr. Abdul, Alam, 2020).

4 VIEWS OF EXPERTS AND PRACTITIONERS:

This chapter covers summary analysis and direct quotes from SRHR experts, mental health experts and one official high government representative from the Ministry of Women and Children Affairs (MOWCA).

Photo 7 RedOrange Media and Communications

All the experts agreed that mental health and SRHR are indeed deeply intertwined with each other, however, both of these issues are neglected by the society and are kept under wraps within households. The mental health experts shared a common concern that they are not much involved in the policy discussion or not consulted during intervention design. All the experts agreed that mental health is in fact two sides of the same coin. Each and every issue that is concerned with a person's SRHR has a direct impact on one's mental health.

It is evident that mental health experts have great potential to add value to policy advocacy in addressing the mental health needs in the SRHR agenda. Without addressing SRHR needs, a positive mental health is not possible. SRHR experts shared that Bangladesh has not made any major progress addressing the needs of LGBTQ community. As they are not recognized, their needs are

also not addressed in National documents, making the community vulnerable to practice their basic human rights. They are judged by doctors at healthcare centers for their different appearance even when they try to access healthcare services for basic health issues. There are many incidents of LGBTQ news which have been covered in a gender insensitivity way. SRHR and mental health experts feel Bangladesh needs to prioritize and understand the need of mental health.

One of the psychologists and an SRHR expert both shared that the LGBTQ population is not recognized by law enforcing agencies. This gives impunity to families and society to abuse them without any fear of repercussion or punishment, thereby leaving this already marginalized group to bear untold abuse and suffering with no avenue for seeking justice or redress. They tend to live a lonely life burdened with mental health problems and suicidal tendencies.

The initiative taken to draft the National Strategy for Adolescent Health Strategy 2017-2030 was praised by all, as it acknowledged SRHR and mental health as important factors in ensuring overall well-being of adolescents. Nonetheless, all of them expressed deep concern regarding implementation at the national and district levels.

SRHR experts highlighted that the commitment to enforce SRHR needs to be concrete, action oriented and time bound. More research is needed to address the underscore needs of SRHR. Experts stressed to include SRHR as part of Universal Health Care (UHC) in the upcoming National 8th FYP. In order to make the field of mental health robust, a structured network of mental health professionals should be developed who can support each other through exchange of views and shared experiences.

SRHR practitioners also pointed out the need for CSE in schools. They also acknowledged that it is difficult to implement CSE in schools as teachers themselves do not find it comfortable teaching children about sexuality and reproduction. Therefore, it is necessary to train the educators first to acclimatize them.

Although youth policy also included SRHR by integrating sexuality education in the academic sector, in reality, sexuality education mainly covered HIV. There is a significant need for capacity development of school teachers on how and what to teach with regards to sexuality. The policy should include a commitment and action plan to develop capacity of duty bearers in order to ensure implementation of the policies. One SRHR expert further explains that mental health problems can be a result of concurrent or past sexual and reproductive health related illness and vice versa. This connection between mental health and SRHR has not been strongly developed in the national policies.

Some Quotes from the interviewee:

> All the development practitioners such as UN, INGOS and donors must focus on implementing activities in all the districts not just selected ones. CSO and development partner should come forward with creative solution to address domestic violence. **(MOWCA)**

> **Dr Abul Hossain, Director of Multi Sector Programme on Violence Against Women, MoWCA,** recommends that the development organizations and UN agencies should work in collaboration with each other. I observed that many NGOs tend to work in the same regions which creates duplication. These duplications should be address by better coordination among the development agencies. Most of the time they work in limited areas, one or two districts, but they can cover all the 64 districts.

Even the 'holy union' of marriage, and the 'biggest event in a woman's life' which is pregnancy can have a negative impact on a person's mental health, which is often ignored because it is assumed that marriage or pregnancy are the 'most glorious' events in a person's life. Mental health within households is not only ignored, but its existence is overlooked, denied and normalized." **(Tamima Tanjin, Clinical Psychologist, Prottoy Medical Clinic)**

Nabakumar Dutta, SRHR practitioner ". The intervention is designed to provide victim centric services but we must also look at abusers' perspective. There are cases where the abuser gets pleasure in abusing another person. This comes from another dark place, they themselves sometime were victims of abuse."

"A woman has been molested for a long period of time by her own father. We ask ourselves after treatment as to what will happen to her when she returns to the same place where she had been molested. There is a need for awareness. Government also needs to look into making safe houses for these victims. **(Minhajul Haque, Vice Chairman Prottoy Medical Clinic Ltd)**

"Some transgender women who used to take hormones from other countries are not being able to do so now due to the pandemic, so they are facing complication including excess bleeding which also trigger mood swing, depression facing mood swings and suicidal tendencies." **-Nabakumar Dutta, SRHR Practitioner.**

"95% LGBT community feel emotionally isolated from their friends and family as they are different. The hypoactive sexual desire disorder is common in Bangladesh but it is never being discussed. There is an increasing rate of rape cases but discussion regarding perpetrator's psychology and victim's psychology is completely missing from development discussion**." (Nabakumar Dutta, SRHR expert)**

I find it ironic, that we hold reservation to sexual health and rights when we are one of most densely populated country. The increasing number of rapes, sexual harassment demand for SRHR and mental health services. **Nabakumar Dutta: SRHR expert.**

In order to remove the stigma against mental health, **Saraban Tahura Zama, National Coordinator of Right Here Right Now** says "Create counter narratives against mental health stigma. This will help to create an enabling environment to accept mental health as a serious issue. Unless there is an enabling environment, it will not be possible to implement plans and laws."

"Married women have more chances of getting abused, as she is forced by her husband to have sex with her no matter what. A woman is married, she is bound to have sex with her husband is the perception. This girl is mentally disturbed, and looks at herself as an object. Women have this tendency too, when they want to give lots of love to her husband and fix him. The reason is that women are brought up in a way that they are taught to sacrifice and compromise. This is transferred from generation to generation." **(Tamina Tanjin, Senior Consultant Clinical Psychologist, Prottoy Medical Clinic Ltd)"**

5 RECOMMENDATIONS WITH OVERALL ANALYSIS:

This chapter provides a short summary analysis of research based on literature review and in-depth interviews on SRHR and mental health followed by specific recommendations for separate actors to establish SRHR and mental health.

The recommendation includes:

- creating a political commitment to SRHR including mental health;
- Involving mental health experts in SRHR intervention;
- commitment and budget allocation for capacity development of duty bearer;
- Institutional capacity development; Improving coordination among inter-ministries and development partners;
- Improving primary health care capacity building; Investing in social behavior change campaigns to address stigma;
- Budget allocation, action plan and developing guidelines for law enforcement

The recommendations are followed by the conclusion drawn from the findings of the study.

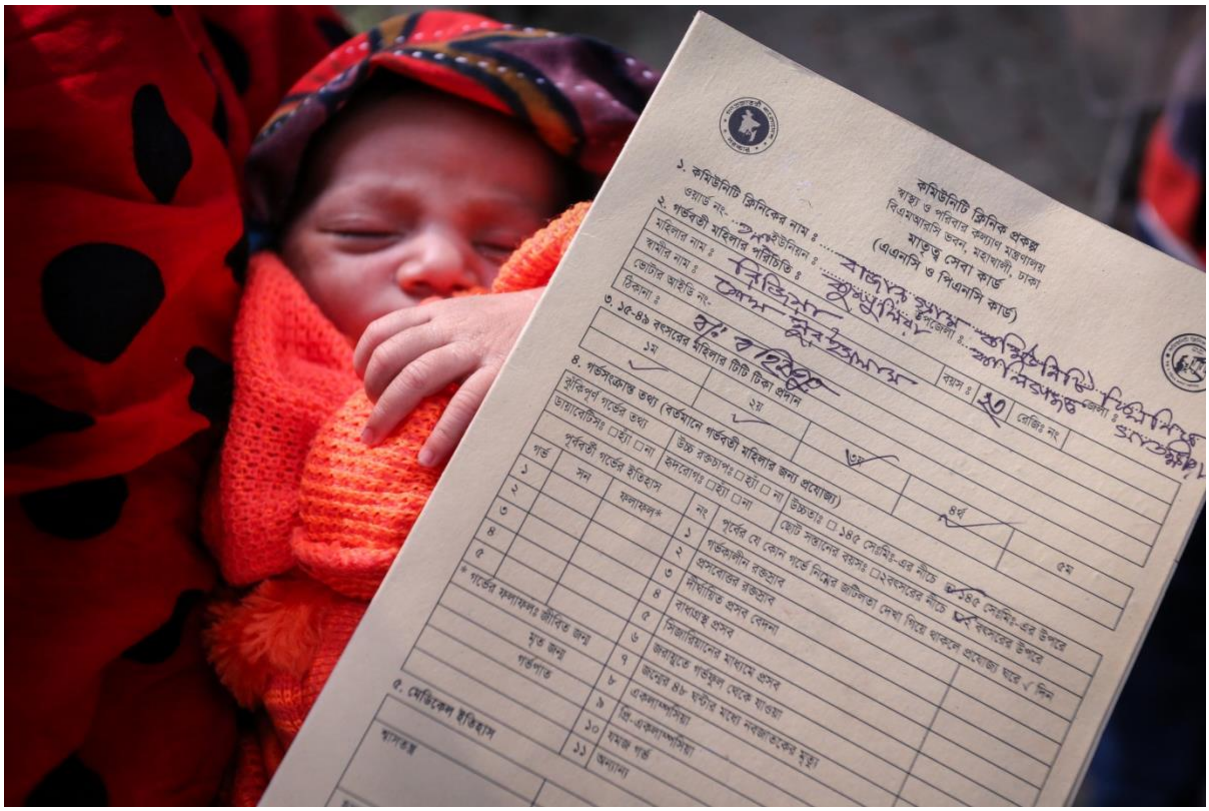


Photo 8 RedOrange Media and Communications

Although, Bangladesh National Adolescent Reproductive Health Policy-2017, National Women Development Policy-2017, Seven-Five Year Plan and various other polices have acknowledged sexual and reproductive health and rights (SRHR), their discussion and subject matter is predominantly limited to reproductive health and family planning, and when it comes to sexual health, the focus is exclusively limited to HIV and STIs.

Different groups have different needs for SRHR and mental health. A life course approach, as adopted in many countries may be one of the models suited to the needs of Bangladesh. This lifelong program recognizes that people have different and changing sexual and reproductive health needs

throughout their lives. The different stages require access to different sets of SRHR interventions. Some SRHR interventions are particularly important for specific population groups at a certain time in their lives (e.g. antenatal care), whereas others can be critical throughout the life course (e.g. prevention and treatment of HIV infection and other STIs). A life course approach to SRHR interventions must also consider the needs of particularly vulnerable groups, such as those with disabilities, adolescents and LGBTI+ individuals, and the implications of legislation around, for example, abortion and age of consent.

The Education Policy-2010 does not reflect on sexual and reproductive health and rights of students. The secondary school curriculum for the past two years has only included gender studies and reproductive health; there is no inclusion of sexual health. It is important that this is included in the future.The educational curriculum must address the vital issues related to sexual health without any prejudice or stigma. Sexuality education provided by schools means easy access to information about one's overall health.

Bangladesh is transitioning to establish sexuality education in Bangladesh so that adolescents do not grow up without proper sexuality or mental health information. Comprehensive sexuality education (CSE) not only improves sexual and reproductive health outcomes but also results in a reduction in the rates of STIs, HIV infection and unintended pregnancy (UNESCO, 2015). It is a matter of regret that even though some national policies such as Youth Policy-2013 and the Seven-Five Year Plan emphasize on the need for sexuality education, in reality none of it seems to have been implemented successfully and there is a lack of comprehensive approach to achieving it. The importance of education in sexuality is directly linked with the quality of life and these experiences form a crucial part of one's well-being. This connection is not made in national policy documents. However, it acknowledged that gender norms act as a barrier to access vital information and services on sexual health. There is a lack of intervention plans and a lack of follow up for said plans in the policies. In such a context, where can information on Sexual Health be accessed?

The answer lies in informal ways ranging from gossips to avenues of the likes of pornography and other mediums which could be extremely misleading and dangerous. Hence, an organized and structured way of introducing anatomy and its connection to sexual health in the education curriculum could pave the way for an educated discussion amongst the young adolescents. The importance of sexual health, its effect on well-being and inevitably, on society, must be made clearer for the policy makers.

Bangladesh has made progress towards reproductive health but SRHR needs for senior citizens are still missing. For instance, at post reproductive age (50 years and beyond) primary health care should be equipped to provide menopausal and post-menopausal care. The primary health care should provide access to information and help the patient to overcome the stigma. The primary health care should put a referral system in place to help the patient get the right treatment with regard to SRHR and mental health.

GBV is one of the biggest challenges to realize within the scope of SRHR. Combating GBV with a greater degree of conviction can help to realize SRHR and benefit mental health. Simply introducing new and stricter laws do not guarantee prevention or decrease in GBV. The regulatory body has drafted some very effective laws, but it is time to reflect on the remaining challenges in implementing the laws.

Understanding human behavior, particularly gender norms which play a role in shaping women and men's (often unequal) access to resources and freedoms, thus affecting their voice, power and sense of self, all of which lead to poor mental health. This connection must be analyzed, and properly understood; only then a well-designed intervention program can be established to provide a solution. Social and behavior change communication (SBCC) can play an important role in understanding and changing human behavior (Ministry of Health and Family Welfare Government of India, 2013). SBCC is acknowledged by national policies and included in family planning but not in

other areas. Ministry of Family Planning highlights on the challenges that, service providers themselves require training on effective ways to disseminate appropriate information and services (Family Planning, 2020). Strong cultural and religious barriers prevent providing FP messages to adolescents and youth prior to marriage or sexual contact.

The literature review and interview findings highlight that timely intervention and programmatic approaches need to be provided for a positive outcome reduction in GBV. Psychologist Albert Bandura, established the theory that human behavior is something that is learned through conscious and subconscious observation of what is presented and subsequently repeated through a process of imitating the same observations (David, 2015). As a result, violent behaviors are not an inherent characteristic of an individual; instead these actions are learned through observation or imitation. Children who witness their mothers being oppressed by their fathers learn that this violent behavior is not only viable but acceptable as well. This theory is relevant in the context of Bangladesh where a majority of children witness domestic violence. As a result, male children grow up learning and believing themselves to be superior to women and therefore having the power to control them. The theory has many aspects and a focal aspect of it is the intergenerational transmission theory, which holds the belief that a girl who observes her mother being harmed by her father is likely to be a future victim of the same; in the same vein, a boy who witnesses his father battering his mother is likely to end up beating his wife in the future (Okun, 1986). Essentially, violent behavior is learned through observation and is transmitted inter- generationally.

Therefore, we should move away from merely monitoring statistics to directly identifying the root causes, especially the factors that influence acts of domestic violence. Productive steps in curbing this phenomenon can only be taken once we understand how and why these acts of criminality occur in the first place (Khandaker, 2019).

5.1 RECOMMENDATIONS FOR POLICY MAKERS

Create political commitment to SRHR including mental health:

It is high time to increase investment and give recognition to the importance of SRHR and its implementation. In order to move towards universal access to SRHR, Bangladesh should adopt the comprehensive definition of SRHR in its entirety and bring about an understanding that its appropriate implementation is linked with wellbeing. Political support is critical to establishing commitment for a comprehensive approach to SRHR. It is equally important, however, to translate political commitments into actionable steps for implementation. We need to define the specific steps of their unique pathway towards enforcement of SRHR. The government needs too progressively expand equitable access to SRHR interventions and to apply a life course perspective throughout this approach.

Involving mental health experts in SRHR intervention:

Engagement of mental health experts is crucial as they have the technical experience and knowledge on victim's internal world which can support in designing effective SRHR interventions. Their expert knowledge can help bridge the gap between SRHR stereotypes, gender bias and other established norms against the real scenario persisting and its adverse effect on mental health. They can help in devising effective training material and providing training right from the top tier of officials cascading down to grass root level. Unless, the importance of SRHR is realized by all stakeholders, due recognition will never be attained. The government should ensure that youth are also integrated in the training and that the training and service delivery are sensitive to everyone's need. The success of any social program is heavily dependent on how the communities view it. Involving mental health experts will also help build trust and confidence in the way public view SRHR. As such campaigns to sensitize the community and influence their thinking positively needs to materialize.

Commitment and budget allocation for capacity development of duty bearer:

In the upcoming Eight-Year Policy, the policy makers should advocate for capacity development of duty bearers in SRHR and mental health. It is important for the duty bearer to understand the economic cost of increasing mental health problems. The local government, local law enforcement and service providers need capacity development training to understand the impact on mental health arising from child marriage, gender-based violence and domestic violence. Overall, online and offline gender training should be compulsory for all. Without understanding gender, SRHR and mental health, we cannot develop a strong response system. This capacity development training must ensure quality training and sufficient budget allocation.

Institutional capacity development:

It is imperative that the teacher who will impart training on SRHR is well qualified on the subject and is able to deliver the training effectively. All teachers of SRHR need clear methodology to teach to teach SRHR. A separate guideline and content should be developed to teach sexuality education. Sexuality education will ensure, an adolescent for instance will be aware of what rape is before he/she falls victim to it. As part of SRHR the school curriculum should include aspects of mental health.

Research institutions of the such as universities should play an active role in engaging development partners and research departments to come up with a viable model which can be exercised. Limited number of academic institutions such as BRAC Public Health and Dhaka University carry research on SRHR. It is high time that private universities also come forward in SRHR through research and surveys related on SRHR and mental health. As more funding and the scope should be extended to all institutions to find innovative ways of better promoting and implementing SRHR.

Academic institutions and workplaces must adopt the High Court Directive on sexual harassment Act -2009 which extensively defined sexual harassment by outlining 11 different circumstances that would constitute acts of sexual harassment, ranging from unwanted physical contact to coerced sexual relations, through abuse of power, to unsolicited sexual remarks, advances and gestures be they in person, in writing or through telephone, etc. It obligated all institutions to form Sexual Harassment complaint committees which will register and investigate sexual harassment complaints filed by women and then take the appropriate disciplinary action against the perpetrator if allegations are found to be true. This directive is yet to be adopted by many schools and universities which shows lackluster approach to such a serious issue.

Improving coordination among inter-ministries and development partners

Coordination is the mechanism through which policies, strategies, plans, peoples, systems, and tools are brought together to achieve a particular goal. The GOB has set forth some very good policies, however due to lack of coordination between implementing partners, some of which are different ministries, the successful implementation of these policies is hampered.

Good coordination is essential to the operations of both the government, and development partners. A lack of effective coordination increases a venture's operational costs and creates a competitive, rather than cooperative environment. In Bangladesh, the effect of ineffective coordination is seen in development initiatives that are frequently misaligned with the capacity of the state budget. Bilateral agreements and strategic partnerships signed with other countries are also poorly implemented due to ineffective cooperation between different ministries and development partners. There are many steps that could be taken to improve coordination. It is time to bring about innovation in the way the different ministries communicate with each other keeping in line with the promise of a digital Bangladesh. The following recommendations should be adopted:

1. Establishing an online software system with multiple entries from different ministries;
2. Designating a coordinating ministry, tasked solely to manage inter-ministerial relations;

3. Establishing a regulatory framework to promote inter-ministerial coordination
4. Creating a system where both govt. and development partners are aligned.

Improving primary health care capacity building:

The issue of mental health is not an uncommon healthcare problem and can largely be addressed in primary care as long as the healthcare worker is able to recognize the problem and due importance is given. Only when this issue is recognized a referral can be made to a specialist. Unfortunately, the quality of care is often low, with poor recognition of the condition, inadequate prescription, and poor compliance with medication and poor provision and uptake of psychological interventions. There is a substantial opportunity to improve the quality and outcome of primary care for mental health challenges. Improved quality of care will require a substantial investment in primary care services, and a reconfiguration of the roles and relationships between primary and secondary care. Some interventions, such as nurse case management, might be relatively low cost and be easily implemented within many healthcare settings. Improved outcome will require a greater allocation of resources to primary mental health care than is currently the case in many health care systems.

Furthermore, male physicians should be educated on working with gender lenses so they do not fall into the trap of gender bias. Effective monitoring is required to ensure patients do not suffer from a healthcare professional's bias and incompetence.

Invest in social behavior change campaign to address stigma: budget allocation, action plan:

Disseminating health information and motivating people to adopt new behaviors, especially in communities where health literacy is low and infrastructure is poor, represent ongoing challenges for global health practitioners. Interpersonal (face-to-face) communication, although an effective technique, generally has limited reach given constraints on people's time, distance, and resources. Mass media for health education is also limited in that it is a one-way communication channel, with information traditionally flowing from urban centers outward, only sometimes reaching remote populations. It follows that many long-established health communication techniques enable only a limited exchange of ideas and input from and within communities (Berrigan 1979). The increasing visibility of social justice movements has brought with it a growing focus on grassroots and community media as instruments of social change, underscoring the need to more actively engage communities, provide an opportunity or space for the exchange of ideas, and stimulate enriching two-way communications (Howley 2010).

Media engagement and discourses must ensure that the content and format of communication materials are acceptable and relevant to the target population, based on a clear understanding of, and adaptation to, the local context. This requires a careful balance between working within existing cultural and social systems, avoiding the reinforcement of harmful practices and relationships, and communicating the benefits of new behaviors and social norms. Our experience is that consumers of community media need to hear and see themselves in the audio and/or visual materials. They need to identify with the environment and characters—the families and individuals featured in the media and believe that they can experience a similar change or impact in their lives.

Law enforcement provision: develop guideline:

It is no news that the offences of sexual assault and the sexual violation have low reporting rates in Bangladesh, and the reasons behind this phenomenon is widely acknowledged. Underreported crime is due to the reason of lack of trust in police and investigation system. As patriarchal legacies among the whole system of police and their attitude towards women especially in rape cases making it difficult for survivors to approach the police. Survivors are often reluctant to make police reports for various reasons, including fear of re-victimization by criminal justice professionals. The police response to the issue of rape is stereotyped and patriarchal as they judge the women through traditional mindset. It is vital that each complainant is treated with respect and dignity whilst noting

their complaint, and act upon them with utmost sincerity and guile. Adequate training should be provided to focus on the importance of being sensitive and patient.

In 2008, MOWCA started a project to set up 4883 adolescent clubs across the country to create a space place and access to SRHR including child marriage, eve teasing, and gender-based violence. The decision made to include 30 members, including 20 girls and 10 boys in club (The Financial Express, 2018). Although, it is a great intervention, it is not yet fully implemented. MOWCA should develop an action plan for establishing adolescent health along with monitoring tools to ensure in effectively.

6 CONCLUDING REMARKS:

The interviews and literature review provide compelling evidence that SRH is ultimately linked with individuals' mental health and productivity. The current increase in the cases of violence indicate psychological disorder. It's time to delve deep into the understanding and complexity of not addressing SRHR and its adverse impact on psychology, which can very well be avoided through proper implementation of effective pragmatic programs. Innovative approaches should be welcomed to test new ideas to solving some of today's greatest sexual and reproductive health and rights challenges. The innovation may be to reach a new target group, introduce a model of service delivery, or to address a sensitive issue, and often aims to benefit a marginalized, vulnerable or disempowered group. Driving innovation from the ground up, will allow stakeholders to use their local knowledge to devise new interventions that respond directly to the needs of the communities they serve.

Because of the size of the problem, the vast majority of mental health needs remain unaddressed. International development assistance for mental health is estimated to be less than 1% of all development assistance for health. The response is hampered by lack of investment in mental health promotion, prevention and care before the COVID-19 pandemic. This historic underinvestment in mental health needs to be redressed without delay to reduce immense suffering among hundreds of millions of people worldwide and mitigate long-term social and economic costs to society.

Bangladesh needs to revise all the policies specially the Education Policy-2010 to ensure sexuality education is given importance and develop a targeted action plan. It must include capacity development of teachers to teach age appropriate sexual and reproductive health and rights content. It is suggested to develop a guideline of sexuality education that must meet International standards. In the upcoming Eight-five year plan, SRHR policy must push forward the SRHR agenda with targeted commitment and budget allocation. The policy discussion must include mental health experts to draw the attention on the importance of SRHR in relation to overall wellbeing.

To establish SRHR nationally, the social stigma needs to be removed even among the duty bearers. Moreover, the 105 year old Lunacy Act was replaced by the Mental Health Act 2018 which still does not cover positive mental health or SRHR. It rather focuses on on mental illness and not on overall mental wellbeing. This needs extensive work to reform the policy. The Mental Health Policy -2018 requires revision and SRHR must be prioritized. Effective monitoring tools need to be included to ensure targets are achieved within timeline and that development agencies along with MOWCA can monitor progress and effective implementation of agreed action plans.

Effects of COVID-19 on the brain are of concern and neurological manifestations have been noted in numerous countries in people with COVID-19. Moreover, the social consequences of the pandemic may affect brain health development in young children and adolescents and cognitive decline in the older population. Urgent action is needed to prevent long-term impact on the brains of both the youngest and eldest members of our society. Local policy-makers identified emergency psychiatry an essential service to enable mental health-care workers to continue outpatient services over the phone.

The effectiveness of this initiative will directly be linked with monitoring and continued evaluation of the cases and how they are dealt with. If proper environment of openness and trust is not created, appointment of these psychologists will prove to be ineffective. Bangladesh does not have a sufficient number ofmental health specialists compared to the size of the population. Government must step in to ensure quality counselling services are provided and that all cases are treated fairly and with due importance. In order to increase the numbers of mental health specialists, the government needs to develop a mental health support system. There is a need to allocate budget in this regard and track progress regularly. Furthermore, the Mental Health Act -2018 should meet the needs of today's population and should play a complementary part in the realms of SRHR. The link between SRHR and mental health should be recognized abundantly in public and that their successful implementation is interdependent.

ANNEX 1 : SNAPSHOT OF RELEVANT NATIONAL DOCUMENT RELATED TO SRHR AND MENTAL HEALTH.

	Polices related to SRHR and mental health	Gaps in Policies implementation
National Strategy for Adolescent Health 2017-2030: This strategy was valid for a period of 10 years until the end of 2016		
Policies related to SRHR and mental health	The previous adolescent health strategy did not take into account of Sexual Health and right but the revised National Health Strategy given important to SRHR and mental health. MOHFW[1] is the lead to develop the strategy with the vision by 2030 all adolescent boys and girls, especially most vulnerable will enjoy a healthy life. There is paradigm shift in addressing adolescent health with combination of strategies thematic areas are: adolescent sexual and reproductive health; nutrition; mental health and addressing violence against adolescents. The human rights principals are guiding principles to ensure SRHR services for all including unmarried, married girls. It also put strong emphasis on tailoring intervention especially targeted at unmarried girls. With regard to monitoring, it made commitment to develop robust system for collecting sex disaggregated data and analysis on SRHR of adolescent to inform policy and programming. Mental health wellbeing is prioritized especially for the age group 10-14 years and focus on preventing of unhealthy behavior that could lead to mental diseases and communicable diseases. It further given important to early development, parenting, domestic violence and sexual abuse especially by family member to ensure good mental	The National Adolescent Health Strategy could be further strengthened by explicitly integrating Sexual Health, reproductive health with mental health. It could further prioritized addressing stigma attached to adolescent sexual and reproductive health leads to further mental health diseases such as depression. As there is no comprehensive mental health assessment of adolescents, the National Adolescent Health Strategy take in to account studies conducted by BRAC and population Council on adolescent mental health. According to the findings of the study shows, depressive symptoms are common among adolescent girls with reproductive problems and sexual abuse and 80% of them do not seek help. The depression has been also linked with childbearing, experience from harassment and marriage. This already provides sufficient evidence to establish a strategy focused on integrating mental health support system to deal with SHR related problems. Besides, incorporating gender and sex education in the educational curriculum, it can also consider including teaching on Human rights including Sexual and Reproductive rights. In reality, Bangladesh is still behind in establishing the commitment made in relation to mental health and SRHR.

[1] *Ministry of Health and Family Welfare*

	Polices related to SRHR and mental health	Gaps in Policies implementation
	health. In page- 34, the next generation health care providers' capacity will be developed to integrate gender sensitive SRHR services for adolescents. The GoB has signed a handful of international treaties such as ICESCR, CEDAW, ICCPR and Beijing+25 (Nazneen, 2017) and agreements related to SRHR. Reproductive rights are part of human rights that are also included in national laws. Furthermore, the GoB has endorsed ICPD's Program of Action (PoA) where Principle 8 stresses, "Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health services, including those related to reproductive health care, which includes family planning and Sexual Health" (Naripokkho, 2017). The commitment of the GoB is further reflected in their national policies, for instance National Health Policy (2011). However, there is not a specific national policy addressing SRHR. The existing national policies only include maternal health, family planning, menstrual hygiene management and reproductive health. Sexual health is not included in any of the policy documents, let alone promotion/execution of it (Naripokkho, 2017). The key objective of this chapter is to assess the current policies and laws in line with the overall objective of the study.	
Social and Behavior Change Campaign (SBCC)	In page-6, social and behavior change given significant attention and identified as cross cutting issues to ensure effective implementation of thematic areas. To ensure adolescent right to decision making, SBCC focused strongly on changing mindset, attitude of gatekeepers, including family members, teachers and service providers to respect adolescent needs. The key strategies include	It is noteworthy that SBCC is considered as effective tool to challenge the discriminatory social norms that denies individual adolescent sexual and reproductive health and right. To translate the commitments in to action requires separate budget allocation for activities as well as monitoring the effectiveness of each SBCC initiative. The key strategies could be further strengthen by incorporating SBCC to effective address

	Polices related to SRHR and mental health	Gaps in Policies implementation
	political commitment to allocate resources to support SBCC interventions and utilize ICT services such as call centers, media to reach key influential (parents, community members and guardian). In 1976 Family Planning begun and became the second-largest social marketing effort in the world (Stauffer, et al., 2016). The success of the family planning reached 2.2 million couple years of protection, among those 60% were from condom sales and another 40% through sales of oral contraceptives (Radha, 2011). This social behaviour change should focus on changing harmful social norms that act as a barrier to access SRHR including mental health.	mental health problems linked with SRHR. The SBCC in relations to promote mental health and SRHR is missing in the family planning brief-2020. This commitments needs to be incorporated in the family planning.
Importance of male engagement	It acknowledges that adolescent boys face pressure to comply with prevailing norms of masculinity, which drives them to risky behaviours such as unsafe sex, violence and substance use. All these factors influence on the health and well-being of adolescents. This also contributes to GBV. The strategy shed light on taking advantage of adolescent clubs to promote SRHR, delay early marriage and delay first pregnancy.	It did not cover ways positive masculinity will be developed in communities. The schools need put strong emphasis on teaching impact of toxic masculinity.
Access to SRHR through adolescent clubs	In page-6, social and behavior change given significant attention and identified as crossing cutting issues to ensure effective implementation of thematic areas. To ensure adolescent right to decision making, SBCC will focus strongly on changing mindset, attitude of gatekeepers, including family members, teachers and service providers to respect adolescent needs. The key strategies include political commitment to allocate resources to support SBCC interventions and utilize ICT services such as call centers, media to reach key influential (parents, community members, and guardian).	This has been reflected on family planning policy-2020. Bangladesh is still in the process of developing the adolescent clubs as well as making existing clubs operational.

	Polices related to SRHR and mental health	Gaps in Policies implementation
Gender based violence - Child marriage	The commitment made to integrate the mental health support system to primary health care and include counselling services. The strategy also taken into account of the fact that it economic cost as experiences of violence and exposure to violence often lead to mental and physical consequences such as low self-esteem, depression and physical injury. It also taken in to account of a study conducted in 2011 by BDHS[2] found that that married before 18 were more accepting of domestic violence than women married after 18 years. This further highlights on the correlation between a culture of violence, child marriage, and adolescent's fertility has a negative mental health consequences.	As, there is no comprehensive mental health assessment of adolescents, a study 2013 reflect that depressive symptoms were identified among adolescents. The implementation and monitoring framework is weak which needs to be strengthened to ensure best and proper use of budget. The attitude of the union chairman towards women often sets the tone for others, hence it is critical that they have a gender supportive attitude.
Bangladesh National Women Development Policy-2011		
Polices related to SRHR and mental health	According to the plan, number of existing laws amended and new laws are made to prevent violence, child abuse which includes, Dowry prevention act, Child marriage act, Women and Children Repression Prevention Act, and Domestic Violence (Prevention and Protection) Act -2010. But, it does not explicitly mention SRHR or Sexual Health and rights of individuals. Some of the polices and laws such as section -509 of the Bangladesh Penal court set up Mobile Court Act to prevent eve sexual harassment on women and girls, the commitment made to Convention on the Elimination of All Forms of Discrimination Against Women(CEDAW page-17) which will indirectly contribute to establishing SRHR. The objective of the policy includes	Government has made significant commitments through policies, legislation and strategies to support women's empowerment and gender equality but no commitment made on SRHR specifically. It does not emphasize on sexual needs of unmarried girls, adolescents or senior citizen and SRHR is completely missing from the plan. However, the existing commitment will contribute to realizing SRHR if commitment is met as planned. Overall, the monitoring of the implementation of the existing policies is weak. Moreover, more attention is required to develop institutional capacity to ensure duty bearer are implementing the laws and meeting the commitments. The policies could be further strengthened by integrating effective monitoring, evaluations and time bound action plan with targets and resource for implementation. The need of unmarried girls, adolescents, transgender sexual and reproductive health

[2] *Bangladesh Demographic and Health Survey*

	Polices related to SRHR and mental health	Gaps in Policies implementation
	providing equal right, equal opportunity, ensuring safety, taking initiative to improve reproductive, physical and mental health (but Sexual Health has been totally ignored. (page-15 16.1, 16.2, 16.3,16.4, 16.8, 16.10, 16.11 and 16.12, 18.3, 18.4)). Furthermore, in page-17 under 17.3 it states ". To revise and amend existing law and make necessary legislation to ensure the human rights of women". MOWCA set up one-stop crisis center (OCC) at divisional level to prevent violence and abuse on women and girls. Established a counselling center through National Trauma Center for women and girls' victim of violence. MOWCA is responsible and commitment to providing legal and other support. Commitment made by MOWCA to organize inter-ministerial coordination to establish sexual harassment and abuse prevention committee at district level and at 12 Upazilla (local level).	related complicity is not being discussed. The stigma attached to Sexual Health related problems are also not discussed which is correlated to overall physical and mental wellbeing. Under 17.3, provides flexibility to revise, amend existing laws to ensure human rights of women are met which could be further strengthened by developing a regular interval process of reviewing and making necessary change periodically. .

	Polices related to SRHR and mental health	Gaps in Policies implementation
Social Behavior Change Campaign (SBCC)	The social behavior campaign is not mentioned in the plan but given the importance to create mass media awareness in prevention of abuse on children and women. The National Women's Development action plan has included awareness and an action plan for sexual harassment in public transport and public places (Pg-410, pg-10, pg-14, pg-38, 281). In page-26, it also made commitment to integrate gender perspective in media policy. The plan acknowledges the social harmful discriminatory norms and in page-30, 46.6 given special important to develop social awareness programs focusing on three areas: as stated in the document*"(1) removal of defamatory statements and remarks to women from the legislations and rules and other documents;(2) awareness of executives of ministry and corporate bodies, officials of the Law and Justice Department, policy makers, officials of law enforcing agencies, and officials of the NGO's; (3) inclusion into curriculum the gender relationship, rights, issues pertaining to women development and training shall receive special importance".* Furthermore, in page-17, 17.2 committed to create strong awareness and implement Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).	The deep rooted harmful social norms require well designed social behavior change campaign to go beyond just creating awareness and ensure new social non-discriminatory norms are formed. The plan is missing on detail_action plan and strategies to implement the social awareness with strong monitoring and indicators to measure the change. The sexual harassment awareness in public place is still not implemented. Separate time bounded action plan, monitoring and gender sensitive indicators is required to ensure commitments are met. It is important to go beyond creating awareness rather than incorporate social behaviour change models. The media and other institutions still lagging behind in incorporating gender sensitive polices including sexual harassment policies in their corporate policy. The systemic change requires capacity development of media in relation to gender, SRHR and mental health to influence society to change harmful social norms that act as a barrier to realizing individual human rights.
Importance of male engagement	In page-18, under 19.11 male and youth engagement has given importance to the prevention of violence against women and girls.	But, later the male engagement has not developed further with action plan and/or intervention.

	Polices related to SRHR and mental health	Gaps in Policies implementation
Access to SRHR through adolescent clubs	The decision to establishing adolescent clubs were taken in 2017 and the policy was developed in 2011. As a result, not reflected in the policy.	These policies require revision to incorporate adolescent clubs to ensure access to mental health and SRHR services to overall wellbeing.
Seventh -Five-year policy-2017-2020		
Polices related to SRHR and mental health	In the National Seven-Five-Year Plan, adolescent mothers' reproductive health and family planning is given importance and transgender needs are acknowledged. Population and family services will be improved to promote delay child marriage and delay the first baby for adolescent mothers. It also committed to ensure access to information and independent decision making with regard to reproductive health. It also given order to educational institutions to formulate and enforce sexual harassment policies and develop mechanism to implement policies. Sexual Health appeared only once in the context of ensuring reproductive health as it states "*Similarly, immunization, maternal and ante-natal care for pregnant women and post-natal care for both mother and child would be ensured through increased facilities as well as information and motivation both in rural and urban areas. Reproductive and Sexual Health care services including counselling would be expanded*." Bangladesh is going through a transition to prepare Eight-Five Year National action plan. Bangladesh has targeted 8.37 percent economic growth and priority will be given to high growth, creating jobs (especial focus on IT and vocation skill training), reducing poverty and addressing inequality. Bangladesh government also seeks additional funds from development partners. [3]	In the National Seven-Five-year Plan adolescent group and their needs has not been strongly identified and did not reflected in the result frame work. In the result frame focuses on net increase in enrolment in the primary, secondary and tertiary education. The adolescent mental health also has been ignored while counselling services mentioned loosely and not reflected in the result framework. Most of academic institutions did not adopted sexual harassment policy nor played a strong role in address the harmful social norms that affect adolescence well-being. According to 2009 High Court directive, every academic institution needs to have anti-sexual harassment committee. In 2019, one principal of madrassa Siraj Ud Doula, along with a group of five people set an 18-year-old girl student name Nuruat Jahman on fire. The event ignited outrage all over Bangladesh. The Directorate of Secondary and Higher Education (DSHE) issued order to 27,000 academic institutions to establish anti-sexual harassment committee. [4]

[3] https://tbsnews.net/bangladesh/govt-seek-aid-837-gdp-growth-8th-5yr-plan-39741

	Polices related to SRHR and mental health	Gaps in Policies implementation
Social Behavior Change Campaign (SBCC)	**In Bangladesh Seven- Five-year plan, media engagement is given important to promote positive image of women empowerment.** Behavior change campaign mentioned only in the context of changing behaviour of newly-wed adolescent couples to delay the first birth.	Bangladesh Seven- Five-year did not put strong emphasis on social behaviour change with regard to overall health.
Important focus on adolescence boy engagement	Seven-Five-year policy put emphasis on male engagement, community engagement, religious group engagement, local government engagement to combatting child marriage. Although, the implementing partners such as local government has limited capacity on gender equality. It also includes male engagement to become agent of change and promote gender equality especially influencing harmful discriminatory social norms which act as a barrier to girls' decision making. Under the section Universal Health Coverage (UHC) commitment made to promote adolescent reproductive health care under activity 1124: "*Games and events held with adolescent girls and boys with messaging on girl's rights and early marriage*."	There is a need for rigorous training on importance of gender equality to local government, police, school teachers and other relevant stakeholders which has not been included. The commitment did not reflect in the result framework, nor strong monitoring indicators included to ensure effective implementation of the plan.
Access to SRHR through adolescent clubs	Under the section Universal Health Coverage (UHC) commitment made to promote adolescent reproductive health care under activity 1124: "*Games and events held with adolescent girls and boys with messaging on girl's rights and early marriage*."	
Education Policy -2010		

[4] https://www.thedailystar.net/frontpage/news/form-cells-tackle-sexual-harassment-1732855

	Polices related to SRHR and mental health	Gaps in Policies implementation
Identifying target group:	Education is considered as one of the effective tool to combat child marriage in National Adolescent health strategy (2017-2030), in Child Marriage national action Plan but no commitment has been made to address harmful social norms or to combat child marriage. It clearly identified different adolescent groups and their needs at different stage of adolescent. It also given importance to improving quality of education. Beginning of 2019, Bangladesh government took a decision modify the educational policy and provide 7 days overseas training for 7000 primary teachers to improve quality of education. MOWCA and UNICEF joined taken initiative where adolescent was trained as "ambassador" to influence gender and discriminatory social norms to combat child marriage	Education has been identified as one of the most effective tool to delay child marriage and also a platform to provide knowledge on SRHR including awareness on child marriage, domestic violence and gender based violence. The policy does not take accountability to play an important role to combat child marriage and GBV. The educational policy required reforming and including important component to ensure overall wellbeing of adolescent health. (UNICEF, 2019). Overall, all academic institutions required additional funding and invest in developing human resource capacity to improve quality of education, including SRHR. It clearly identified different adolescent groups and their needs at different stage of adolescent. It also given importance to improving quality of education. Beginning of 2019, Bangladesh government took a decision modify the educational policy and provide 7 days overseas training for 7000 primary teachers to improve quality of education. MOWCA and UNICEF joined taken initiative where adolescent was trained as "ambassador" to influence gender and discriminatory social norms to combat child marriage.
Access to SRHR through adolescent clubs: Sexuality education	The education policy does not cover adolescent clubs' activities as it was drafted in 2010 and the adolescent clubs established in 2012. The education policy requires revision and incorporates institutions commitment to ensure SRHR services for adolescent through adolescent club. The teachers and management require SRHR sensitizing training to ensure clear common understanding on important of SRHR for adolescents especially for girls to ensure wellbeing in adulthood	In reality, schools are still lagging behind in providing sexuality education and gender studies have still not included. Moreover, it's also did not reflect on integrating and strengthening comprehensive sexuality education programmes at all academic and training institutions. Strengthening comprehensive sexuality education programmes at all academic and training institutions.

	Polices related to SRHR and mental health	Gaps in Policies implementation
Family Planning -2020		
Identifying adolescence target group:	The policy does not highlight SRHR services to all adolescent rather gives more importance with regard to reproductive health. According to National health strategy, family planning is the ministry leading SRHR programming but the family planning is putting less on SHR. Bangladesh government has allocated $ 615 million to family planning ministry. The family ministry made six commitments, one of which was targeted towards adolescent SRH needs. As it states "The government of *Bangladesh commits to increasing adolescent-friendly SRH and FP services, providing adolescent SRH services at one-third of maternal newborn and child health centers.*	The policy does not cover SRHR needs for all adolescent married and unmarried. The commitment is more towards married adolescent's reproductive health.
	According to National Adolescent Health Strategy as it states "Bangladesh commits to adopting innovative service delivery approaches, like behavior change and Information Communication Technology (ICT). Improve choice and availability of long-acting and permanent methods, including for men, and post-partum and post-abortion services."	
Social Behaviour Change Campaign (SBCC) **Child Marriage, sex harassment**	It gives importance to male involvement in family planning to overall improve reproductive health and gender outcomes. It also includes family planning will department will work with NGOs and private sector to address the needs of youth especially young couples. It further commits to work with leaders, communities to delay marriage and child birth.	In the National Adolescent Health Strategy behaviour change is mentioned to promote SRHR and mental health (including post-partum or post abortion services) but it did not reflect on Family Planning policy brief-2020.
Important focus on adolescent boy	In the family planning policy, there is no mention of awareness of SRHR through adolescent clubs. With regards to addressing adolescent	It is focused on family planning and birth control but it did not cover adolescent Sexual Health especially unmarried adolescents.

	Polices related to SRHR and mental health	Gaps in Policies implementation
engagement	health, it stated "*Focus on adolescent reproductive health to reduce early marriage and pregnancy. Reduce the adolescent pregnancies through social mobilization, implementation of the minimum legal age for marriage and upgrading one third of the MNCH centres to provide adolescent friendly SRH services including Family Planning."*	
Access to SRHR through adolescent clubs	In the family planning policy, there is no mention of awareness of SRHR through adolescent clubs. With regards to addressing adolescent health, it stated "*Focus on adolescent reproductive health to reduce early marriage and pregnancy. Reduce the adolescent pregnancies through social mobilization, implementation of the minimum legal age for marriage and upgrading one third of the MNCH centres to provide adolescent friendly SRH services including Family Planning."*	The policy support limited SRHR services for example, focusing mostly on adolescent's pregnancies. According to National Health Strategy 2017, unmarried adolescents, who fall outside the existing reproductive health care services system, have also been given priority to create access to information and services on SRH. But, family planning has not taken into account of unmarried girls SRHR needs.
Child Marriage Restraint act-2017		
Polices related to SRHR and mental health	In 2017, The National Parliament of Bangladesh approved Child Marriage Restraint act (CMRA) and replaced 1929 act to strengthen penalties of child marriage. The new CMRA -2017 still remain silent on existing gaps in the legal framework. For example, under previous 1929 CMRA, Bangladesh witness minimum improvement in child marriage. The national stakeholders identified some gaps such as poor implementation and failure to create local government officials to report child marriage. The policy include prevention commitment consists of nationals/districts/sub districts/unions and local government officials, officials from non-government organizations and community influential to combat child and force marriages.	Child marriage, force marriage is one of worst form of gender based violence which does not get acknowledged as much it needs attention. Generally, punishment for rape is imprisonment for 10 years, fine or imprisonment for life. But, force sex with in force marriage or child marriage is still not consider rape. There are two laws with regard to rape: The Bangladesh Penal Code (section-375) and Prevention of Oppression Against Women and Children Act 2000 states "sexual intercourse by a man with a woman without her consent is considered rape.

	Polices related to SRHR and mental health	Gaps in Policies implementation
	Bangladesh government allocated separate budget of US$10,839,848 to implement National Action Plan. Girls Not Brides (Bangladesh) demanded for separate allocation of national budget 2020-2021 to combat child marriage especially during such pandemic. To void the child marriage needs to follow a procedure set forth in the applicable personal law. (Child Marriage act -2017)	

	Polices related to SRHR and mental health	Gaps in Policies implementation
Change Campaign (SBCC) **Child Marriage, sex harassment**	It acknowledged existing cultural, social harmful traditional beliefs and norms is the key determinant behind high prevalence of force and child marriage. Moreover, other religious beliefs lend tolerance to end child marriage. MOWCA and UNICEF Bangladesh have jointly launched National Action plan to end child marriage. At the policy level, child marriage has been integrated with in mainstream education, protection and health. Strong emphasis will be focus on change the existing harmful social norms by impactful intervention to establish new norms to delay marriage. MOWCA with partnership with UNICEF is implementing social behavior change campaign through multimedia campaign to end child marriage with a slogan "raise the beat to end child marriage". The campaign includes radio, television public awareness on ending child marriage.[5]	Overall, budget allocation increased for MOWCA but no specific allocation made for combat child marriage. No monitoring report found with the progress with implementing National Action Plan to end child marriage. [6] In reality, the country wide child marriage prevention committee is not active. Under the previous 1929 CMRA, in the case of Muslim parties, a marriage is valid if the parties have reached puberty following Muslim personal law. In 2017, CMRA is still silent and marriage remain valid that violates the minimum required age. Under the Muslim law, the girls are provided a short window to dissolve the marriage as according to the law, when she was under the age of 18; however, dissolution of marriage on this basis is possible only where the marriage has not been consummated and the marriage must be repudiated by the age of 19. [7]
Important focus on adolescence boy engagement	In 2019, UNICEF and MOWCA jointly agreed to developing monitoring and evaluation framework for the implementation of National Action Plan to combat child marriage. It has also taken into account of sensitizing boys on GBV involve them as agent of change to promote gender equality and combat child marriage.	The male engagement needs to further strengthen with setting specific targets and gender sensitive indicators to measure the effective of the intervention.

[5] *https://www.unicef.org/bangladesh/en/ending-child-marriage*

[6] https://www.share-netbangladesh.org/gnb-bangladesh-demands-specific-budget-allocation-for-ending-child-marriage/

[7] https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/64829505_ending_impunity_for_child_marriage_bangladesh_2018_final-web.pdf

	Polices related to SRHR and mental health	Gaps in Policies implementation
Access to SRHR through adolescent clubs	In 2018, MOWCA committed to set up 4883 clubs across the country to ensure access to SRHR and prevent child marriage, other gender based violence.[8]	There is no secondary information found on progress on establishing adolescent clubs and providing quality of SRHR services providing to the adolescents.
Mental Health Act 2018		
Polices related to SRHR and mental health	Bangladesh followed mental health policy name Lunacy Act formed in 1921 and later in 2018 first mental health policy was drafted. The revised policy only takes into consideration of extreme mental health disorder.	
Social and Behaviour Change Campaign (SBCC)	Social and behavior Change or creating basic awareness with regard to adolescent mental health is completely absent in the policy document. The mental health focused on serious mental health disorder. The policy has gaps not addressing social stigma related to mental health. Although, mental health policy is reformed recently in 2018 but it fails to integrate commitment made by other national action plan such as National Action Plan to end child marriage -2017	The policy does not take into account of adolescent mental health into consideration. It is more focused on providing support to extreme mental health disorder such as schizophrenia. In Bangladesh, there is serious stigma to address mental health or SRHR issues especially for adolescents. The act ignored important of psychology to break the stigma around mental health and SRHR. It did not cover the impact of poor mental health due to inexistence of mental health support system. The link between SRHR and mental health has not been considered by the policy makers.
Important focus on adolescence boy engagement	No discussion found around providing mental health support to adolescent through clubs.	The document is gender insensitive and no strategy developed to address harmful social norms.

[8] *ttps://thefinancialexpress.com.bd/national/project-starts-to-launch-4883-adolescent-clubs-across-country-1537613156*

	Polices related to SRHR and mental health	Gaps in Policies implementation
Studies conducted during COVID-19		
Bangladesh government Need Assessment COVID-19[9]	The finding from Need Assessment highlights on birth registration is largely stopped but it must continue to reduce future child marriage. The need assessment highlights on that programming should put ore focus on structural issues causing violence against adolescent and children such as social norms, particularly with gender norms. Virtual Emergency Courts, counseling services need activation to ensure the access to justice for physical and mental violence on adolescents. The assessment found 42% adolescent indicated that physical violence such beating has increased and 40% increase on calls for the child helpline.	Gaps in the documents addressing SRHR and mental health needs
UNICEF'S preliminary finding on child marriage during COVID-19	On 22nd July 2020, UNICEF shared *"Preliminary findings of the Data Brief on Child Marriage in Bangladesh"* which highlights important facts related to deep rooted social norms such as Child brides are more likely to justify domestic violence than their peer who married in adulthood. The attitude toward physical punishment shows that 37% mothers who were married before age 18 believes that physical punishment is require raising children.	On 5 April 2020, GoB allocated $8.5 billion as emergency stimulus package to fight COVID-19 but no amount has been explicitly allocated as emergency supports to the victims of domestic violence. Among the five overall sectorial priorities mental health and SRH are not in the top priority areas. However, under health, reproductive health is fourth priority, education and child protection is fifth priority areas. No significant action plan adapted to tackle the shadow impact on COVID-19 on adolescent lives.
Violence on record cases **From – March –May**	Bangladesh Mahila Parishad collected the data from reports published in 14 national dailies between March and May, and shared with human rights organization[10]. Total number of violence cases: 13,494, 116 children were raped, 18 faced attempted rape, 170 child marriage, 552 unnatural child deaths and 3 children faced sexual	No significant action plan adapted to tackle the shadow impact on COVID-19 on adolescent lives.

[9] *Government of Bangladesh have taken a decision to carry out that all assessments in the initial days and weeks of a disaster should be joint assessments to make sure participation of all stakeholders and ownership of the results. The Needs Assessment Working Group (NAWG)*

[10] *https://tbsnews.net/bangladesh/crime/480-women-children-fall-victim-violence-last-3-months-88882*

	Polices related to SRHR and mental health	Gaps in Policies implementation
	harassment while receiving food or other. According to Manusher Jonno Foundation, 462 girls were victims of child marriage in June year while the number was 170 in May.[11]	
COVID-19-19 policy response to mental health	On 25th April 2020, Bangladesh organized the subcommittee meeting with National Institute of Mental Health (MIMH) technical committee with regard to COVID-19 mental health response. Again, the response is focused on serve mental health disorders and ignored adolescent mental health needs.	The mental health response failed to provide strategic direction and action plain for overall mental health wellbeing. Compare to the number of adolescent population, there is a need for increasing helpline numbers as well mass public awareness on helpline number. MOWCA needs to strengthen the monitoring and collecting sex-disaggregated data and keep record of type of complains are register. Separate strategy required for strong national wide helpline, ensuring quality of counselling and ensuring safety of adolescents.
Support provided by Ministry of Women and Children Affairs (MOWCA)	Ministry of Women and Children Affairs (MOWCA) providing helpline number for GBV through One Stop Crisis Centers at upazila level and National Trauma Counseling Centers. MOWCA shared that the Help Line is in fact receiving approximately 10,000 calls a day now, up from an average of 6,000 calls before the COVID-19 outbreak.	To tackle the COVID-19 shadow impact on adolescent lives requires strengthen data collection, strategy adaption to ensure adolescent mental wellbeing and protection from violence

[11] *https://www.thedailystar.net/editorial/news/spike-school-dropout-and-child-marriage-predicted-1932393*

	Polices related to SRHR and mental health	Gaps in Policies implementation
Gender Monitoring Network calls	UN Women facilitated Gender Monitoring Network with the civil society organization and government to engage in consultation on how COVID-19 pandemic is affecting women and girls. The signatories call on the Bangladesh government to ensure a gender sensitive, inclusive and based on human right. There are 12 actions proposed to gender responsive COVID-19 response. The action plan 12 covered nationwide advocacy and media campaign addressing prevent gender based violence, especially child marriage; action plan 3 strongly propose to declare GBV as essential lifesaving services which requires additional budget allocation; and action plan 5 focus on prevention of sexual exploitation and abuse in quarantine. (annex-2 details of 12 action plans)	The 12 action plan included SRHR specifically in action plan 6 which states "Pay attention to the significant role that women are playing as frontline health workers and community health workers, by raising awareness amongst the general public to combat social stigma surrounding women health professionals and ensuring their access to women-friendly PPE and support for their mental, physical and sexual and reproductive health. Support them manage their family care responsibilities through flexible hours and access to COVID-19-safe childcare service." This provides SRHR services to health care workers not focused on adolescent boys and girls which needs urgent separate attention. As, adolescent one of most vulnerable group who are driving force for future social and economic growth. Separate clear action plan required for ensure Bangladeshi adolescent wellbeing is prioritized.

ANNEX 2: QUOTES FROM INTERVIEWS WITH EXPERTS

Tamima Tanjin, Clinical Psychologist at Prottoy Medical Clinic:

She argues that SRHR and Mental Health are in fact two sides of the same coin. Each and every issue that is concerned to a person's SRHR has a direct impact on one's mental health, be it child marriage, experiencing changes during puberty, sexual harassment or a person's gender identity.

She quoted "married women are more prone to getting abused, as she is forced by her husband to have sex with him against her will. It is albeit wrongfully considered that if a woman is married, she should be obligated to have sex with her husband, which leads her to believe that she is an object of physical pleasure. This can give rise to adverse mental health issues, particularly by giving into her husband's abusive demands with a view to maintaining peace in the household. The reason for this behavior is that women are brought up in a way that they are taught to sacrifice and compromise. This is transferred from generation to generation. Even the 'holy union' of marriage, and the 'biggest event in a woman's life' which is pregnancy can have a negative impact on a person's mental health, which is often ignored because it is assumed that marriage or pregnancy are the 'most glorious' events in a person's life. Mental health within households is not only ignored, but its existence is overlooked, denied and normalized. By the same token, when the husband is unaware of proper and safe sexual practices, it affects the wife adversely causing her more sufferance."

Nabakumar Dutta, a renowned SRHR practitioner:

One of the most vulnerable groups in Bangladesh is the LGBTQ population. These people are invisible as their existence is not acknowledged by the government. As a result, they are deprived of their rights, including basic healthcare. They are judged by doctors at healthcare centers for their appearance even at the point of seeking basic healthcare. When it comes to their mental health, many among this group suffer from gender dysphoria, as they want to change themselves physically with the help of hormones and/ or surgery. Nabakumar Dutta quoted "as there are limited medical gender transformative services in Bangladesh for this group of people, they end up taking pills containing progesterone or estrogen that are harmful for them, and undergo surgeries with the help of unskilled doctors. This results in serious health issues for people who try to transform their bodies. In the case of gender transformation with the help of medicines, this may cause a change in hormones, causing extreme mood swings, anxiety and depression. Before the pandemic, they could go to countries such as Thailand or India for their treatment, but due to restrictions owing to COVID-19, they are unable to continue their treatment. This is leading to health complications and mental stress and even suicidal tendencies as they feel emotionally isolated from their friends and family. They also suffer from hypoactive sexual desire disorder which is common in Bangladesh but never discussed. Although, the Mental Health Act 2018 replaced the 105 year old Lunacy Act that was created in 1912, the changed name of the act would have one believe that the Act governs mental health, but the reality is that it predominantly focuses on a person's property rights, and it looks at mental health as a topic which relates to drug abuse."

Nabakumar Dutta stated "Even though the SRHR interventions are designed to provide victim centric services, one must look at abuser's perspective. There are cases where the abuser takes pleasure in abusing another person. This comes from a dark place, at times, they themselves were victims of abuse in the past. Many support services are available at upazilas but unmarried girls don't necessarily access these services because of the fear of being questioned and judged, moreover, these services lack confidentiality and privacy." In another example he cites a case where lack of awareness in sexual orientation led a parent to take their daughter to a psychologist with a view to finding a cure from being a lesbian. The doctor prescribed her medication which resulted in the girl losing her mental stability and descending into extreme depression. She was also subjected to see a counsellor who advised her to pray to the almighty to recover from "this disease"

He also highlighted that Bangladesh have 50 clinical psychologists and 1 mental health expert for 80,000 people. There are 1600 doctors for 70 lakhs patient thus one can imagine the gaps in services. We have found cases, where HIV patients go through serious mental health crisis and they want to harm others by spreading HIV. Adolescent go through puberty changes without any knowledge of their own Sexual Health. In many cases, as they do not have access to right information regarding SRHR, they fall into the trap of poor mental health. They slowly developed mental health problems such as depression, anxiety and increased tendencies to commit suicide.

Nabakumar Dutta stated "I find it very ironic that we hold reservation to Sexual Health and rights when we are one of most densely populated country. The increasing number of rapes, sexual harassment demand for more SRHR and mental health services. In the counselling session, male struggle to share their rape incidents compared to women. Excessive anger can also be a leading sign of sexual abuse or rape at childhood."

S M Shaikat, Executive Director, SERAC-Bangladesh:

People shouldn't be defined as illegal even if they are undocumented. The word 'illegal' stigmatizes people. This stigma should be removed. There has been hardly any effort made to remove this stigma associated with this word and acknowledging undocumented people having rights. When people become illegal they also become invisible. On the topic of adolescents, he witnesses, many young adolescents who cannot share their sufferings with their parents, leading to depression and suicidal tendencies. When the parents are not able realize this voluntarily, the children are left to feel lonely and looking for people like them for support and reassurances. They create a separate world of their own where they bury themselves in pain and suffering. Even when they seek treatment, which is seldom, their experience generally turns out to be traumatic due to the way they are judged by the health professionals. They feel they are looked inferiorly for the way they feel and behave. The health professional makes this very obvious with the way they gaze at them during the meeting. This further exacerbates their plight causing more harm, thus they end up seeking no kind of help, and simply go through this trauma with no place to go and as such they feel they will be better off leaving the country and settling in a country that gives them respect, acceptance and acknowledgement.

Minhajul Haque, Vice Chairman Prottoy Medical Clinic Ltd.:

He gives compelling evidence for ensuring that safe houses made available for the victim of abuse. He cites a case where "a daughter who is sexually abused by her own father has nowhere to go even after seeking a certain degree of intervention. It defies logic sending her back to her abuser, causing her more trauma and suffering. More needs to be done to create awareness in this regard, and government can play an effective role by being more vocal and exercising relevant laws to curb this act of violence. He also finds links between drug abuse, mental health and SRHR. He states that in many cases, people who face sexual abuse seek respite in drugs. This gradually leads to depression and has a profound effect on an individual's mental health."

Dr Abul Hossain, Director of Multi Sector Programme on Violence Against Women, Ministry of Women and Children Affairs (MoWCA):

Dr Hossain says that more ground level work needs to be done combining people from all sectors of society prior to introducing sexuality education in the school's curriculum. This is particularly applicable in the context of Bangladesh where patriarchy and religious sensitivity play a major role in governance. Therefore, the strategy should be to make progress gradually and with caution, first starting with reproductive health, and slowly moving on to other pressing concerns of SRHR. Abul Hossain (MOWCA) recommends that the development organizations and UN agencies should work in collaboration with each other. He also observed that many NGOs tend to work in the same regions over and over again. He emphasizes that when a project is run, it should cover all over Bangladesh. Most of the time they work in limited areas, one or two districts, but they can cover all the 64 districts if they coordinate with each other. All the development practitioners such as UN,

INGOS and donors must focus on implementing activities across all the districts and not just a selected few. CSO and development partner should come forward with creative solutions to address domestic violence.

ANNEX 3: QUESTIONAIRE

Introduction:

Share-Net International, a knowledge Platform on Sexual and Reproductive Health and Rights based in the Netherlands funded a project conducting a study focusing on Bridging the Gap between Mental Health and SRHR', led by Architects of Change and RedOrange Media and Communications. The objective of this project is to identify, analyze and investigate gaps between SRHR and mental health in national policies; and to highlight opinions and perspectives of experts on mental health and SRHR. With this project we intend to create evidence that can be shared with stakeholders from government and non-government sectors so that they may look at SRHR as an essential component of mental health. The study will generate knowledge that can be used as evidence to prove that SRHR and mental health are closely connected to each other, and that one can achieve a healthy mental state only when their sexual and reproductive health and rights are properly addressed. The project through its study will highlight the gaps in Bangladesh National Policies and studies such as National SRH Adolescence Policy 2013, Mental Health Act-2018 and Seventh Five Year plan. This gap analysis study will be resourceful evidence to advocate for stronger linkage between SRHR and mental health in the upcoming Eight-Five Year and in the revision of Mental Health Policy. Furthermore, it envisages to support the GoB and development practitioners in adapting policies and improving the best practices.

The core objectives of the policy review are:

- To identify, analyse and investigate the gaps between SRHR and Mental Health in the Bangladesh Mental Health Act of 2018
- To highlight the perspectives of academicians, researchers, practitioners and policy makers towards mental health and SRHR
- To produce an evidence that can be shared with the relative stakeholders from the government and non-government sectors

Semi-structured interview:

Questions and interview guidelines for the interview are given below. The interview will be recorded with your permission. Clips of the interview will be used in a video based on this project.

List of questionnaire:

Interview guidelines	Interview questions
Introduction	Introduction of- the interviewers, the project, the participant. Would you like to be anonymous?
Understanding the relationship between SRHR and mental health	1. How much importance should be given to mental health when addressing sexual and reproductive health related issues? 2. Where do Bangladesh stand in meeting the needs of sexual and reproductive health of adolescents, youth, LGBT+ population, especially unmarried girls? During the epidemic, how SRHR services are available and accessible especially for youth,

	adolescent girls and LGBT+ population? 3. Do you think adolescent sexual and reproductive help has any relationship with depression, anxiety or other type mental health issues? If, yes, can you please elaborate? How many cases of mental health issues are linked with sexual health or reproductive health?
Current policies, plans and strategies	4. In what ways are current policies, plans and strategies of the government addressing SRHR and mental health? What are the policy gaps that need urgent attention? 5. In your review, do you think SRHR and mental health needs are adequately recognized and addressed in the current national polices? 6. What polices are in place to support SRHR and what is the progress with implementation of polices? 7. How much government is prioritizing the mental health and SRHR issues in reality?
Recommendations	8. What is needed to be done to ensure mental health needs are integrated with SRHR? 9. Do unmarried girls face stigma related to their sexuality and impact on mental health? How the stigma effect on their mental health well-being? 10. Please share, your thoughts on quality of mental health experts, support system in Bangladesh compare to other countries. Do we have quality counsellors, mental health experts, psychologist and psychiatrist compare to the need of adolescent?
Opinion	11. Is there anything you would like to add?
Conclusion	Conclusion. Interviews will be shared with them later.

ANNEX 4: REFERENCE

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