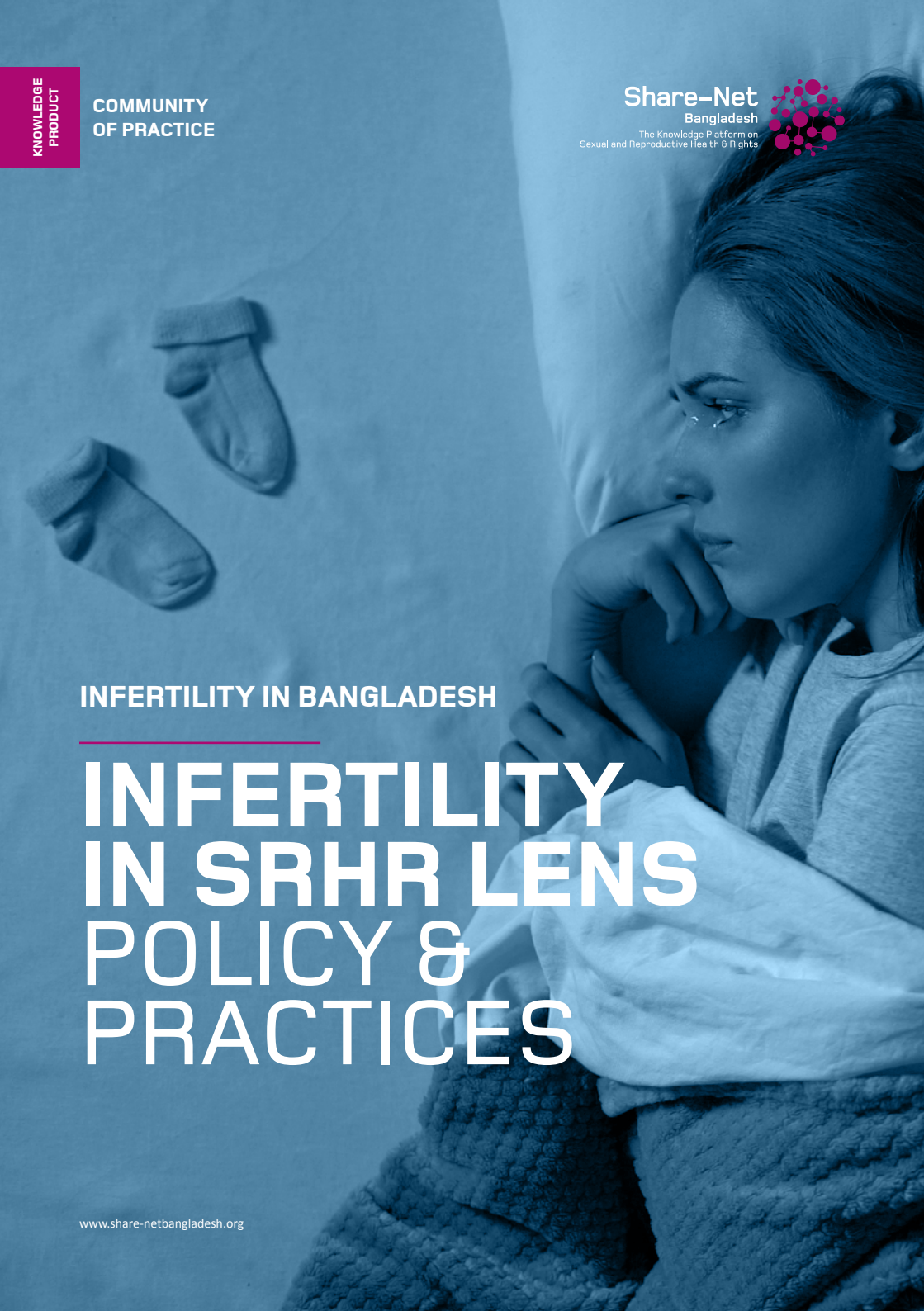
KNOWLEDGE PRODUCT

COMMUNITY OF PRACTICE

Share–Net Bangladesh
The Knowledge Platform on Sexual and Reproductive Health & Rights



INFERTILITY IN BANGLADESH

INFERTILITY IN SRHR LENS POLICY & PRACTICES

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ABBREVIATIONS

SRHR	Sexual and Reproductive Health and Rights
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
WHO	World Health Organization
ART	Assisted Reproductive Technology
HIV	Human Immunodeficiency Virus
MFSTC	Mohammadpur Fertility Services and Training Centre
MR	Menstrual Regulation
FGD	Focused Group Discussion
IVF	In Vitro Fertilization
MCH	Maternal and Child Health
MCH-FP	Maternal Child Health and Family Planning
MC-RAH	Maternal, Child, Reproductive, and Adolescent Health
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
MOWCA	Ministry of Women and Child Affairs
TB	Tuberculosis
OGSB	Obstetrical and Gynaecological Society of Bangladesh
MOHFW	Ministry of Health and Family Welfare
SDG	Sustainable Development Goals
REI	Reproductive Endocrinology and Infertility
BSMMU	Bangabandhu Sheikh Mujib Medical University Hospital
A&RH	Adolescent & Reproductive Health
SOGI	Sexual Orientation and Gender Identity
BAPSA	Association for Prevention of Septic Abortion

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1. Introduction

This study has been conducted in response to Share-Net Bangladesh's aim to bring together the Communities of Practice (CoP) that consists of social and medical researchers, development practitioners, academicians, health workers, government officials and legal experts to engage with one another to find solutions and take critical issues forward to develop a knowledge product on infertility in Bangladesh as an integral part of sexual and reproductive health and rights (SRHR).

1.1 Background of the Study

Approximately 8-12% of all couples are infertile worldwide. Infertility rates vary among different countries ranging from less than 5% to over 30% (Kumar and Singh, 2015). A global review of infertility from the World Fertility Survey and others estimated infertility rates in South Asian countries including Bangladesh as 4% (Vaessen, 1984; Farely, 1988, cited in Kumar, 2007). Another estimate of overall primary and secondary infertility in South Asia, on the basis of women at the end of their reproductive lives in the age group 45-49 years, suggests an infertility rate of approximately 15% in Bangladesh (ibid), which is the highest among all South Asian countries. Bangladesh has an estimated population of 163.05 million and the country's population growth rate or average annual change in the population is 1.37 percent. In Bangladesh about 3 million couples are infertile and about 24.51 million patients receive infertility advice or treatment. (F. Ashraf et all, 2017)

As Bangladesh is already overpopulated, controlling population

priority is more on controlling the population and reproduction and fertility control dominates the focus of health policy (Nahar, 2018). For this reason, infertility never gets enough attention as a public health problem, even though people, mostly the women who are unable to have a child, face social exclusion. Therefore, in Bangladesh childlessness is much more than just medical illness (ibid).

Infertility study needs more attention. Infertility has a wide spectrum of physical, psychological and social effects, specifically on women. Like in many other countries motherhood is considered as an identity marker for women in Bangladesh. It is considered as 'role failure' if a woman fails to conceive even if her husband has a medical issue. Social stigmatization and isolation are the outcomes of such failure that may lead to physical and psychological abuse. On the other hand, men who have problems reproducing, also experience masculine crisis, they avoid seeking treatment of it which in turn expands the social dimensions of infertility. Gender diverse community, being in the margin of the society also have unheard stories regarding fertility and infertility. So, study on infertility in Bangladesh deserves special attention to address the gender related unfairness and prejudice while also making and implementing effective policy to address the issue. Although we know about the social and psychological effects of infertility and the factors associated with it in Bangladesh, there is a huge research gap both in social and public health aspects of it. Such research is a must if we want to develop an effective management system and address infertility while making treatment regime available and affordable and spreading awareness and empathy for the suffering people.

1.2 Scope of the Study

Despite the serious consequences of 'infertility' from public

health importance, there is a dearth of scientific data and evidence (research, statistics, and reports) to bring into light the magnitude of infertility in Bangladesh. In addition, while SRHR has been receiving considerable importance in recent years, however, there is a visible silence to connect 'infertility' as an important component of SRHR and the entrenched stigma and taboo attached to it.

In this situation it is urgent to bring this important subject to the notice of SRHR policy & practice domain in a comprehensive and integrated way.

Highlighting the above, this study is designed following broad and specific objectives with a goal of developing a knowledge product. The understanding is that the expected knowledge product will reveal the social dimensions of infertility and will work towards eliminating social taboos regarding infertility and to draw attention to policies and advocacy awareness of different funds to spend on infertility in order to make it a core component of SRHR, highlighting universal access to infertility case management and leaving no one behind.

1.3 Literature Review

Infertility is an issue affecting millions of individuals, and yet information and education about infertility, as well as fertility treatments, remain difficult to access for many.

Infertility is estimated to affect as many as 180 million people worldwide[1]. Primary infertility is caused by anatomical, genetic, endocrinological, and immunological problems leading to the inability to have a child. Secondary infertility which refers to the kind of infertility where a woman has had at least one pregnancy and live birth previously, is more

1 *W. Ombelet, "Global access to infertility care in developing countries: a case of human rights, equity and social justice" Facts Views Vis Obgyn (2011). Available athttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987469/*

common than primary infertility, and is easily preventable. Secondary infertility is usually caused due to sexually transmitted infections, poor health care practices, including unsafe abortion and poor maternal care, exposure to toxic substances, and socio-cultural practices such as endogamous marriages (marriage between relatives), and female genital mutilation. It is estimated that about 10.5% of women around the world have experienced secondary infertility, and roughly 2% experienced primary infertility[2].

The World Health Organization (WHO) defines infertility as "a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse." [3] This definition however does not capture the many other ways in which individuals and couples may not be able to realize their reproductive intentions, including because of social and economic factors. For instance, the heteronormative lens of biomedical definitions of infertility negates the experience of individuals from the LGBTI community. It is also important to keep in mind that the definition of infertility varies between cultures and that the biomedical definition cited above may not capture variation in cultural perceptions of infertility. A childless person or couple does not view themselves as 'infertile' until they define the state of childlessness as a problem[4]. The issues related to the definition of infertility impact the ability to estimate the prevalence of this issue, which leads to difficulties in designing policy responses which uphold the rights of all persons without discrimination.

The right to form a family is guaranteed in Article 23 of the

2 *See https://www.mhtf.org/2017/01/18/the-burden-of-infertility-global-prevalence-and-womens-voices-from-around-the-world/*

3 *See https://www.who.int/reproductivehealth/topics/infertility/definitions/en/.*

4 *ZubiaMumtaz et al., "Understanding the impact of gendered roles on the experiences of infertility amongst men and women in Punjab", in Reproductive Health Journal (2013), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3562138/*

International Covenant on Civil and Political Rights. Human rights issues related to infertility also implicate the right to non-discrimination, the right to health, the right to education, and the right to decide the number and spacing of one's children, among others. Despite its integral relationship to numerous human rights, as a result of significant scientific advancement in the past years, only recently has infertility been analysed through a human rights lens.

Issues of fertility and infertility do not exist in a vacuum but are impacted by societal and political forces. There is a history of State interest in encouraging strong fertility rates, as a means to ensuring national strength, economic growth, and protection from outside aggression. Promotion of fertility has also been mobilized in service of populist discourses in certain countries to adopt pro-natalist policies. Thus, analysing fertility/ infertility from a human rights perspective will go beyond individual decision making in order to also unpack how Government authority is used to encourage certain women to reproduce, while simultaneously discouraging other women (*eg.* women with disabilities, women living with HIV, indigenous and first nations women, transgender and intersex people, women who are racial, ethnic and/or religious minorities, migrant women, women living in poverty, women who use drugs, criminalized women, etc.), and linking such moves to human rights dimensions. Indeed, different levels of control of fertility should be examined, including individual (bodily autonomy), family, community/societal and State level, which combine to impact reproductive choices as well as how fertility and infertility is perceived.

Various factors can contribute to infertility, many of which have their roots in human rights concerns. Lack of access to adequate health care has a strong impact on the likelihood of having an underlying condition which contributes to infertility, delays in being diagnosed, and barriers to treatment. In many

places, weak health infrastructures and inadequately trained health workforce may also contribute to increased incidences of infertility[5]. Lack of access to quality maternal health care, as well as safe abortion care impact infertility. WHO has estimated that 34 million women, mainly from developing countries, have infertility as result of either maternal sepsis or unsafe abortion. Coercive practices such as involuntary sterilization also lead to infertility, and have been documented particularly among women and girls living with disabilities, those living with HIV, indigenous and ethnic minority women and girls, as well as women and girls living in poverty. Exposure to environmental toxins further predisposes certain women to higher rates of infertility. Those who are most likely to suffer such exposure are often marginalized in other ways, including living in poverty.

Issues of infertility can create devastating social stigma, rooted in harmful gender stereotypes. For instance, in societies where the identity and social status of women are tied to childbearing and motherhood, the consequences of infertility can be severe. Women are also frequently blamed for fertility issues, regardless of whether the medical issue is actually in their body or their partners. They may be stigmatised and alienated from their families and communities, and can also face a higher risk of violence.[6] The stigmatisation can be extreme in some countries, where infertile people are viewed as a burden on the socioeconomic well-being of a community. This amplifies the guilt and shame felt by the woman. [7]

5 *See forinstance, "Woes of the Womb", a report produced by the Ombudsman of the Republic of Malawi on an investigation of alleged malpractices resulting in removal of uteruses from expectant women in public health facilities (2019). Available at https://www.ombudsmanmalawi.org/files/pdf/woes%20of%20the%20womb.pdf*

6 *Stellar et al., A systematic review and narrative report of the relationship between infertility, subfertility, and intimate partner violence, International Journal of Gynaecology and Obstetrics (2015). pp. 6-8.*

7 *See https://www.who.int/bulletin/volumes/88/12/10.011210.pdf?ua=1*

Infertility treatments themselves are often stigmatised. For example, in some settings donor technologies are considered highly as contrary to deeply held religious beliefs. Beyond specific religious prohibitions, there is often a generally-held view that in vitro fertilisation (IVF) and other assisted reproductive technology (ART) procedures are simply "socially unacceptable." [8]

Infertility also has a profound impact on women's mental health. It can cause various psychological issues including stress, anxiety, depression, diminished self-esteem, declined sexual satisfaction, feeling like less of a woman and reduced quality of life. [9]

Furthermore, negative attitudes towards infertile people, including stigmatisation and abuse, can have economic implications. Infertility has been linked to increased risk of divorce or abandonment, which then also often carries economic consequences. Women may lose access to land, which is usually owned by men, as well as other belongings and their homes. [10]

The cost of infertility treatment in general is also often a major barrier for people with less economic means, including those in low-income countries.

Threaded throughout discussions on fertility and infertility, there are gender stereotypes which have a strong influence on who is understood to be desirable in terms of forming a family,

8 *Marcia C. Inhorn et al., "Assisted reproduction and Middle East kinship: a regional and religious comparison" in Reproductive Biomedicine & Society Online (2017). Available at https://www.sciencedirect.com/science/article/pii/S2405661817300175#!*

9 *KatayounBakhtiyar et al, "An investigation of the effects of infertility on Women's quality of life: a case-control study", BMC Women's Health (2019). Available at https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-019-0805-3*

10 *S.J. Dyer and M. Patel, "The economic impact of infertility on women in developing countries - a systematic review", Facts Views Vis Obgyn (2012). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987499/*

as well as who is counted as having fertility problems. For example, while for heterosexual, HIV-negative, cis-gender, able bodied women, there may be extreme societal pressure to reproduce; for lesbian, gay, bisexual, transgender, and intersex persons, HIV-positive women, and disabled women, their fertility may be discouraged and face barriers when realizing their reproductive intentions, and in some cases they have even been sterilized to prevent their reproduction. Similar stereotypes apply to minority and indigenous women in many contexts.

Analysing infertility from a human rights perspective therefore requires attention to wider structural discrimination across several dimensions, and an intersectional approach, in order to understand the barriers women from certain groups face when realizing their reproductive intentions.

1.4 Objective

1.4.1 Broad Objective:

- To explore socio-political and gender aspects of infertility issues in Bangladesh and way forward.

1.4.2 Specific Objectives:

- To explore community level knowledge regarding infertility and study social norms and attitude towards infertility;
- To understand how infertility issues are affecting different segments of people (*i.e.* men, women, people from gender diverse community);
- To examine relevant policies at the national level intersecting infertility and SRHR;
- To identify different treatment options affecting users in infertility-case management comprehensively;
- To suggest specific recommendations for addressing infertility

2. Methodology

This study mostly relied on qualitative methodology to identify the subjective experiences and thoughts of a few but significant relevant individuals.

- **Conducting Qualitative Study while collecting Case studies**
  In the first phase, the study focused particularly on the social and environmental factors which lead certain women and individuals to experience psychological stress and mental health problems connected to infertility. This study also explores how they navigate issues of infertility. Case studies were collected through KIIs from the couples who have experienced infertility. Couples and other respondents for in depth qualitative study were reached with the help of infertility treatment centers and strict ethical guidelines were followed while interviewing them. However, to include gender diverse communities in the study, information was also collected from people belonging to diverse gendered communities.

The framework for the qualitative study is as such:

Categories of respondents	Number of KIIs
Women experiencing Infertility	3
Men experiencing Infertility	2
People from diverse gender community	4
Officials/Experts working on infertility treatment	2
Couples who got positive result after taking infertility treatment	2
Total	**13**

- **Conducting FGD with people in general**
  To understand people's perception regarding infertility and to explore how those contribute to create the discourse regarding infertility, an FGD was conducted in Dhaka University premises with random people. There were both combination of male and females and they were from different disciplines.

- **Advocacy Workshop**
  As it is still doubtful if there is any particular policy or amendments regarding infertility, an online Advocacy Workshop was conducted including relevant bodies like DGHS, DGFP, MoWCA, The Obstetrical and Gynaecological Society of Bangladesh (OGSB, a National forum of Obstetricians and Gynaecologist of Bangladesh), Infertility Treatment Centers, Media and other experts in order to identify scopes of developing policies regarding infertility (List of the participants is attached as Annex).

2.1 Ethical Consideration

While conducting content analysis with the secondary data, proper referencing was ensured to validate the arguments. While collecting primary data, research objectives were articulated. To protect informant's rights, they were informed of all data collection devices and activities. Their consent was taken verbally. There was no provision of taking written consent from the informants as they may consider it as a concern of insecurity to sign in papers placed by outsiders even though they can read. However, verbatim transcriptions and written interpretations will be kept confidentially considering the rights, anonymity, interests and wishes of informants.

3. Findings

Though this study is a small-scale one, the insights achieved from the respondents were quite significant that sketches different social perceptions, practices, aspirations and services regarding infertility. This study did not look for actual data of how many persons are experiencing infertility in our country, but this study help assume that there are crucial social issues like, frustration, depression, anxiety, psychological disorder, marital conflict, comments from family, friends, neighbors, society, social isolation, economic deprivation marital instability as the consequences of infertility. There are still different loopholes to address infertility from the perspective of Human Rights. However, the findings of the study will open room for discussion.

3.1 Infertility is a rising social concern

As soon as an attempt has been taken to unfold the situation on infertility, it has been known from the service providers and people in general that cases of infertility is on rise in the recent years. More people are being revealed to be infertile, more people are seeking treatment. Though the number has increased, as the issue is less prioritized, there is huge gap between scientific knowledge and people's perception and practices that has many other social implications.

3.1.1 Lack of knowledge and misconceptions on infertility persists

Even though family planning has become a buzzword in Bangladesh, people in general hardly have knowledge on infertility. People know that having no child may be referred to infertility in the simplest term, but the time period for determining infertility is not known. People have no idea if there is any preventive method; they still have doubt if all the "modern (e.g. IVF)" treatment of infertility should be taken as "permitted by religion". Cases of seeking unauthorized local treatment are still commonplace in our country. Respondents in the FGDs said that they have heard of using "Tabij", "Panipara" as the treatment of infertility. Even people who are taking treatment for conceiving, still do not know the causes behind their problem. Though in most of social development issues, the more educated and more economically sound people seem to have better knowledge, in case of infertility people from all economic and educational background seem to have the same confusions, only few exceptions are there. As one of the respondents in FGD said,

> *"I know one couple, who are educated, has university degrees and they live in a prominent area in Dhaka, you can assume their status, they are trying to have a baby. I do not know whether they tried any scientific treatment or not, they bring "panipara" from our village with the hope of a baby."*

3.1.2 Lack of knowledge in the service area leading to infertility

In any particular case of infertility, the cause is immediately identified as physiological. However, there are many other

interlinked factors that may lead to infertility, such as lack of knowledge. The FGD respondents shared stories where seeking local treatment for ovarian infection resulted in infertility.

Unsafe abortion and unsafe MR both are taking place due to lack of knowledge among the authorized service centers and these practices can be the reasons behind infertility.

3.1.3 Lifestyles issues are threatening fertility

Rising exposure to electronic devices that effuse heat and radiation are making people, men in particular prone to infertility, as the respondents of FGD said referring to few online reports.[11] From such references it can be conferred 'that the correlation might be right as both exposure to electronic devices and cases of infertility are rising proportionately.

Service providers and experts opined that obesity, excessive consumption of coffee, alcohol, having multiple sexual partners (prone to contract sexually transmitted diseases), having co-morbidities (TB), stress conditions all have negative impacts on fertility.

3.1.4 Socio-economic discrimination effect both fertility and treatment of infertility

The cost of infertility treatment is still high and centered to the capital which is not affordable for all. Historically the policy mindset is missing for designing a comprehensive package in a planned-way (primary care-secondary care-tertiary care) for 'Infertility' case management. If we look into the service delivery structures of the two directorates of the MOHFW, we can see a visible negligence with regard to service provisioning of Infertility Care. Some examples are given below:

11 *https://timesofindia.indiatimes.com/life-style/parenting/getting-pregnant/late-night-use-of-gadgets-can-cause-male-infertility-study/articleshow/80302210.cms*

Public Health System

DG Family Planning: Here, service delivery is solely designed focusing on MCH-FP, meaning for reducing fertility. This is mainly because of population size in Bangladesh. As a consequence, by default 'Infertility' case management has been sidelined.

DG Health: In this Directorate, the presence of Community Clinics, which are situated close to community people with potentials for primary screening, counseling and referring infertility cases in respective health facilities for proper care. However, in reality these are not happening in a planned way.

Private Health System

In the private sector, even though there are available infertility case management facilities, those are designed with profit making goals, with limited or no counseling support for couples to understand the problems and to way-out to a comprehensive case management plan.

Though the respondents from Mohammadpur Fertility Services and Training Center, the only government service center for infertility in Bangladesh, said that the diagnosis cost and doctors' fees are reasonable there, the cost of medicines there are indeed high (one injection per month cost BDT 11 to 12 thousand), which they need to take for long run. Despite the MFSTC, diagnosis cost is very much expensive.

On the other hand, the preventive measures are also being affected by socio-economic status. As the experts from the advocacy workshop said, many cases of infertility are treatable only with nutritional supplements. Due to lack of awareness and affordability, a large number of people in our country are having nutritional deficiency and becoming more prone to infertility.

3.2 Infertility is a gendered concern

Infertility is a medical issue; it has certain social dimensions as well as gendered dimensions. People belonging to different gender identity have different experiences.

3.2.1 Women have to shoulder the guilt of infertility

Being a mother is considered as utmost goal of a woman. Thus, infertility mostly leads to rejection, social stigma and inferiority. During the KIIs female respondents shared their experiences of being humiliated, stigmatized for not being able to reproduce. As one (female) respondent said-

> *"I cannot even take any other's kid at my lap, my mother-in-law scolds that when I cannot hold my own kid, I should be ashamed before touching any kid."*

The relatives often suggest the husbands to remarry. Though the husbands in the interviews were found to be supportive, the peer pressure was truly heart-breaking. Some women accept violence and abuses because they think they deserve these because of their childlessness.

Though anyone of a couple can be infertile, at first women are suspected to be the guilty. One (male) respondent said that when they were not having any kid, they tried several things for the wife. After so many years they came to know that it was he actually and then started taking treatment for himself.

3.2.2 It is harder for men to accept their inability to reproduce

Undoubtedly, women experience most of the turmoil due to their inferior status in society, such disruption is just another feather in the whole wing of oppression. But as men in general are accustomed to most of the social privileges and celebrations, inability to reproduce clashes with their masculine identities which they just cannot accept. Hence, firstly men cannot accept their inability to reproduce, secondly, they hide it and thirdly, they avoid seeking treatment.All of these three traits have severe psycho-social implications.

3.2.3 People from gender diverse community have the most complex experience

The way our society want women and men to have children, it denies the perspectives of gender diverse community to reproduce the other way, even though they may be biologically fertile.

Throughout the dialogue with few people from this community, it was revealed that “Hijras” are born male living female life (except intersex). Some are post operatives. Some are with male genitals. But the relationship they prefer to have is with male partners, where biological reproduction is absolutely impossible. Outside the Hijra Parampara life (Hijra culture of living under the leadership of Guru. This culture is rich in particular rituals and practices.), reproduction has never been an obstruction. Even the most powerful ‘Gurus’ can produce children and maintain both of the parampara and family life as the same time though it is not widely practiced or encouraged somehow.

But when any person from such community want to live like a woman as she feels to be so, she feels the urge of motherhood. When for an infertile couple adopting a child

is quite acceptable, it is not an easy task for the Hijras; no orphanage or anybody allow them to adopt. They can only adopt the most unwanted kids, mostly from the sex workers. But it is still not the whole story. When a Hijra person bears kids anyway, when the kids grow up, they deny calling them "mother"; they deny any relationship with them for being "Hijra". Thus, they are the most deprived of all.

3.3 Positive changes have started to take place

The policy commitments of our government to SDGs highlighting diversity, equity and inclusion, are all the welcoming initiatives towards addressing the plights of women, families suffering from infertility. However, relevant stakeholders have started thinking of infertility as a crucial concern.

Professor Parveen Fatima, Founder Chairman of Reproductive Endocrinology and Infertility (REI), BSMMU and pioneer in infertility treatment informed that she has started working on infertility in Bangladesh since 1999. According to her-

> *"I successfully introduced Test Tube Baby in Bangladesh. Initially the sector was narrow but that expanded gradually. Currently, there are many centres which work intensively on infertility. Even the government has started to think of it in a way that there are two hospitals in the family planning sector that are working on infertility, not on IVF treatment, but at least on the baseline."*

According to Dr. Md. Jaynal Haque, Program Manager (A&RH), MCH-Services Unit-

> *"Maternal health related programmes at field level, which are conducted from the Directorate General of Family Planning, includes the preventive measures like counselling and referral. Though infertility is still absent in policy, it will be included in the upcoming operational plan".*

Regarding the treatment of infertility, Muniruzzaman Siddiqui, Director of MFSTC agreed that there is a shortage of facilities from government side. Still, MFSTC is providing many services except IVF. As he informed-

> *"Under the leadership of Dr. Nasrin Sultana, MFSTC has already arranged training programme abroad for the service providers which ensures that priority for infertility treatment is increasing from the government side. The poor people, who cannot afford the private clinic, can come to MFSTC."*

Throughout the study, advocacy with government officials and relevant stakeholders was successful to draw a commitment of addressing infertility in the upcoming operational plan. As Dr. Mohammed Sharif, Director (MCH-Services), & Line Director (MC-RAH), DGFP just reassured that

> *"Bangladesh has already achieved tremendous success in Public Health. Infertility has been taken under consideration to be included in the upcoming operation plan. DGFP is ready from the administrative side."*

For gender specific psycho-social counselling, there are emerging institutions which give opportunities for addressing infertility issue. For example, the Department of Clinical Psychology in Dhaka University. There are also Infertility centres in public and private sectors with psycho-social counselling wings.

A few pharmaceutical companies started to manufacture the medicines in Bangladesh that may cost less than the foreign medicine.

4. Conclusion and Recommendation

Infertility needs to be built-in with the perspective of Universal access to SRHR. Relying on the goodwill of physician and other relevant stakeholders, few recommendations can be suggested to uphold the present situation.

However, few specific recommendations can be as follows:

1. Research: Researches on Infertility can be the first step for finding solutions as it will provide statistics on the affected people in Bangladesh as well as the socio-cultural dimensions and interconnection among different medical-non medical factors regarding infertility. Though we have come a long way in the Bio-Medical field, social perspectives are hardly present in that. The scope for social research in this field is still narrow, and experiences of men who struggle to reproduce a child are missed largely. When following SDG we proceed leaving no one behind, people belonging to marginalized community like disability, sexual orientation and gender identity (SOGI) all should be in the discussion, every person's concern need to be heard.

Prof. Dr. Saleha Begum Chowdhury, immediate former Secretory General, OGSB, rightly pointed out that-

> *"We only know from few researches that women are humiliated, battered, abandoned etc. Reality can be much more severe. So the need of research is a must."*

Indeed, knowledge from social research will help bring light to the policy makers.

2. Sensitization: In Bangladesh, people in general, even the service providers to some extent are the ones who make insensitive comments to people not being able to have a child, and increase the mental stress. It is important to sensitize people on how to talk on this issue. Definitely infertility treatment is improving day by day; there will be certain cases of infertility which will never be treatable. So people in general must accept that and needs to be empathetic towards that.

3. Focus on Prevention: As Professor Jesmin Banu, Chairman, Infertility, BSMMU suggested-

> *"To reduce infertility we need to work on prevention, we need to address unsafe abortion, obesity in adolescent, adolescent endometriosis to which causes infertility."*

As soon as infertility came forward as a social concern, lack of knowledge, nutritional deficiency all were identified as hidden causes of infertility. In this regards Professor Parveen Fatima, Founder Chairman of Reproductive Endocrinology and Infertility (REI), BSMMU suggested that-

> *"Nutritional Factor is very much important. 80% infertility is being cured with Vitamin D and other nutritional supplements, which are not even costly at all. But these require awareness. Even there are cases when husband and wives are not cohabiting in a proper way. Hence the health visitors may go to the couples and create a favorable environment to discuss these all."*

Dr. Parveen Faima also urged to prioritize life planning. In

recent time, people are more to education and career but they are failing to combine the plan of having babies. Delaying is often causing infertility. Hence people need to be more thoughtful in this regard.

4. Integrating Counseling: As Infertility is not seen beyond its medical perspective; its effect on a person's mental health is ignored. Counseling facilities must be made available to all people who are going through infertility as they always face mental trauma and distress.

5. Consideration of adoption: Legal adoption of children is not a common procedure in Bangladesh. Also, many people are either not willing to adopt, or not inspired to adopt. Moreover, adoption laws are not friendly for single people and people from gender diverse community. If the adoption laws are revised, and if campaigns are carried out to make people realize the beauty of adoption, then many people can experience the beauty of parenthood and many children can have parents.

6. Developing a Guideline: Infertility must be considered as a core SRHR issue and must get national attention in order to raise advocacy and awareness. Most importantly, there needs to be a proper guideline. It is urgent that a comprehensive guideline and policy on infertility should be framed. MOHFW has a wide scale Health System structure covering community, union, upazilla, district, division and national level which can be utilized for addressing Infertility cases holistically.

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Annex

List of participants in the Advocacy Workshop for Developing Knowledge Product on Infertility in Bangladesh

Name	Designation
Dr. Mohammed Sharif	Director (MCH-Services), & Line Director (MC-RAH), DGFP
Dr. Md. Jaynal Haque	Program Manager (A&RH) MCH-Services Unit, DGFP
Dr. Farid Uddin Ahmed	Deputy Director (MCH& MH), DGFP
Dr. Azizul Alim	PM, Maternal Health, DGHS
Muniruzzaman Siddiqui	Director, MFSTC
Prof Dr. Sameena Chowdhury	Former President & Chairman, OGSB hospital
Prof. Dr. Saleha Begum Chowdhury	Immediate Past Secretory General, OGSB

Name	Designation
Prof Fatema Rahman	Prof of OBGYN & Head of Reproductive endocrinology and infertility
Prof. Jesmin Banu	Chairman, Infertility, BSMMU
Prof Parveen Fatima	Founder Chairman of Reproductive Endocrinology and infertility (REI), BSMMU
Dr. Nighat Sulatana	Medical Officer, BAPSA
Dr. Helena Jabeen	Senior Consultant (Gynae & Obs) MFSTC
Dr. Nasrin Sultana	Asst. Professor, MFSTC
Dr. Sayed Saikh Imtiaz	Professor, Department of Women and Gender Studies, University of Dhaka Advisor, Center for Men and Masculinities Studies
Shamima Akhter Chowdhury	Freelance Consultant
Tahia Rahman	Executive Director, Center for Men and Masculinities Studies

Brief report on Advocacy Workshop

The study required to examine relevant policies at the national level intersecting infertility and SRHR. As it was doubtful if there was any particular policy or amendments regarding infertility, the research team suggested conducting an online Advocacy Workshop including relevant stakeholders in order to identify scopes of developing policies regarding infertility. In this regard, an online advocacy workshop was conducted via zoom on 17th November, 2021 at 2:30 pm.

In the event there were respected stakeholders joining from different bodies, mostly relevant to health and fertility concerns. Ms. Shamima Chowdhury facilitated the workshop.

In the beginning, after brief introduction of the participants, Ms. Tahia Rahman presented a short presentation on Fertility Situation in Bangladesh. While presenting available statistics on infertility, she clarified the objective of the study that mostly infertility is seen as a medical issue but it has broader social perspectives and hence this study tries to reveal those so that policy measures can be taken. Dr. Imia, lead researcher and chair of this ICoP added that though we have succeeded a lot in bio-medical sector, we ignore the social dimensions and in case of infertility, it is mostly though as woman's issue, experiences of men, how infertility creates masculine crisis are still to be explored. Hence stands one of the core objectives of initiating this study.

After her presentation the floor was open for discussion. Honorable participants conveyed their gratitude for initiating such study as they really felt it was very much needed. The practitioners and government officials informed that though there is still lack of proper guideline or policy, work on infertility has been on progress and the government has plan

to take it as a priority concern and in the next operation plan, infertility will be under consideration.

Lastly, they all urged to work together with the hope that such research activities will be being conducted onward so that more can be learn on this issue.

Informants of KIIs:

1. Dr. Nighat Sultana, Medical Officer, BAPSA
2. Dr. Julia Ahmed, Independent Consultant (Sexual Reproductive Health Rights, Health System Strengthening, Gender Mainstreaming)

Data Collection Tools:

Target Group/ List of Interviewees	Data Collection Tool	Checklist/Key questions
(wo)men having problems giving child birth	**4 KIIs (2 with men+2 with women having problems giving child birth)**	1. Demographic information (Age, occupation, location, family structure etc.) 2. How would you define infertility? How is it a problem in your society? 3. How has infertility issues impacted your life? 4. Would you please explain or give specific examples of incidents that specifically show impact in your life? 5. Do you know about the treatment of infertility? Would you please tell us about treatment regimens available for infertility in Bangladesh? 6. How have you accessed or failed to access such treatment regimens?

Target Group/ List of Interviewees	Data Collection Tool	Checklist/Key questions
		7. What stage of treatment are you in right now? Where did you seek remedies? How did you decide to seek treatment? 8. Would you please tell us why a couple fails to get a child? 9. What is your opinion regarding the impact of STI/RTI on infertility? Please explain. 10. How would you evaluate the existing treatment facilities available in Bangladesh? Please state some good and bad characteristics/features of the available facilities. 11. Who has been the most supportive among your family/ peers/ community? What made them so supportive? 12. How as a man/woman you think you have faced discrimination in the society for not being able to give birth to a baby? 13. How can we build better acceptance of not having child at the family and community levels? 14. How could we integrate infertility issues in national curriculum? 15. How could adopting a child be an alternative to infertility problems? Would you please elaborate your thought about this?
Officials/ Experts working on infertility treatment	**2 KII**	1. Qualifications, designation, areas of interest in regards to infertility.

Target Group/ List of Interviewees	Data Collection Tool	Checklist/Key questions
		2. Do you think there are enough provisions of services to treat infertility in Bangladesh? How do you see the quality of the services? What are the significant strengths and drawbacks in infertility treatment in Bangladesh? What are your recommendations to address the existing challenges? 3. Do you think services are available equally for people from different gender, socio-economic backgrounds, and geographical locations? What are the common socio-economic characteristics of service receivers? 4. What factors do you think drive to infertility? 5. Is there provision of infertility treatment services for the gender-diverse population? What do you think about this? 6. Is there any provision for gender specific psycho-social counselling for infertile person? 7. Has there been any endeavours to remove the social stigma around infertility by your organization?

Target Group/ List of Interviewees	Data Collection Tool	Checklist/Key questions
		8. Do you think the current policies adequately and effectively address the issue of infertility? If not, what policies can be reframed? What can be done better? 9. What are the success rates of your treatment? Has there been any significant change in the pattern of infertility service uptake? Do you think the prevalence of infertility has significantly increased or decreased over the years? 10. What are the views on the expansion of infertility education? 11. What role do you play to remove the social stigma around infertility? If not, why?
Couple who has got positive result after taking infertility treatment	**2 KIIs**	1. Demographic information (Age, occupation, location, family structure etc.) 2. How has infertility issues impacted your life? 3. Would you please explain or give specific examples of incidences that specifically show such impact in your life? 4. Would you please tell us about treatment regimens available for infertility in Bangladesh? 5. How did you decide to seek treatment? How have you accessed such treatment regimens?

Target Group/ List of Interviewees	Data Collection Tool	Checklist/Key questions
		6. Would you please tell us why a couple fails to get a child? 7. What is your opinion regarding the impact of STI/RTI on infertility? Please explain. 8. How would you evaluate the existing treatment facilities available in Bangladesh? Please state some good and bad characteristics/features of the available facilities. 9. Who has been the most supportive among your family/ peers/ community? What made them so supportive? 10. How as a man/woman you think you have faced discrimination in the society for not being able to give birth to a baby? 11. How can we build better acceptance of not having children at the family and community levels? 12. How could we integrate infertility issues in the national curriculum? 13. How could adopting a child be an alternative to infertility problems? Would you please elaborate your thoughts about this?

Target Group/ List of Interviewees	Data Collection Tool	Checklist/Key questions
Gender Diverse Community	**2 KIIS**	1. Demographic information (Age, occupation, location, family structure etc.) 2. When have you got to know about your sexual orientation? 3. Would you like to continue your life in "Parampara" or would you like to have some heir (reproduction of children)? Would you feel any threats/risk regarding this? 4. Do you think that a gender diverse community is deprived of the right of reproduction? What would you recommend to change this?
Community people	**FGD**	1. What do you know about infertility? How do you see infertility? What do you think are the causes behind infertility? How did you know what you know about infertility? 2. Do you think infertility is treatable? How should we address the issue of infertility in families and communities? 3. What are the available treatment options that you know about? Are these available in your locality? 4. Do you have any dearest one with infertility? What is your feeling to him/ her?

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