Monograph 6

Population Management Issues

General Economics Division (GED)

(Making Growth Work for the Poor)

Planning Commission, Ministry of Planning

December 2021

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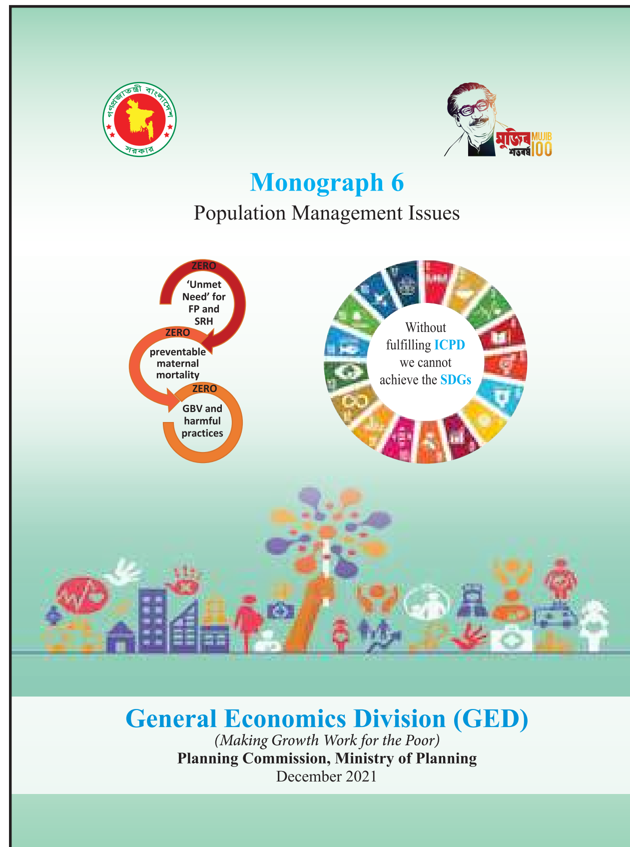
Population Management Issues



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M. A. Mannan, MP
Minister
Ministry of Planning
Government of the People's Republic of Banglades

MESSAGE

It gives me immense pleasure to learn that the General Economics Division (GED) of the Bangladesh Planning Commission has generated evidence-based knowledge and information on emerging critical population issues, e.g. 'ICPD Commitments of 3 Zeros: Actions and Strategies in Bangladesh'; 'Gender Based Violence: A challenge for Reaching SDGs'; 'Addressing High Unmet Need for Family Planning and its Subsequent Impacts on Adolescent Pregnancy and Maternal Mortalities and Morbidities in Bangladesh'etc. The decision to publish Monograph-6: Population Management Issues containing three important policy papers prepared under the IPDIPP project is a praise worthy step.

The population strategy adopted in the 8FYP (July 2020-June 2025) rightly emphasized on rapid recovery from Covid-19 to restore human health, employment, income and economic activities, GDP growth acceleration, social mobilization to stop child marriage and prevent gender based violence, increase female participation in the labour force, employment generation and rapid poverty reduction. The plan suggested a broad-based strategy of inclusiveness with a view to empowering every citizen to participate in full and gain benefit from the development process, and helping the poor and vulnerable with social protection-based income transfers. Population planning should be taken into consideration to maintain a balance between population, development and environment.

The policy papers have been prepared through extensive consultations with the representatives of concerned Ministries/Divisions, Agencies, population experts, development partners, academia, researchers, civil societies, think tanks and NGOs. I thank all of them for their active participation, valuable cooperation and contribution in the process. It is worthy to mention that this document would enable to see the current situation critically, identify the gaps in the existing policies and help to guide the macro and micro planning process to face the challenges for effective population management to advance the International Conference on Population and Developmet (ICPD) Plan of Action (PoA) and achieve SDGs.

I would like to appreciate GED officials for providing their efforts in preparing this Monograph, which will be beneficial for the policy makers, researchers, academia, planners and development partners dealing with the population management and development issues. I also appreciate UNFPA for their contribution in preparing this Monograph. I would humbly wish wide circulation of this important policy document to impact progressive social and economic changes.

(M. A. Mannan, MP)

Dr. Shamsul Alam
Minister of State
Ministry of Planning
Government of the People's Republic of Bangladesh

MESSAGE

It is indeed a great pleasure for me to know that the General Economics Division (GED) of the Bangladesh Planning Commission has prepared several evidence-based policy papers and briefs on emerging critical population issues, e.g. 'ICPD Commitments of 3 Zeros: Actions and Strategies in Bangladesh'; 'Gender Based Violence: A challenge for Reaching SDGs'; 'Addressing High Unmet Need for Family Planning and its Subsequent Impacts on Adolescent Pregnancy and Maternal Mortalities and Morbidities in Bangladesh'etc. These policy papers focused on the challenges towards achieving the commitments of International Conference on Population and Development (ICPD) Programme of Action (PoA), root cause of gender-based violence, challenges of family planning and reproductive services in Bangladesh and its impacts on health and various development indicators in relation to exploring effective strategies for achieving national and international development goals. This is really encouraging to know that these knowledge and information will be used as inputs during the preparation of National Plan and policies that will contribute to advance the International Conference on Population and Development (ICPD) Programme of Action (PoA) and reaching the Sustainable Developmental Goals by 2030.

In order to effectively realize the government's Vision 2041 as well as the SDGs by 2030, GED has prepared the Eighth Five Year Plan (July 2020-June 2025), which emphasized on appropriate policies and institutions, and devised suitable development strategies for promoting prosperity, fostering inclusiveness, reducing poverty, and inequality. Bangladesh has undergone remarkable demographic, social, economic, environmental, and political changes over the past 25 years and made substantial progress in reducing TFR, maternal mortality, child marriage and increasing education and income levels, including by improving the educational and economic status of women.

Currently, the population of Bangladesh is largely made up of young people, with roughly half aged under 25 years. The population dynamics have changed, and age structures are more favorable to economic development than they were previously, population growth would nevertheless continue and this will have profound implications for development and hence, need utmost proper planning by integrating critical population issues. The country is already halfway through the demographic "window of opportunity" period as the dependency ratio started to decline in the 1990s. Planning Commission has a key role in development planning and public expenditure management. GED has been working with Ministries/Divisions in adopting necessary actions and programmes to achieve the strategies and targets outlined in the 8FYP. Besides, IPDIPP Project of GED is advocating in adopting appropriate investments, policies and governance, so that Bangladesh can take huge advantage of this 'demographic bonus'.

Effective implementation of the plans and programmes will mostly rely on the actions taken by the respective Ministries/Divisions and stakeholders from both public and private sectors. In this situation, Monograph-6 will help to guide the macro planning process to face the challenges for population management to achieve the goal of attaining maximum from our human resources.

I would like to appreciate GED officials for providing their efforts in preparing this Monograph, which will be beneficial for the policy makers, researchers, academia, planners and development partners dealing with the population management and development issues. I would like to take the opportunity to thank UNFPA for providing necessary supports in preparing this Monograph through the project "Strengthening Capacity of the General Economics Division (GED) to Integrate Population and Development Issues into Plans and Policies". I would like to wish wide circulation of this important policy document to impact progressive social and economic changes.

(Professor Shamsul Alam)
M.A. Econs., PhD

Dr. Md. Kawser Ahmed
Member (Secretary)
General Economics Division (GED)
Planning Commission

FOREWORD

At the fifty years' celebration of our great victory of independence and the joyous Mujib birth centenary, the General Economics Division (GED) of Bangladesh Planning Commission has prepared the monograph on 'Population dynamics and Development issues' by compiling policy papers and policy dialogues conducted by the 'Strengthening Capacity of the General Economics Division (GED) to Integrate Population and Development Issues into Plans and Policies' (IPDIPP) project during 2019-2021. The Monograph-6 contains three policy papers -i) ICPD Commitments of 3 Zeroes: Actions and Strategies for Bangladesh; ii) Gender based violence: A challenge for reaching SDGs; and iii) Addressing high unmet need for family planning and its subsequent impacts on adolescent pregnancy and maternal mortalities and morbidities in Bangladesh. These policy papers were produced to generate evidence based knowledge on critical population dynamics and its functional linkages to socioeconomic development along with emerging issues to advance the International Conference on Population and Development (ICPD) Programme of Action (POA) and reaching the Sustainable Developmental Goals (SDGs) by 2030.

Bangladesh Government has taken several steps as per its commitment to the ICPD Plan of Action (POA) to overcome the challenges of three zeroes, i.e. zero unmet need for contraception, zero preventable maternal deaths, and zero gender-based violence and harmful practices, and has made significant progress in this regard. The Maternal Mortality Ratio (MMR) per 10000 Live Births declined significantly both in urban and rural areas during 2001 to 2020. However, some challenges still remain in this area such as high incidence of gender based violence which is one of the key obstacles for women's empowerment. The percentage of child marriage of the women in Bangladesh is the highest in the South Asian Region, which is 58.9 percent as per BDHS (2017-18) Survey. We have to go a long way to achieve the ultimate success in terms of three zeroes. Achieving ICPD Programme of Actions (POA) and SDGs require establish an interrelationships between population dynamics, available resources, the environment and social and economic development for a harmonious and sustainable development. Bangladesh aspires to become an upper middle-income country by 2031 and be a developed economy by 2041. The country also has a strong commitment in achieving the targets of the SDGs by 2030. Appropriate policy measures and programmes need to be taken to achieve the long-term and medium-term goals and targets of the country.

Under this background, IPDIPP project of GED has taken initiatives to prepare policy papers on various critical emerging issues related to population dynamics and development and also conducted workshops and policy dialogues, which provided space for different relevant stakeholders to provide their important

views, comments, observations on the topics. I would like to take the opportunity to express my whole-hearted gratitude and thanks to Dr. Hossain Zillur Rahman, Executive Chairman the Power and Participation Research Centre (PPRC), Dr. Sayed Saikh Imtiaz, Associate Professor, Department of Women and Gender Studies, University of Dhaka and Dr. Abu Jamil Faisel, Former Country Representative, Engender Health & Reproductive and Sexual Health Specialist for their hard works in preparing the policy papers included in the Monograph-6. I am grateful to all the participants for their valuable feedback/comments/observations to the policy dialogues and workshop, which enriched the policy papers.

I would like to take this opportunity to thank all team members of IPDIPP project including concerned GED and UNFPA officials for their hard work and notable efforts in preparing the Monograph 6. This population monograph would not have been possible without the generous contribution of the UNFPA. I specially thank our Hon'ble Minister, Ministry of Planning Mr. M.A. Mannan, MP and Hon'ble Minister of State, Ministry of Planning Dr. Shamsul Alam for their kind intimate supports and inspirations in bringing out such an evidence based publication.

I hope this Monograph-6 will be useful for the policy makers, research communities and others in enhancing the knowledge and understanding on various population dynamics and development issues discussed in the policy papers. The information and recommendations would also be highly valued in adopting appropriate polices in respective areas.

(Dr. Md. Kawser Ahmed)

ACKNOWLEDGEMENTS

The General Economics Division (GED) acknowledges the valuable contribution of all concerned from the Ministries/Divisions, Development Partners, NGOs and CSOs in preparing the Monograph-6. The GED carried out the task under close guidance of the Hon'ble Member (Secretary), GED. I also appreciate the United Nations Population Fund (UNFPA) for providing necessary technical and financial supports in preparing and printing the Monograph through the "Strengthening Capacity of the General Economics Division (GED) to Integrate Population and Development Issues into Plans and Policies (IPDIPP)" Project. The Monograph-6 has been prepared by compiling three policy papers and the outcomes of the policy dialogues conducted by the IPDIPP project on-i) ICPD Commitments of 3 Zeroes: Actions and Strategies for Bangladesh; ii) Gender based violence: A challenge for reaching SDGs; and iii) Addressing high unmet need for family planning and its subsequent impacts on adolescent pregnancy and maternal mortalities and morbidities in Bangladesh.

I would like to take the opportunity to express my whole-hearted gratitude and thanks to Dr. Hossain Zillur Rahman, Executive Chairman the Power and Participation Research Centre (PPRC), Dr. Sayed Saikh Imtiaz, Associate Professor, Department of Women and Gender Studies, University of Dhaka and Dr. Abu Jamil Faisel, Former Country Representative, Engender Health & Reproductive and Sexual Health Specialist for working hard and putting all efforts to prepare policy papers and made keynote presentations in the policy dialogues. I am profoundly grateful to our Hon'ble Minister, Ministry of Planning Mr. M.A. Mannan, MP and Hon'ble Minister of State, Ministry of Planning Dr. Shamsul Alam for their kind supports and guidance in preparing the monograph. I would also like to express my deep gratitude to Dr. Md. Kawser Ahmed, Member (Secretary), GED and Mr. Md Mafidul Islam, Chief, GED for their valuable contributions, directions and guidance.

I believe analysis, findings and policy recommendations would help in generating knowledge, deepening understanding of policy makers, academics, researchers, Government officials and national experts on how to capitalize demographic dividend by adopting right social and economic investments and policies in these areas. All these will definitely lead us to a better direction on how the demographic benefits can be accelerated, prolonged, and directed towards reaching the ICPD Programme of Actions (POA) and Sustainable Developmental Goals by 2030. I extend my sincere thanks to all team members of IPDIPP project, concerned Government and UNFPA officials for their support and contribution.

(Dr. Munira Begum)
Joint Chief, GED and Project Director

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Dr. Hossain Zillur Rahman

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Gender Based Violence: A Challenge for Reaching SDGs

Dr. Sayed Saikh Imtiaz

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Addressing High Unmet Need for Family Planning and its Subsequent Impacts on Adolescent pregnancy and Maternal Mortalities and Morbidities in Bangladesh

Dr. Abu Jamil Faisel

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POLICY PAPER: 1

ICPD Commitments of 3 Zeroes:
Actions and Strategies for Bangladesh

Prepared by

Dr. Hossain Zillur Rahman*

December 2020

***Executive Chairman,** *Power and Participation Research Centre (PPRC)*

Acronyms

BDHS	Bangladesh Demographic and Health Survey
BMMS	Bangladesh Maternal Mortality and Healthcare Survey
CSE	Comprehensive Sexuality Education
DGHS	Directorate-General of Health Services
DGFP	Directorate-General of Family Planning
DH	District Hospitals
FP	Family Planning
GED	General Economic Division
ICPD	International Conference on Population and Development
LAPM	Long Acting Planning Method
MCH	Mother and Child Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal Newborn and Child Health
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government Rural Development and Co-operatives
NEET	Not in Education, Employment or Training
ORS	Oral Rehydration Solution
PPRC	Power and Participation Research Centre
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate

Abstract

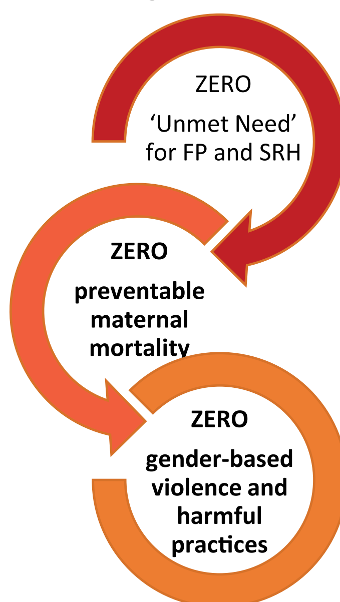
Population goals have been reset at 3 zeroes – zero 'unmet need' for FP and SRH, zero preventable maternal mortality and zero gender-based violence and harmful practices. Bangladesh has a well-recognized history of achievements on population goals but near-term trends underscore complexity of 'last mile' challenges. Significant service disruptions during the Covid-19 pandemic has exposed the systemic weaknesses of FP and SRH services. Compounding such weaknesses is conflicting policy signals on population goals one of whose unintended consequences has been a decay in the field presence of family planning workforce. A systemic vacuum in urban primary healthcare and lack of governance oversight over the dominant role of the private sector in FP and MNCH also serve as critical barriers towards realizing the commitments for 3 zeroes. Policy and action priorities derived from an effective reading of ground realities are a strategic urgency. The approach has to be one of phased action plans, innovative engagement with key stakeholders including the youth and policy advocacy to establish broad policy buy-in.

1. RESETTING GLOBAL POPULATION AGENDA: ICPD25 AND THE COMMITMENT FOR 3 ZEROES

The International Conference on Population and Development (ICPD) in Cairo, 1994 first signaled a paradigm shift in how the global community prioritized approaches to population policy. Cairo marked a shift from bureaucratic notions of population control to empowering notions of choice and enabling conditions. Twenty-five years down the line, ICPD 2019 in Nairobi dubbed ICPD25 has further reset the agenda focusing both on 'unfinished business' and an action plan driven by closer attention to ground realities.

ICPD25 crystallized global population agenda around three core commitments (Figure: 1):[1]

Figure: 1



Government of Bangladesh, represented at the conference by Minister for Health & Family Welfare, Minister for Planning as well as Member, GED, Planning Commission in charge of drafting the 8th 5YP, has endorsed these commitments and prioritized preparation of actions and strategies to attain these goals.

2. POPULATION POLICY IN BANGLADESH: A HISTORY OF ACHIEVEMENTS

2.1 Fertility decline and primary healthcare success

Bangladesh has been noticeably successful in bringing about a decline in fertility. This remarkable decline at a low level of development - from 6.3 births per woman in 1975 to 2.3 births per woman now[2] has been an outcome of both demand and supply side drivers. A social campaign approach galvanized the demand.[3] A decline in child mortality due to oral rehydration solution (ORS) success against the killer diarrhea gave the confidence to reproductive-age women to opt for smaller families. An effective and accessible supply chain on contraceptives played its due role.

[1] *UNFPA, 2019, Nairobi Statement on ICPD25: Accelerating the Promise.*

[2] *Bangladesh Bureau of Statistics, 2015, Fertility Differentials in Bangladesh: Trends and Determinants: Population Monograph: Volume 14, Ministry of Planning, Government of Bangladesh*

[3] *Author's conversation with Late Sir Fazle Hasan Abed in 2019*

Population success went hand-in-hand with primary healthcare success: Rise of CPR - 8% in 1975 to 62.4% in 2014 - closely aligned with decline in under-5 child mortality – 143.8 per 1000 live births in 1990 to 32.4 in 2017.[4]

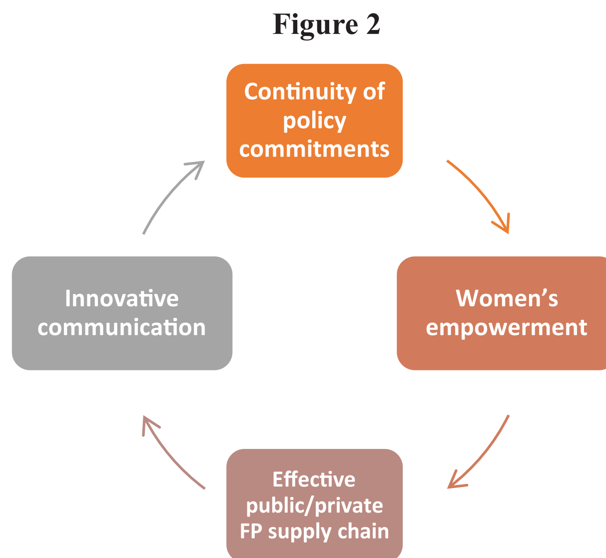
2.2 Contribution to economic success

The fertility decline was not only a signature social achievement but contributed to economic success too. Between 1990 and 2010, a quarter of the incremental per capita income growth can be attributed to the fact that there were lesser people to divide up the economic pie than there would have been if we had continued with the 70s-80s fertility rate.[5]

2.3 Four enabling factors

Four enabling factors stood out in achieving the fertility decline: continuity of policy commitments, unwavering focus on women's empowerment, effective public-private partnership particularly in the FP delivery chain, and, innovative communication to raise awareness among the mass public on family planning, importance of population control and child health (Figure 2).

Figure 2



Conceptualization by Hossain Zillur Rahman, 2019

3. EMERGING CONCERNS ON NEAR-TERM TRENDS

3.1 A problem of premature complacency

While Bangladesh has marked many successes on population goals over the four plus decades of its existence, the preceding decade has brought out several areas of critical concerns. These trends in the ground realities are doubly troubling because early successes appear to have triggered a discourse ambivalence particularly among policy-makers about the urgency of maintaining an unwavering focus on population policy.

A dominant perception of being "on track" due to MDG-era successes actually belies the complexities of the "last mile" challenges that have surfaced in the SDG-era. Table 1 describes four outstanding concerns.

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[4] *NIPORT, 2019, Bangladesh Demographic and Health Survey 2017–18: Key Indicators, Ministry of H&FW, Government of Bangladesh*

[5] *S.R. Osmani et al, 2003, The Macroeconomics of Poverty Reduction: The Case Study of Bangladesh, UNDP; Hossain Zillur Rahman, 2010, Bangladesh 2030: Strategy for Accelerating Inclusive Growth, PPRC/DCCI, Dhaka*

Table 1

Population Goals: Trends and Statistics of Concern

Dimension	*Trend*
Stalled maternal health indicators	Decline in MMR stalled
	Continuing high rates of unintended pregnancies
	Stall in rate of use of long-acting FP methods
Adverse social trends	Age at marriage stuck at 16
	Highest rate of adolescent pregnancy in South Asia
	Worrying rise in gender-based violence
Population density	TFR stalled at 2.3 vis-à-vis target of 2
	Population density overall and urban population density in particular reaching unsustainable limits
Demographic dividend	29.8% of youth not in education, employment or training (NEET)

3.2 Stalled maternal health indicators

Over the long-term, maternal mortality rate (MMR) has declined reasonably well declining from 322 per 100,000 live births in 2001 to 194 in 2010. [6]However, over the preceding decade, the rate of decline appear to have stalled with BMMS 2016 showing no further decline in MMR.[7] The recourse to an alternative data source[8] for 2019 which shows a decline in MMR to 169 has proved controversial both because this data source was never used for MMR estimate earlier thus rendering the absence of a comparable base-line a key drawback. Be that as it may, set against the SDG 2030 MMR target of 70 per 100,000 live births, the policy challenge of being 'off-track' on the MMR target is clear.

[6]NIPORT, 2001 & 2010, Bangladesh Maternal Mortality and Healthcare Survey (BMMS), Ministry of Health & Family Welfare, Government of Bangladesh

[7]NIPORT, 2016, Bangladesh Maternal Mortality and Healthcare Survey (BMMS), Ministry of Health & Family Welfare, Government of Bangladesh

[8]Bangladesh Bureau of Statistics, 2019, Sample Vital Registration Survey (SVRS), Ministry of Planning

To a large extent, the plateauing of MMR is reflective of specific weaknesses in women's access to family planning (FP) and sexual and reproductive health (SRH) services.[9] Various studies suggest rate of unintended pregnancies remain considerably high. [10]Such high rates of unintended pregnancies are driven by unmet need for FP and SRH services. BDHS 2017 reports overall unmet need among married women to be 12% while for the age group 15-24, the rate is 16%.[11] An additional area of concern is the stalled rate of adoption of long acting planning methods (LAPM) which stands at 8.6% against a 2020 target of 20%. The operation of FP services appear to encourage short-term methods which carries its own problem of high rate of discontinuation which stood at 37% in 2017.[12] The problem of unmet need is also seen in the spike in post-partum pregnancy of the older married group in their late 20s and 30s, due to an absence of integrated health-FP service in facilities. Nearly 44 percent of post-partum women have an unmet need for family planning.[13]

The precarious state of MNCH services has also been exposed during the covid-19 crisis which witnessed significant disruptions in MNCH services at district levels.[14] An important factor bearing on maternal mortality is the unwarranted rise in C-section deliveries. 23% of upazila health centres opt for C-section deliveries while the figures are 10% in government hospital and 90% in private hospitals. Poorly executed C-section deliveries can lead to hemorrhage and possible fatality. There are poorly understood sociological factors also to take into account if the goals of reducing maternal mortality rate is to be realized. The increasing privatization of MNCH services often with an over-commercialized mentality results leads to a problem in wide variance in the perceptions of the service-providers and service-recipients regarding delivery post-partum care. The importance of feeling safe and retaining one's sense of dignity is as important as the technical aspect of MNH services. It is important to ensure that the focus on institutional delivery also meets these sociological expectations of women.

3.3 Adverse social norms and trends

The second area of concern is adverse social norms and trends impacting on women's choice and their health. Despite the legal age of marriage being 18, median age of marriage has been stuck at 16.3.[15] The same data source reports that 59% of women aged 20-24 were married before the legal age of 18.[16] The low age at marriage combined with poor access to counseling and FP services have resulted in Bangladesh having the highest rate of adolescent pregnancy in South Asia -108 per 1000 live births.[17]

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[9] *UNFPA, 2020, Ensuring Equity in Access to Services and Effective Contraception: Family Planning in Bangladesh, Policy Brief*

[10] *https:// www.guttmacher.org, 2017/infographic/2017/unintended-pregnancy-Bangladesh*

[11] *NIPORT, 2019, Bangladesh Demographic and Health Survey (BDHS) 2017, Ministry of Health & Family Welfare, Government of Bangladesh*

[12] *ibid*

[13] *Secondary analysis of BDHS 2017*

[14] *Sigma Ainul, Md. Saddam Hossain, Md. Irfan Hossain, Kamruzzaman Bhuiyan, Sharif M. I. Hossain, Ubaidur Rob, Ashish Bajracharya., Bangladesh. COVID-19 and Disruptions in Maternal Health Services in Bangladesh: Evidence from National Level (Routine Service) Data. Research Brief. Dhaka, Bangladesh: Population Council. August 2020*

[15] *ibid*

[16] *ibid*

[17] *Mohammad Mainul Islam, Md. Kamrul Islam, Mohammad Sazzad Hasan, Mohammad Bellal Hossain, Adolescent motherhood in Bangladesh: Trends and determinants, PLoS One. 2017; 12(11): e0188294. Published online 2017 Nov 27. doi: 10.1371/journal.pone.0188294 PMCID: PMC5703513*

A vicious circle of consequences is thus in danger of becoming entrenched. Unmet need for family planning is leading to unwanted pregnancies which is leading to unsafe abortions, which in turn is contributing to a slowing in the decline of the critical SDG indicator of maternal mortality rate (MMR). The persistence of child marriage coupled with a very poor state of education on sexual and reproductive health rights (SRHR) is leading to a disproportionate unmet need for family planning among the 15-19-year olds. A further twist in this near-term trend is that the rate of unwanted adolescent pregnancies is highest among the urban slums.

A related adverse social trend is gender-based violence which can impact women's well-being physically, psychologically, sexually and even economically. Bangladesh Bureau of Statistics in its Violence against Women Survey of 2015 reports 54.7% of ever-married women as having experienced some form of violence in the preceding twelve months.[18]

3.4 Unsustainable population density

The third area of concern is the population density which, within the scarce land mass of Bangladesh, is rapidly reaching its sustainable limits. On current TFR (total fertility rate), the population of Bangladesh will hit 200 million by 2031.[19] Much of this population growth will be located in the cities and, in particular, the burgeoning urban slums. Population Census of 2011 shows that Dhaka City itself had an astounding population density of 55,169 persons per sq.km.[20] Can such densities be sustained if the service needs of the burgeoning population, in particular of women and children, is to be meaningfully met? This is where the stalling of TFR over the last decade at 2.3 as against the target of 2 becomes a critical concern as is the fact that population is still growing at the rate of 1.3%.

3.5 Unrealized demographic dividend

The fourth area of concern pertaining to near-term trends is the demographic dividend. While the annual addition to the workforce is around 2 to 2.3 million, employment creation—both domestic and external—currently can accommodate only half of this number. The statistic which is really alarming is that 29.8% of15-29 yearoldsare currently neither in education, nor in employment nor in training (NEET).[21] These ground realities cast a long shadow on the goal of realizing the demographic dividend and poses troubling question about quality and relevance of prevailing state of education.

[18]*BBS, 2016, Report on Violence Against Women (VAW) Survey 2015, Ministry of Planning, Government of Bangladesh*

[19]*BBS, 2015, Population Projection in Bangladesh: Dynamics and Trends 2011-2061, Ministry of Planning, Government of Bangladesh*

[20]*BBS, Population and Housing Census 2011: National Volume 3: Urban Area Report, Ministry of Planning, Government of Bangladesh*

[21]*BBS, Labour Force Survey 2016-17, Ministry of Planning, Government of Bangladesh*

4. BARRIERS TO PROGRESS ON ‘LAST MILE’ CHALLENGES

What are the key barriers to progress on the adverse near-term trends described earlier? Four groups of factors merit attention here (Figure 3).

Figure 3

Barriers to Progress on ‘Last Mile’ Challenges

Conceptualization by Hossain Zillur Rahman, 2020

4.1 ‘Mission confusion’ on population policy

The first has to do with what may aptly be termed as ‘mission confusion’ on population goals. Bangladesh formulated its first population policy in 1976, the second in 2004 and the last one in 2012which had targets set for 2015. There has been no updating of the policy since 2015 despite the fact thatmuch of the 2015 targets set in the 2012 policy remain unfulfilled. This in itself need not have been a concern but what is certainly of concern was the arbitrary shift in policy mind-set that appear to have diluted policy prioritization of the goal of limiting population growth. [22]The signaling effect of such change in policy position – effected not through a deliberative process of the high-level National Population Council but through a ministry circular of October, 2018 – has been considerable on morale and direction of family planning activities on the ground. The combination of these factors – an outdated population policy, inactive National Population Council which has not met since 2009, and conflicting policy signals – has created a sort of ‘mission confusion’ that has pushed FP and SRH services to the policy sidelines with all the detrimental consequences for realizing targets described in the preceding section.

[22]*October 2018 circular of Ministry of Health & Family Welfare, Government of Bangladesh*

Two important consequences of the ‘mission confusion’ has been the introduction of a policy dilemma around community versus institutional approach to service-delivery and poor progress in integrating FP-and-health services. De-emphasis of community approach based on home-visits in FP activities and subsequent loss of directions has led to serious loss of morale and decay of the FP field workforce.[23] Interestingly, a revealing data in this context is the decline in exposure to FP messages from 47% to 30% over the 1994-2014 period.[24] This is a further confirmation of the decaying role of FP field workforce.

At another end, ground realities indicate a lack of integration of health and FP services. While health facilities of DGHSprovide much of the public sector maternal health services, the health facility survey of 2017 found that most of these facilities lack FP services.[25] From user standpoint, this lack of integration of FP and health services seriously impacts negatively on women’s health and is a likely factor in the stalling of the FP-related indicators noted earlier.

4.2 Child marriage and GBV

The second barrier has to do with adverse norms and social environmental factors impacting on persistence of high rates of child marriage and gender-based violence (GBV). The law stipulating age of marriage for girls at 18 has been weakened with legal loopholes and social norms continue to embrace these loopholes and contribute to the high rates of child marriage. A legitimizing rationale often invoked for such adverse social norms is real and perceived environment of insecurity for women and girls. While such insecurity indeed may be the case, the point is not to accept this rationalization for child marriage but to deepen the social campaign that solidifies the social norm against child marriage while simultaneously addressing the issue of insecurity.

The question of insecurity also impinges on the other issue of gender-based violence.Progress against gender-based violence is hampered by multiple factors encompassing adverse social norms in particular aggressive masculinity, absence or weaknesses in redressal opportunities and rampant culture of impunity. A particular area of concern is female insecurity in public spaces – public transportation, open spaces and institutional spaces.

4.3 ‘Unreached’ adolescents

The third barrier to progress on the ‘last mile’ challenges is institutional and programmatic weaknesses in reaching the key demographic of adolescents. The reality of ‘unreached adolescents’ is particularly manifest in three critical areas – SRH awareness, human capital enhancement and civic education. In all three areas, the barriers pertain to pedagogic limitations of existing awareness programs as well as poor coordination and integration amongst the key service ministries of education, women and children affairs, local government and social welfare. Though a formal nod, albeit limited, has been given to SRH education in terms of inclusion in curriculum, significant attitudinal and pedagogic capacity gaps generally render the delivery of such education largely ineffectual.

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[23] *BDHS*

[24] *ibid*

[25] *NIPORT and USAID, Bangladesh Health Facility Survey 2017, MOHFW, Government of Bangladesh*

4.4 'Out-of-focus' urban poor

The fourth and final barrier pertains to 'out-of-focus' urban poor who face severe gaps in primary healthcare, human capital enhancement services and redressal against violence services.[26] Immunization rates in urban slums was 72% compared to 92% in non-slum areas.[27] Rates of 15-49 year pregnant women with 4 ANC was 36% in urban slums compared to 61% in non-slums.[28] Rate of early marriage (before 18) was 66% in urban slums compared to 53% in non-slums.[29] Net secondary attendance ratio was 33% in urban slums compared to 62% in non-slums.[30]

The comparatively worse outcomes for urban poor on the indicators noted above is not explained only by their economic poverty. To an important extent, public investment in primary healthcare andquality primary and secondary schooling for the urban poor populations has been a low priority resulting in the disparities in outcome noted earlier.

5. REALIZING 3 ZEROES: FOURPOLICY PRIORITIES

5.1 Overcome 'mission confusion' on population goals

The first policy priority to realize the commitments towards 3 zeroes is to overcome the conflicting policy signals that have weakened policy consensus on population goals and contributed to a loss of momentum and morale in FP activities. A false choice of whether to prioritize the reaping of the 'demographic dividend' or limit the population growth appears to have taken hold within a large segment of the policy world. Ironically, the consequence of this mission confusion has been that neither the demographic dividend is being reaped adequately nor the trend towards unsustainable population densities is being slowed. Overcoming this 'mission confusion' and engaging high-level policy voice to signal a unified message on way forward is thus a critical priority. Two specific policy steps to consider in this regard are:

- Revisit Population Policy 2012 and urgently prepare an updated Population Policy considering the stalled indicators and meaningful way forward to realize 3 zeroes commitments, and
- Activate the National Population Council to provide high-level endorsement for updated and unified population policy goals.

5.2 Reverse the decay in FP field presence

Loss of morale and direction has over the last decade introduced serious capacity and human resource deficits in FP field implementation which are a barrier to realizing the 3 zeroes commitments. Significant percentages of positions remain vacant.[31] Reversing this decay in FP field presence is of strategic urgency. Specific capacity deficits such as clinical training on LAPM are but one example of easily addressed capacity need in the absence of which rates of LAPM have stalled while short-term methods have dominated with high rates of discontinuation. The efficacy of the FP field presence has also been affected by an institutional strategy shift away from home-based delivery of FP counseling and services to one of the client coming to an institutional centre. A rethinking of this institutional strategy shift from home-based versus institution to one of home-based and institution is also a priority to reverse the decay in FP field presence and ensure more effective achievement of 3 zeroes commitments.

[26] *BBS-UNICEF, Child Well-Being Survey, 2016*

[27] *ibid*

[28] *ibid*

[29] *ibid*

[30] *ibid*

[31] *UNFPA, 2020, Ensuring Equity in Access to Services and Effective Contraception: Family Planning in Bangladesh, Policy Brief*

5.3 Establish governance oversight over the private sector which is a dominant provider of FP and maternal health services

The private sector is a major actor in the provision of FP and maternal health services.[32] 32% of deliveries take place in private facilities.[33] However, the sector's role is disproportionately in the provision of services for short-term methods.[34] A relatively unaddressed issue is the lack of meaningful governance oversight over the private sector's role in FP and maternal health services. Two adverse consequences of such a situation that pose barriers to the achievement of the 3 zeroes commitments are the gradual orientation of the FP market towards short-term methods with the attendant risk of high discontinuation rates and commercial promotion of cesarean section that has resulted in 33% of deliveries being by C-section.[35] Establishing a governance oversight that can counteract such private sector service outcomes is a policy priority.

5.4 Address critical service gap of urban primary healthcare

Prevailing health infrastructure has a striking gap pertaining to urban primary healthcare services. There are no comparable counterparts in the cities to rural Community Clinics and Union Health Centres for the urban population. In the urban areas, jurisdiction over health service delivery was traditionally bifurcated with the Local Government Institutions (LGIs) being responsible for providing primary health and public health services and Ministry of Health and Family Welfare (MOHFW) is responsible for secondary and tertiary health services. Over time, rapid urbanization with its attendant growth of urban poor requiring primary healthcare services has posed a major challenge to this existing distribution of primary healthcare jurisdiction. Plagued with jurisdictional ambiguities and coordination gaps between MOHFW and MOLGRDC, service delivery, monitoring and supervision and other system related gaps of urban primary healthcareare a major factor in the comparatively worse primary and maternal healthcare indicators for the burgeoning low-income urban population. [36]The major coordination gaps include overall lack of coordination between MOHFW and MOLGRDC, lack of coordination between Directorate General of Family Planning (DGFP) and City Corporations for delivering family planning services and related monitoring and supervision, lack of coordination between DGFP and DGHS for providing family planning services at the MCHs and DHs.[37]

Meaningful exploration of solutions have in recent years floundered on an either-or framing of the jurisdictional question between urban local governments and ministry of health & family welfare. The challenges are both immediate and strategic. The priority is on achieving an effective delineation of roles and responsibilities for all relevant stakeholders including the private sector. Multi-stakeholder consultations by PPRC have underscored the need for a phased approach and innovative advocacy to establish adequate policy buy-in.[38]

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[32] *UNFPA, 2020, ibid*

[33] *BDHS 2017*

[34] *UNFPA, 2020, ibid*

[35] *ibid*

[36] *Chowdhury ME, Abdullah M, Alam A, et al (2016). Technical Assistance for Assessment of Contribution of Ministry of Health and Family Welfare (MOHFW) for Urban Health Services. Planning Wing, Ministry of Health and Family Welfare, Government of Bangladesh*

[37] *PPRC, 2019, Analytical Report and Policy Brief on Urban Primary Healthcare Services, Report prepared for The World Bank, Dhaka.*

[38] *Ibid.*

6. REALIZING 3 ZEROES: SIX ACTION PRIORITIES

6.1 Reframe social and policy campaign narrative on child marriage prevention

Despite enactment of 18 as legal age of marriage for girls albeit with caveats introduced later that diluted the efficacy of the law, child marriage remains a key barrier to realizing the commitments to 3 zeroes. Campaign against child marriage also officially exists but has failed to create much momentum. A rethinking, not on the goals per se but on the campaign approach, may have become necessary. The key action priority here will be to reframe the policy and social narrative on ending child marriage with emphasis put on new focus areas such as comprehensive sexuality education (CSE), gender-based violence and overall girl empowerment.

6.2 Reality check on existing SRH counselling and education for adolescents and promotion of innovative new approaches

There have been initiatives over the years on SRH education and counselling including adoption of National Strategy for Adolescent Health in 2016.[39] High rates of adolescent pregnancy, high unmet need for FP counselling and services amongst this demographic and worrying levels of gender-based violence indicate that impact of such initiatives have been limited. Effective SRH counselling and education particularly for adolescent is a key priority for realizing the commitments to 3 zeroes. A relevant action priority is to undertake a reality check on existing SRH education curriculum and related awareness and counselling services to identify lessons for rethinking and identification of innovative new approaches. An important priority for innovation will be peer-led CSE.[40]

6.3 Bring back the agenda of male contraception

It will be ironic and contrary to the goal of women's empowerment inherent in the 3 zeroes if the burden of realizing the FP targets of 3 zeroes were to fall entirely on the women. The male-female ratio in using any modern FP method is 1:6 for short-acting methods and 1:4 for permanent methods.[41] It is a moot point as to why male contraception as an agenda appear to have been relegated to the sidelines of the policy, provider and social discourses alike. Existing methods of delivery of FP services have been noted as a possible factor – access barriers due to male sterilization services available only in upazila health centres on one hand and preponderance of female workforce for community outreach program.[42] Be that as it may, bringing back male contraception into the FP program agenda is an important action priority towards realizing the commitments to 3 zeroes including addressing access barriers and outreach strategy.

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[39] *Ministry of Health & family Welfare, 2016, National Strategy for Adolescent Health 2017-2030, MCS Services Unit, MoHFW, Government of Bangladesh. UNFPA & UNICEF.*

[40] *www.kotha.org*

[41] *UNFPA, 2020, Ensuring Equity in Access to Services and Effective Contraception: Family Planning in Bangladesh, Policy Brief*

[42] *ibid*

6.4 Strengthen integration of FP and maternal health services to address unmet need

Prevailing service provision has an anomalous situation wherein the DGHS facilities delivering maternal health services lack FP services. This is a serious barrier to better user experience and underlie the high levels of unmet need among adolescents and post-partum women. Integrating FP services in DGHS facilities and redressing capacity deficits such as clinical training on LAPM among nursing and FP staff are examples of 'low hanging fruits' that can be plucked towards addressing the commitments of unmet need and other commitments towards 3 zeroes.

6.5 Ensure data quality and regular monitoring of progress on 3 zeroes indicators

Recent years have seen debates on data quality as well as outdated data pertaining to population goals. Data has to be both updated and credible to contribute to the critical goal of progress monitoring. Improving administrative processes to ensure generation of routine data that can analyzed for monitoring purposes is a priority as is quality survey data that can provide insights relevant to more effective monitoring and corrective steps. An important institutional priority here is viable partnership platforms that can bring together credible stakeholders from diverse sectors including government, academia, professionals, youth and private sector.

6.6 Targeted programs to address gender-based violence

While there may be broad consensus on the need to address gender-based violence, the challenge really is of targeted programs that can have tangible and meaningful impact on redressing such insecurity for women and girls. Over the years, Bangladesh has indeed witnessed several targeted programs as for example against acid-throwing but the phenomenon of gender-based violence is too entrenched and require far stronger and wider attention. Of particular importance here is to make public spaces safer for women and girls and promote behavioral norms in institutional spaces that can transform these into gender-friendly spaces. Two immediate action priorities that merit attention here are i) safety program on public transportation and ii) gender-sensitivity training in police, local government, district administration and service ministries.

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POLICY PAPER: 2

Gender Based Violence: A Challenge for Reaching SDGs

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Abbreviations

ASK	Ain o Salish Kendra
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BMMS	Bangladesh Maternal Mortality and Health Care Survey
BMP	Bangladesh Mahila Parishad
BPA	Beijing Platform for Action
CBO	Community Based Organizations
CEDAW	Convention on the Elimination of Discrimination against Women
CMMS	Center for Men and Masculinities Studies
DEVAW	Declaration on the Elimination of Violence against Women
DNA	Deoxyribonucleic Acid
DWA	Department of Women Affairs
FnF	Friends and Family
GBV	Gender based Violence
GDP	Gross Domestic Product
GoB	Government of Bangladesh
HIS	Health Information System
HMN	Health Metrics Network
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technology
NGO	Non-Governmental Organizations
MHSC	Mental Health Service Centres
MoWCA	Ministry of Women and Children Affairs
MSPVAW	Multi-Sectoral Programme on Violence Against Women
OCC	One-Stop Crisis Centre
RRRI	Repatriation and Integration
SANE	Sexual Assault Nurse Examiner
SMS	Short Message Service
SRHR	Sexual and Reproductive Health and Rights
SVRS	Sample Vital Registration System
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAW	Violence against Women
VAWG	Violence against Women and Girls
VGD	Vulnerable Group Development

Abstract

Gender-based Violence is surely a severe form of Human Rights Violence and addressing gender-based Violence is a crucial concern to achieve Sustainable Development Goals. Sustainable Development Goals, officially known as Transforming our world: the 2030 Agenda for Sustainable Development, a set of 17 "Global Goals" with 169 targets between them (UN,2015) to balance the three dimensions of sustainable development: the economic, social and environmental where concerns for women were repeated in most of the targets. These goals and targets will be impossible to achieve if society cannot utilize the full potentials of women. To use women's full potentials for the development a society must ensure that it is free of gender-based violence. In the context of Bangladesh, there have been various studies on the trends of GBV, mostly VAWG by government bodies and non-governmental organizations which identified that there remains slight decrease in few forms of violence over the last couple of years but still, the trend of VAWG, mostly sexual violence is in a rising trend and the number of such cases is still very high. The most frustrating scenarios are that the rate of rape cases is very high in recent years, many incidents end in death, sometimes the victims are killed and sometimes the victims decide to commit suicide. Recent years have observed that children are becoming easy targets of sexual violence. Along with women's empowerment with different sectors like education and employment, new forms of violence like cybercrimes and sexual violence at workplaces are on the rise too. The causes that prevail and sustain the forms of violence are multifactorial and interlinked with each other. Family disputes, greed, rejection, etc. can be found as the immediate causes of VWAG. Social customs like child marriage, dowry, and lack of women-friendly services are the intermediate causes that pave the way to VAWG. But deeper analysis would identify micro-level practices like reproducing hegemonic masculine practices and behavior and gender division of labor that play as the underlying causes of GBV which make combatting GBV complex and difficult. The GoB has string will and visions to end GBV which have been reflected in various laws, policies, and specialized programs for women. To complement governmental initiatives to defeat the underlying factors of GBV, specific recommendation can be drawn such as conducting studies on men and masculinities to understand the perspectives of perpetrators, considering men as a partner for positive change for women empowerment, continuing women-friendly policies and programs and creating a network among GoB and civil society actors.

1. Introduction

1.1 Background

From the very early stages of life, unfortunately in our society, women remain in the secondary category, belonging to lower identity, and violence against women and girls (VAWG) has always been there to marginalize women. Social “customs” like Sati, dowry, Fatwa, child marriage have just revealed how severe the situation could be. Violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men (BPA 1995). This situation is very alarming as VAWG “takes an enormous toll on the lives of individual victims as well as the larger society, through innumerable behavioral, health, psychological and economic consequences’ (White et al, 2011; 10) and is becoming normalized in Bangladesh.

With the target to shift the world into a sustainable and resilient path, on September 25th, 2015, the United nations introduce Sustainable Development Goals, officially known as Transforming our world: the 2030 Agenda for Sustainable Development, a set of 17 "Global Goals" with 169 targets between them (UN, 2015) to balance the three dimensions of sustainable development: the economic, social and environmental where concerns for women were repeated in most of the targets.

SDGs specifically discusses on Gender equality in goal 5 which devotes to achieve gender equality and empower all women and girls and sets target to end all forms of discrimination against all women and girls everywhere (5.1), to eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation (5.2), to eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (5.3), to recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate (5.4), to ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision making in political, economic and public life (5.5), to ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences (5.6), to undertake reforms to give women equal rights to economic resources, as well as access to ownership and control over land and other forms of property, financial services, inheritance and natural resources, in accordance with national laws (5.a), to enhance the use of enabling technology, in particular information and communications technology, to promote the empowerment of women (5.b), to adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels (5.c).[1]

[1] *https://www.unwomen.org/en/news/in-focus/women-and-the-sdgs/sdg-5-gender-equality*

Bangladesh, complying with the recommendations of United Nations and Sustainable Development Goals adopted in 2015 is committed to conducting periodical surveys to generate official statistics on (a) the prevalence of different forms of VAW, (b) injury sustained due to VAW and (c) help-seeking behavior of women exposed to VAW to guide policy formulation, programs, and interventions and to improve existing legal frameworks (Bangladesh VAW survey 2015). So it is the prime time to analyze the trends of Violence against Women, search for the root causes to come up with the solution to combat all forms of Violence against Women, and to accelerate the achievement of SDGs.

1.2 Objective of the Study

The broad objective of this study is to review the available documents on VAWG in Bangladesh. Hence the specific objectives would be as follows:

To analyze the trends of VAWG in Bangladesh;
To identify the underlying factors behind the cases of VAWG;
To evaluate the existing coping mechanisms including laws, policies, and programs;
To suggest more scopes to work on to prevent VAWG in Bangladesh.

1.3 Methodology

This study used secondary analysis relying on secondary data for understanding the VAWG situation in Bangladesh. In social research practice, secondary data refers to the data that was collected by other researchers who may have different research objectives. Both the quantitative and qualitative data can be used for secondary analysis. There might be different sources of secondary data including the official government sources and trusted non-governmental organizations or research and academic institutions. Hence the study reports from Government bodies like BDHS 2014, VAW Report 2015, BMMS 2016, SVRS 2018, and Study reports from MoWCA, Study reports from UN Bodies, academicians, and development organizations were taken into consideration. Although the study has not collected empirical data, it has tried to use insights from the empirical study to give specific recommendations.

1.4 Conceptualizing VAW

The concept of gender-based violence should be clear to decide the boundaries of discussion. Though gender-based Violence was prevalent in all historical ages, attempts to conceptualize violence against women and gender-based violence started after the 1980s. The 1979 UN Convention on the Elimination of Discrimination against Women (CEDAW) contained no clear reference to VAW but afterward, General recommendation No. 19 on violence against women, adopted by the Committee on the Elimination of Discrimination against Women at its eleventh session in 1992 states that discrimination against women –as defined in article 1 of the Convention[2] - includes gender-based violence, that is, ‘violence which is directed against a woman because she is a woman or that affects women disproportionately’, and, as such, is a violation of their human rights (CEDAW/C/GC/35). includes gender-based violence, that is, ‘violence which is directed against a woman because she is a woman or that affects women disproportionately’, and, as such, is a violation of their human rights (CEDAW/C/GC/35).

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[2]*Discrimination against women includes any distinction, exclusion or restriction that affects women's enjoyment of political, economic, social, cultural, civil or any other rights on an equal basis with men.*

In 1993, the United Nations General Assembly defined violence against women as "any act of gender-based violence that results in or is likely to result in, physical, sexual or psychological harm or suffering to women including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life" (United Nations, 1993). The United Nations referred to "gender-based" violence to acknowledge that such violence is rooted in gender inequality and is often tolerated and condoned by laws, institutions, and community norms as part of strengthening and enforcing that inequality (Heise, Ellsberg, and Gottemoeller in Bott et al, 2004). Council of Europe Convention on preventing and combating violence against women and domestic violence also echoed the definition in article 3a.[3]

The Beijing Platform for Action adopted in 1995 expanded the definition of DEVAW while specifying the forms of violence against women as followed; Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.[4]

The BPA also focused on "violations of the rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery, and forced pregnancy; forced sterilization forced abortion, coerced or forced use of contraceptives; prenatal sex selection; and, female infanticide."[5]

The BPA, for the first time, addressed the intersectional vulnerabilities incorporating women belonging to minority groups, indigenous women, refugee women, women migrants, including women migrant workers, women in poverty living in rural or remote communities, destitute women, women in institutions or detention, female children, women with disabilities, elderly women, displaced women, repatriated women, women living in poverty and women in situations of armed conflict, foreign occupation, wars of aggression, civil wars, terrorism, including hostage-taking, mentioning they are "particularly vulnerable to violence."[6]

[3] "violence against women" is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

[4] Article 113, Beijing Platform for Action.

[5] Article 114 and 115, Beijing Platform for Action

[6] Article 116, Beijing Platform for Action

However, Bangladesh VAW survey 2015 classified violence against women in five broad heads which are Physical Violence ranging from slapping, throwing acid and many more,[7] Sexual Violence,[8] Economic Violence,[9] Controlling behavior[10] and Emotional Violence[11] but the survey mostly focused on Domestic Violence, committed by the counterpart (though 7.4% respondents were never married) ignoring the cases of violence in all other settings. Moreover, all the prominent declarations so far encompass all forms of gender-based violence (physical, sexual, and psychological), particularly against women. Hence, while analyzing the situation, the above-mentioned definitions and criteria will be taken under consideration and hence the missing points will also be discussed from the author's insightful works.

2. Situation Analysis of Gender based Violence in Bangladesh

2.1 Recent Statistics of GBV

From January 2014 to December 2017, a total of 17,289 cases of women and child rapes were recorded throughout Bangladesh. The total number of victims in those cases was 17,389, of which 13,861 were women and 3,528 children.[12] In a survey, 87% of women and girls reported that they experience sex and gender-based violence at least once in their lifetime (BBS, 2011). According to the Bangladesh National Women Lawyer's Association, almost 90% of girls aged 10-18 encounter public sexual harassment.[13]

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[7] *Slapped, punched or threw something at you by which you were injured, Pushed you or shoved you or pulled your hair?, Burnt you with hot things, Threw acid intentionally Threw hot water/oil/ milk/peas etc. intentionally, Kicked you, dragged you or beat you up, Intentionally suffocated you or choked you by hand?, Intentionally burnt you?, Threatened with or actually used a gun, knife or any other weapon against you? , Hit you with a stick or any other heavy things?*

[8] *Did you ever have sexual intercourse with your husband against your will? Did you ever have sexual intercourse with your husband against your will in fear of future torture or any kind of harm? Did your husband ever perform any unusual sexual behavior which seems defaming or disgraceful to you? Other kind of sexual torture*

[9] *He refuses to give enough money for household expenses, even though he has money for other things? Refuses to provide regular pocket money? Are you married in condition with giving money or property as dowry? Does he pressure you to get money or belongings from your father's house?*

[10] *Does he try to restrict you from the company of your friends? Does he restrict you from going to your parental house? Does he insist on knowing (with suspicious mind) what you are doing and where you are at all times? Does he ignore your feelings and opinions without caring or thinking about your priorities? Is he angry if you speak with your relative or nonrelative males? Is he often suspicious that you are unfaithful? Does he expect you to ask his permission before seeking health care for yourself? • Does he force you to maintain vail/hijab (Parda)? Does he obstruct your studies or employment? Does he forbid you in going out for recreation? • Does he utter attacking words against your Parents? Does he force you to use contraceptive method for birth control or forbid using it? Does he misbehave with you for giving birth to a girl child? • Does he misbehave with you due to complain from your mother-in-law or sister-in- law or other family members? • Does he often get angry without any reason? Other*

[11] *Did your husband insult you in a manner by which you were humiliated or felt bad about yourself at any time? Did your husband belittle or humiliate you in front of other people? Did your husband do anything to scare or intimidate you on purpose (such as scream at you or break something)? Did your husband verbally threaten to hurt you or act in a manner by which you were terrified? Did your husband torture you for socializing with your neighbours or other women? Did your husband threaten to marry other women?*

[12] *https://bdnews24.com/bangladesh/2018/02/19/bangladesh-sees-more-than-17000-rape-cases-registered-in-four-years*

[13] *http://www.stopstreetharassment.org/2010/06/90-of-bangladeshi-girls-ages-10-18-experience-sexual-harassment/*

Statistics of Bangladesh Mahila Parishad (BMP) show that a total of 5,235 women and girls fell victim to different types of violence, including rape and torture, across the country in 2017.

However, the number of victims was 4,896 in 2016 while 4,436 in 2015, 4,654 in 2014 and 4,777 in 2013, according to the BMP data.
In 2017, as many as 969 women and girls were victims of rape. The number of rape victims was 840 in 2016 while 808 in 2015, 666 in 2014 and 696 in 2013.
In 2017, at least 164 women fell victim to sexual abuses while the number was 80 in 2016, 68 in 2015, 44 in 2014 and 40 in 2013.

Source: Bangladesh Mahila Parshad (https://www.daily-sun.com/amp/post/376207)

Bangladesh Bureau of Statistics conducted two round systematic study on Violence against women and girls. The recent study was conducted on 2015. The study, covering a good number of sample, 21,688 (though mostly covered ever married women as high as 19,987) tried to identify different forms of violence that women have gone through in the previous years. In the context of our country this is the largest study in recent years, referring the number of the participants, to identify the immensity of Violence against Women and Girls in Bangladesh.

According to the VAW report 2015, almost two thirds of ever married women in Bangladesh have experienced some form of partner violence in their lifetime. The most common form of violence that they experience is controlling violence through which 55.4% ever married women have gone through. Almost half, 49.6% of ever married women have experienced physical violence. 28.7% experienced emotional violence and 27.3% reported to experience sexual violence. Though Bangladesh law is yet to criminalize Marital Rap in Bangladesh, it was a firm step by this study to address sexual violence within marriage. However, it is needless to say that many women experienced multiple forms of violence and the number is as high as 57.7%(VAW Report 2015). Twenty-eight percent of women agree that a husband is justified in beating his wife for silly reasons (BDHS 2014).

This study also attempted to sketch the different contextual dimensions. Partner Physical Violence was higher in rural areas that is 51.8% than in urban areas excluding City Corporation that is 48.5%. Rate of physical violence was reported to be much lower in the city corporation areas, which is 29.4%. According to division, it was highest in Rajshahi 60.1% and lowest in Chittagong42.5%. However, the study did not go in depth to find out the root cause for such variation. Prevalence of physical violence was highest among the youngest age groups. However, most of the respondents reported to experience partner physical violence two-five times during the study year.

Prevalence of Sexual Violence is also reported to be higher in rural area (28.4%) than in City Corporation (14.4%). Similar to Partner physical violence, sexual violence rate went highest for Rajshahi division (34.2%) and it was found to be least in Sylhet (19.8%). And consistently younger women were more prone to sexual violence. More than one quarter of women (27.8%) women experienced non partner violence physical violence during their lifetime and 3% of women reported to experience sexual violence which is highest among 20-24 age group.

According to the survey, "husbands house" was the most common place for physical violence to occur(76.8%), followed by 'working place (21.9%) 11.4% violence among the respondents reported about "educational institutions" and 9.4% mentioned vehicles, roads and streets. But rate of sexual violence was higher in working place (32.8%) and in vehicles, roads or streets (18.3%).

Over the years, according to VAW report 2011 and 2015, with the exception of physical violence slightly, the prevalence of all other forms of partner violence decreased significantly. However, beside broad studies by the government, the number of cases of violence have been counted by prominent NGOs like Ain o Salish Kendra and Odhikar.

According to Bangladesh Mahila Parishad, the overall picture of VAW in 2015 is found not only disappointing but also alarming. The trend and frequency of VAW clearly suggests that it remains as the biggest obstacle to establish women's human right at home and outside the home arena. It is revealed from BMP's data base that a total of 4,436 incidents of different types of violence have occurred in different parts of the country. The largest number of victims of VAW during this period was related to rape (1,092), gang rape (199) murder of women and children (714), dowry related violence (589), and suicide (336).[14]

BMP finds rape as most common form of violence against women in 2018

Staff Correspondent | Published: 00:06, Jan 03,2019

Women in Bangladesh fall victim to rape more frequently than any other forms of violence against women, according to data collected on violence against women by Bangladesh Mahila Parishad.

The database is compilation of reports published in 14 newspapers between January and December, 2018.

Dozens of women were rape every month taking the total number of incidents of rape to 697 at the end of the year.

Besides, 182 incidents of gang rape reportedly took place during the same period.

Rapists killed 63 of the victims, showed the BMP data.

Around 217 women were sexually assaulted.

The BMP listed 35 kinds of violence against women including acid attack, arson, abduction, human trafficking, dowry-related violence, murder, fatwa, and child marriage.

Around 488 women were killed during the same period.

Rape-victims rarely get justice and many of them try to commit suicide to escape social stigma.

In 2018, 377 women committed suicide while 258 attempted suicide.

Source: http://www.newagebd.net/article/60705/bmp-finds-rape-as-most-common-form-of-violence-against-women

Table 1: Trends of VAWG in Bangladesh from 2015-2019

		2015	2016	2017	2018	2019
Rape	Incidents	846	724	818	732	1253
	Death after Rape	60	37	47	63	62
	Committed Suicide after Death		16	11	7	10
Domestic Violence	Incidents	373	394	-	409	337
	Women murdered by their husband/family	212	270	213	297	246
	Women Committed Suicide	54	45	-	49	
Sexual Harassment	Incident	205	244	255	116	221
	Women Committed Suicide	10	6	12	8	12
	Murdered due to protest	-	-	-	12	12
Dowry	Number of Women Physically Tortured	101	108	122	80	50
	Women Tortured to death	187	126	145	85	78
	Committed Suicide	10	-	-	-	3
	Case Filed	158	95	188	108	60
Acid Attack	Incidents	35	34	32	22	15
Fatwa and Salish	Incidents	12	12	10	7	

Source: Ain o Salish Kendra[15]

[14]*See http://www.mahilaparishad.org/wp-content/uploads/2016/04/2015-Final-Annual-Report-BMP.pdf*
[15]*http://www.askbd.org/ask/*

Table 2: Incidents of Violence in Bangladesh in 2019 (till October).

Category	Incident	Number
Rape (January-October 2019)	Rape	1253
	Attempts to rape	200
	Death after rape	62
	Committed suicide after rape	10
Sexual Harassment (January-October 2019)	Number of Women harassed	221
	Committed suicide because of harassment	12
Domestic Violence (January-October 2019)	Women murdered by their husbands	173
Dowry (January-October 2019)	Physically tortured	50
	Tortured to death	78
	Case filed	75
Acid Attacks (January-October 2019)	Acid attacks	15

Source: Ain o Salish Kendra[16]

A comparison of the reported cases of different forms of VAW from 2001 to 2018 suggests that though the incidents of rape are in a declining trend, the number is still very high in recent years (Table 2). Among all form of violence against women and girls, it stands as the highest. The incidents of sexual harassment/stalking are also alarming (Table 3). Moreover, a high number of women are killed after death and there are women who committed suicide consequently (Table 2).

Table 3: Incidents of Rape in Bangladesh from 2001-2018.

Year	Total Number of Victim of Rape (Women, children, Unidentified age of females)	Total Number of Victim of Gang Rape (Women, children, Unidentified age of females)	Total Number of Victim Killed after rape (Women, children, Unidentified age of females)Killed after rape	Committed suicide after rape(Women and Children)
2018	635	177	47	2
2017	783	203	32	9
2016	757	212	31	3
2015	789	277	65	5
2014	666	227	66	12
2013	814	236	71	6
2012	805	197	75	10
2011	711	239	90	13
2010	559	214	91	7
2009	456	176	97	8
2008	454	180	98	9
2007	459	191	79	1
2006	639	-	126	-
2005	907	-	126	-
2004	896	-	117	-
2003	1336	-	142	-
2002	1350	-	114	-
2001	622	-	-	-
Total	13638	2529	1467	85

Source: Odhikars[17]

[16] *http://www.askbd.org/ask/*

[17] *http://odhikar.org/statistics/statistics-on-violence-against-women/*

Table 4: Incidents of Sexual harassment/Staking in Bangladesh from 2001-2018.

Year	Number of victim girls	Number of protesting female relatives/friends attacked (by stalkers)	Number of protesting male relatives/ friends attacked (by stalkers)
2018	157	8	44
2017	242	24	83
2016	271	15	84
2015	191	10	95
2014	272	16	40
2013	333	9	89
2012	479	20	129
2011	672	42	201
Total	2617	144	765

Source: Odhikar[18]

Consequences of sexual Harassment/Stalking was also been documented and that also reflects mortal cases. It was notable here that the rate of suicide was in declining number till 2016 but in 2017 the number of suicide cases exceeded the previous ones and in 2018, though it declined again, it was higher than that of 2015 or 2016 (Table 3).

Table 5: Consequences of Sexual Harassment/Stalking in Bangladesh from 2001-2018.

Consequence of sexual harassment/ stalking girls: 2011-2018					
	Situation of girls				
Year	**Suicide**	**Killed**	**Injured**	**Assaulted**	**Abducted**
2018	9	2	33	27	4
2017	17	4	42	42	3
2016	7	4	35	53	7
2015	8	7	14	25	2
2014	14	2	35	20	8
2013	13	6	21	15	12
2012	18	3	24	15	9
2011	29	6	59	91	12
Total	115	34	263	288	57

Source: Odhikar[19]

The situation gets worse when there are case of rapes committed by the law enforcement agencies. The number of victims remain unchanged in the recent years (Table 4).

[18] *http://odhikar.org/statistics/statistics-on-violence-against-women/*

[19] *http://odhikar.org/statistics/statistics-on-violence-against-women/*

Table 6: Incidents of Rape by law enforcing agencies in Bangladesh from 2001-2018.

Years	Total victim girls	Allegations against law enforcement agencies								
		Police	RAB	Jail police	Army	Ansar	Police and Ansar jointly	Village police	DB police	BGB
2018	5	1			2					2
2017	4	4								
2016	4	4								
2015	4	3				1				
2014	6	5			1					
2013	7	3	1		1	1	1			
2012	13	10			1	2				
2011	4	1			1	1			1	
2010	6	3			1	1		1		
2009	3	2							1	
2008	5	3	1	1						
2007	3	3								
2006	3	3								
2005	3	2	1							
2004	1	1								
2003	4	2			1					1
2002	7	7								
2001	8	3			4					1
Total	90	60	3	1	12	6	1	1	2	4

Source: Odhikar[20]

Cases of Dowry Related Violence are still very high. Data shows that around 2001-2004, there were fewer cases of Dowry related violence which got a rising trend up to 2012, as much as 8822 cases that year. Recent years show a declining trend but still it is not close enough to the end.

[20]*http://odhikar.org/statistics/statistics-on-violence-against-women/*

Table 7: Incidents of Dowry Related in Bangladesh from 2001-2018.

Dowry related violence against (married) women January 2001 - December 2018				
Years	**Killed**	**Physically abused**	**Suicide**	**Total**
2018	71	69	2	142
2017	118	127	11	256
2016	107	94	5	206
2015	119	77	6	202
2014	123	103	11	237
2013	158	261	17	436
2012	273	535	14	822
2011	305	192	19	516
2010	235	122	22	379
2009	227	81	11	319
2008	188	71	10	269
2007	138	47	13	198
2006	243	64	8	315
2005	227	123	19	369
2004	166	78	11	255
2003	261	85	23	369
2002	191	90	28	309
2001	123	31	3	157
Total	3273	2250	233	5756

Source: Odhikar[21]

Acid Violence is the only arena where recent data show significant success to reduce acid violence. From 40 cases in 2016, 52 cases in 2017, there were only 26 cases of Acid Violence in 2018 where number of adult women were 11. (Table 6)

Table 8: Incidents of Acid Violence in Bangladesh from 2003-2018.

Year	Adult Women	Adult Men	Girls	Boys	Unidentified Sex(Children)	Grand Total
2018	11	5	6	4	0	26
2017	33	9	9	1	0	52
2016	26	7	5	2	0	40
2015	29	10	7	1	0	47
2014	44	7	10	5	0	66
2013	36	10	5	2	0	53
2012	58	17	20	10	0	105
2011	57	25	10	9	0	101
2010	84	32	16	5	0	137
2009	64	20	13	4	0	101
2008	73	34	15	11	0	133
2007	96	42	-	-	23	161
2006	105	36	-	-	20	161
2005	104	55	-	-	37	196
2004	191	65	-	-	51	307
2003	181	95	-	-	61	337
Total	1192	469	116	54	192	2023

Source: Odhikar[22]

[21] *http://odhikar.org/statistics/statistics-on-violence-against-women/*

[22] *http://odhikar.org/statistics/statistics-on-violence-against-women/*

2.2 Trends of VAWG in Bangladesh

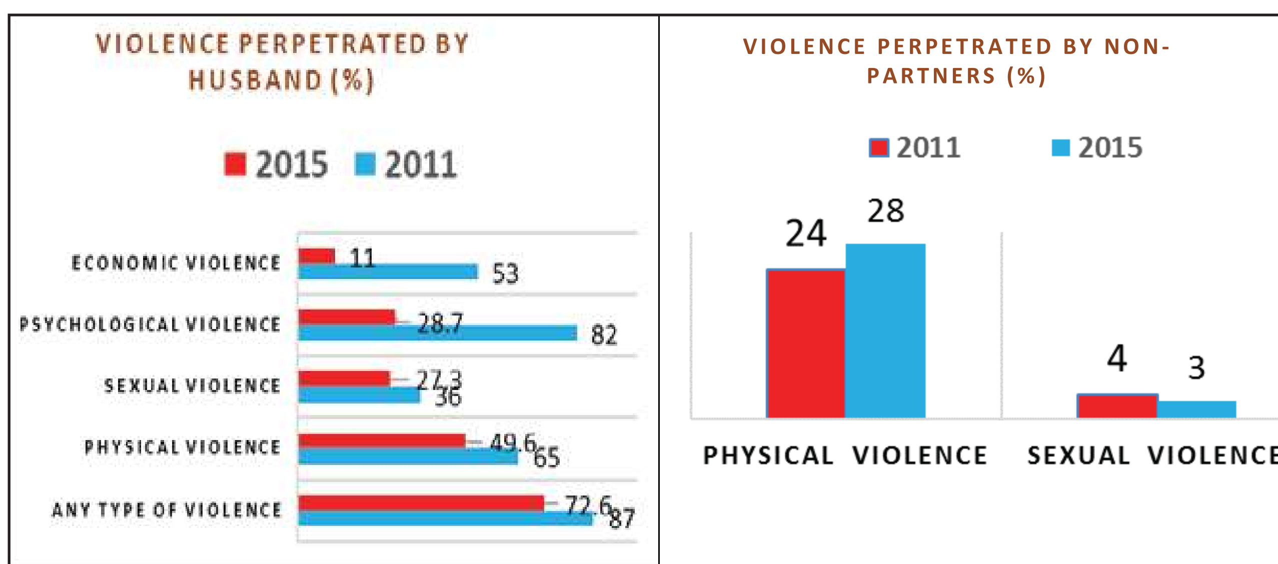
2.2.a Is VAWG really increasing over the last couple of years?

There is a debate on whether violence against women and girls is increasing over the last two decades; a group believe that it is not increasing rather it is being reported more than ever whereas another group wants to argue that it is increasing and the situation has very little or no connection of being reported more than ever. Without being part of this debate it can be argued that at present the level of VAWG in Bangladesh is simply intolerable and we must act immediately.

2.2.b VAWG statistics suggest a high prevalence of VAWG in Bangladesh

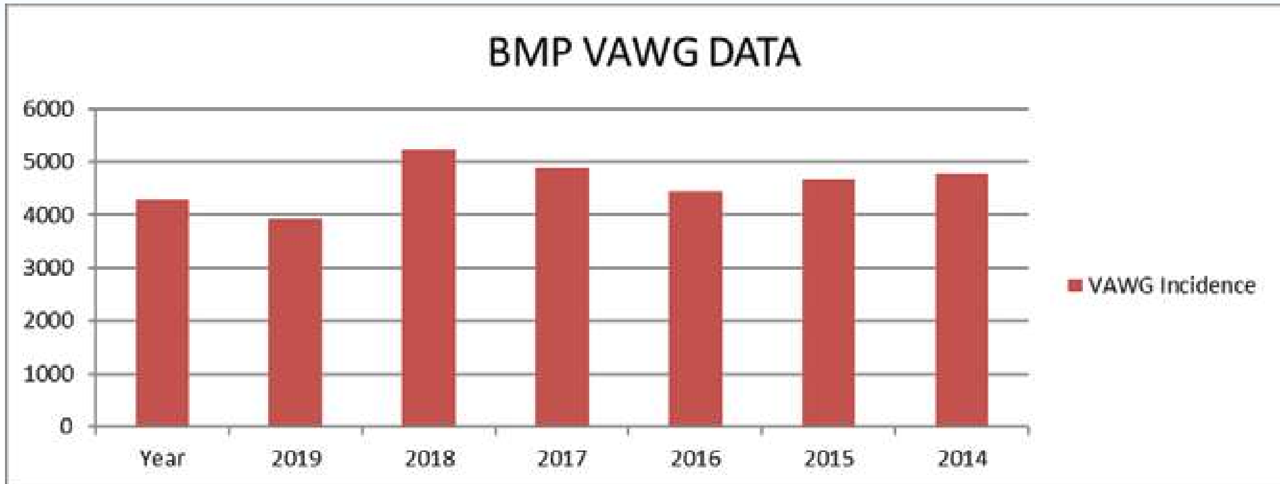
Bangladesh Bureau of Statistics conducted two round systematic study on Violence against women and girls. The first one was conducted in 2011 and the second one in 2015. According to these studies, in 2011, 87% of married women faced any type of violence by their partners in their lifetime and 77% faced violence in the last 12 months whereas in 2015 the percentage as 72.6% and 54.7% respectively. In case of violence from no-partners 2011 data shows that 25.11% of Bangladeshi women experienced any type of violence from non-partners and 8.44% of which occurred within the last 12 months of the survey whereas the percentage were 23.80% and 4.37% respectively. This rate is undoubtedly very high.

Figure 1: Violence perpetrated by husband and non-partners



Most of the NGOs, who keep VAWG data based on published reports in the newspaper, suggested that VAWG has been increasing. Statistics of Bangladesh Mahila Parishad (BMP) show that a total of 4290 women and girls fell victim to different types of violence, including rape and torture, across the country until November, 2019. However, the number of victims was 3,918 in 2018, 5,235 in 2017, 4,896 in 2016 while 4,436 in 2015, 4,654 in 2014 and 4,777 in 2013, according to the BMP data.

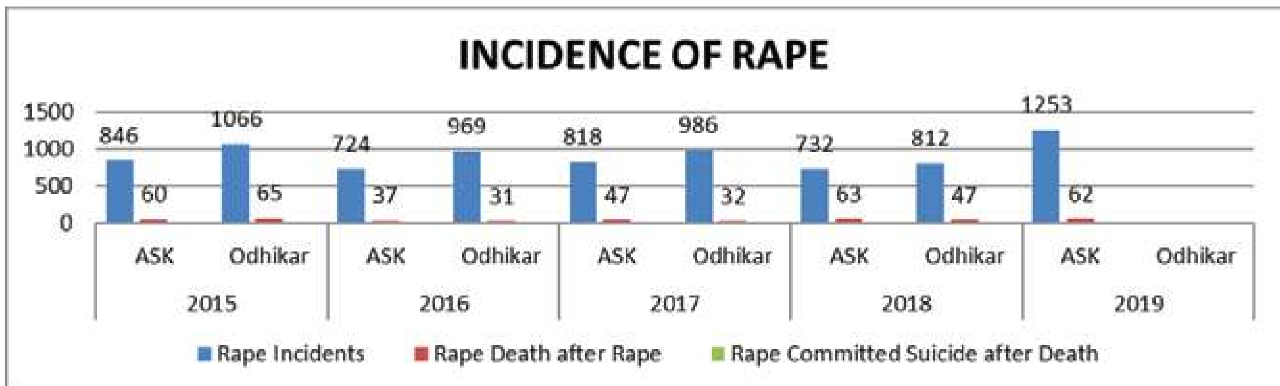
Figure 2: Chart of BMP Violence against Women data



2.2.c Rape is on rise

Rape is one of the most pervasive form of human rights abuse and has always been used as a weapon to confine women within the boundaries of patriarchy. Over the last couple of years Bangladesh has observed an increase in rape cases. Based on the data from Ain-O-Salish Kendra it can be inferred that rape is increasing in an alarming rate. In 2018 the total reported case of rape was 846 whereas the number is 1253 until October 2019.

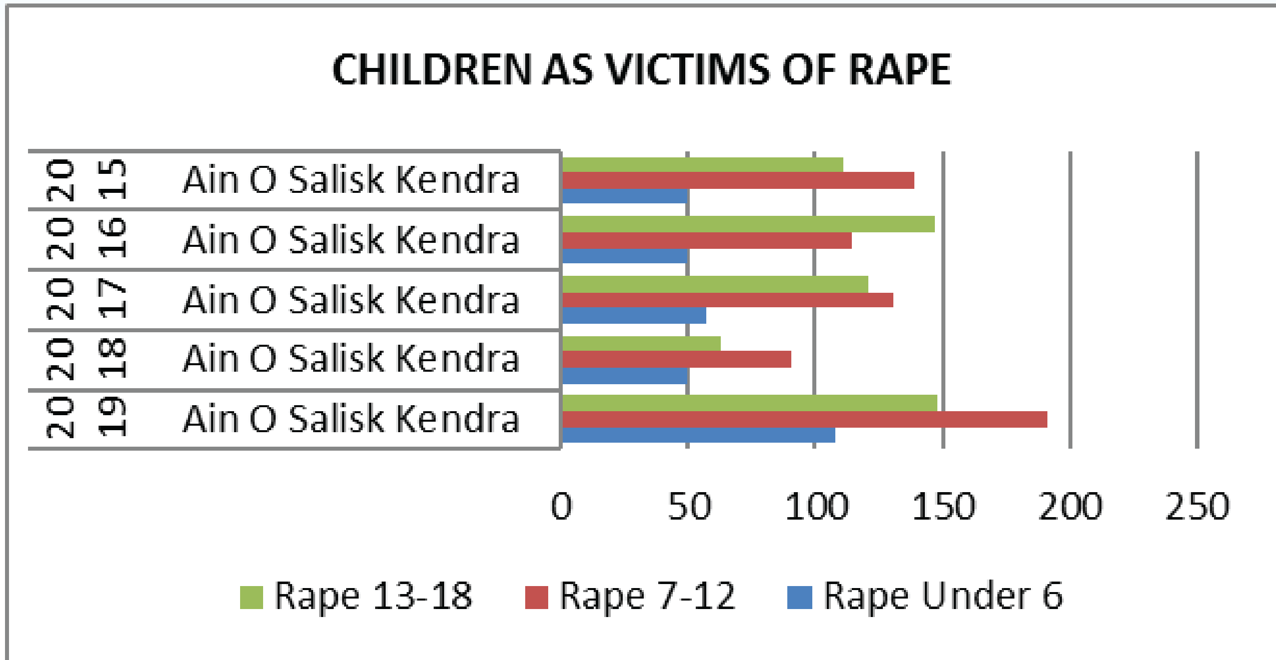
Figure 3: Incidents of Rape



2.2.d Children are becoming easy targets of sexual violence

Over the last couple of years the pattern of rape is shifting where children and underage are increasingly becoming targets for rape. A comparative picture of last five years confirms this pattern; in 2015, 50 under 6 aged children were victims of rape whereas the number is 108 until November 2019. Similarly, 139 children aged 7-12 were victims of rape in 2015 whereas the number was 191 until November 2019. There might be many reasons behind such incidences but a few important reasons are that children could be targeted easily for rape as they are weak, in most cases fail to report to their parents and guardians are not aware of the possible threat for the child.

Figure 4: children as victims of rape

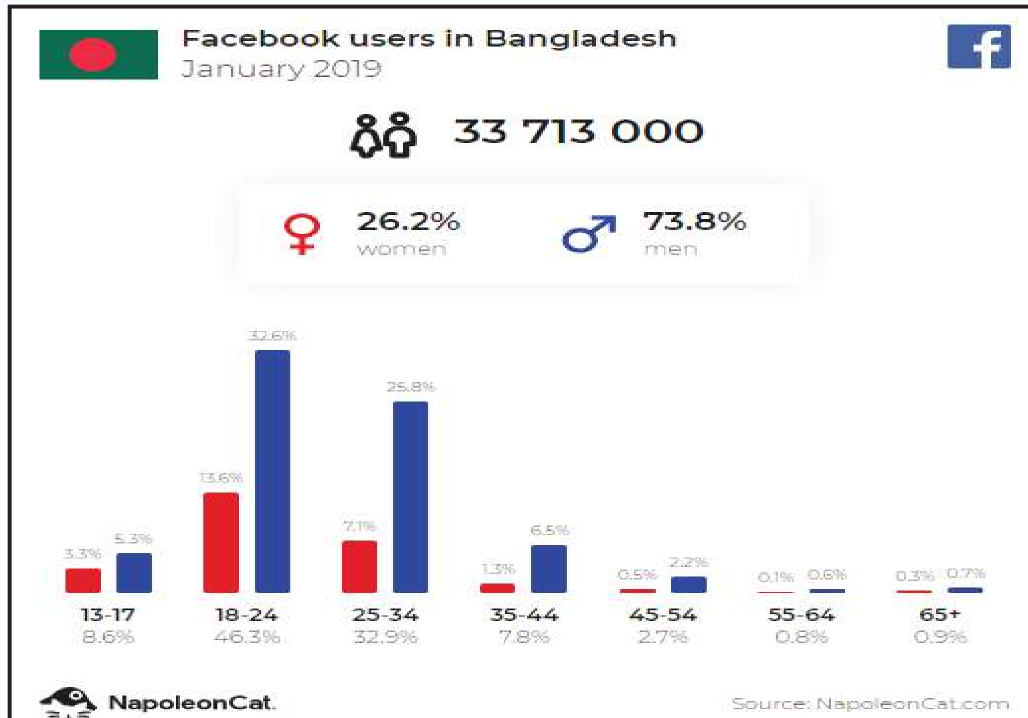


2.2.e Cyber Violence against Women and Girls is very high

Due to proper steps by the Government, Bangladesh is becoming a role model for digitalization in the world. Unfortunately, this expansion of Information and Communication Technology (ICT) and growing internet penetration is affecting women and girls negatively as access to ICT has also opened new possibilities to commit crime against women and girls; now this generation of women and girls are observing new forms of violence like cyber stalking, non-consensual sex video,23 cyberbullying, and trolling etc. Offensive and often aggressive sexual advances and defamatory messages in cyberspace from anonymous and fake sources have become an issue to experience regularly for many women and girls (along with a few men and boys as well) who are active in the cyber space. Moreover, due to advance in technology and access to it, many of them are becoming victims of false and altered unclothed pictures along with spam, fake sex-act videos, rape threats, and indecent proposals in the social media. In spite of unprecedented digitalization in Bangladesh, due to pre-existing patriarchal social-psychological norms and absence of social awareness as well as inadequate legal protections, it is not surprising that women and girls are becoming primary victims of violence in the cyberspace. According to a study 73 percent of women internet users have reported cybercrime (Zaman, Gansheimer, Rolim, & Mridha, 2017). As of December, 2017 the government's Information and Communication Technology Division's Cyber Help Desk has received more than 17,000 complaints, 70 percent of complainants were women.

[23] *Some called it "revenge porn" although I personally think these kind of videos can and should never be termed as porn.*

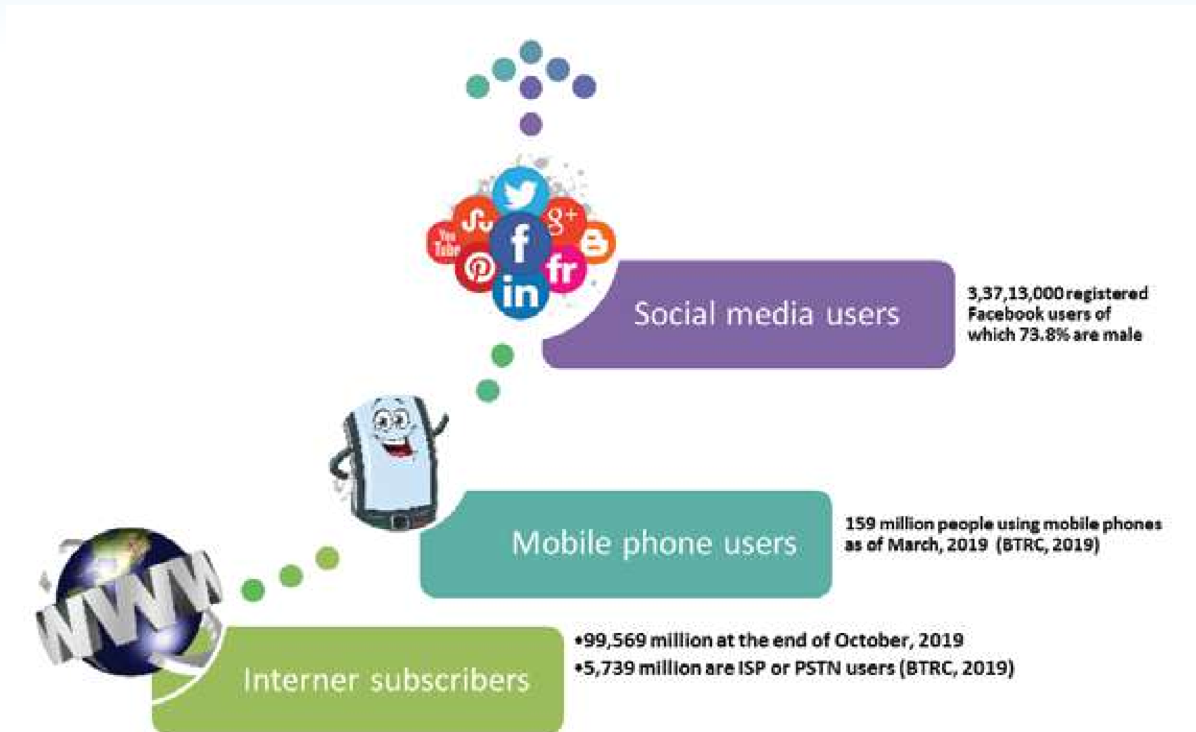
Figure 5: Facebook users in Bangladesh



2.2.f Rate of divorce is on rise: Are couples failing to leave in harmony?

Ever increasing rate of divorce cannot simply be correlated with the increase in VAWG. However, rate of divorce and reasons behind such divorce can help to understand the change in social relations, especially within in the household. SVRS (Bangladesh Sample Vital Statistics) report 2018 shows that there is a tendency for the crude divorce rate to increase over time: from 0.7 in 2006 to 0.9 in 2018. In the last seven years, the divorce rate application has increased by a massive 34 percent throughout the country according to data compiled by the Bangladesh Bureau of Statistics (BBS). The report stated that at least 50,000 divorce applications were filed in Dhaka North and South City Corporations between 2012-2018, which means on average one divorce application was filed every hour. Under the leadership of Seikh Hasina, Bangladesh has achieved unprecedented success in women empowerment. Not only women have entered into non-conventional jobs like serving the army and air-force but they have also entered into higher leadership positions. Women's participation rate in the labour force has increased by eight times in the last four decades—from four percent in 1974 to 35.6 percent in 2016. A quick analysis of the causes of divorce mentioned by women and men indicated during the time of divorce suggest that while women are trying to come out of obsessive relationship and domestic violence, men are trying to ensure their control. Moreover, men are not ready to share the burden of household work. Therefore, the new generation of empowered women who are less dependent on the spouse for money, the household is increasingly becoming an arena for gender imbalance. There are clear signs that men are failing to cope up with the new generation of empowered women or empowered women are failing to live with the age old patriarchal system.

Figure 6: Number of internet, social media and mobile phone users



2.2.g Workplace requires addressing safety measures for women

The women are entering in the workplace in large numbers, at the same time the cases of sexual harassment are increasing in recent days. According to a study by ActionAid Bangladesh, 80% of garment workers in Bangladesh have experienced or witnessed sexual violence and harassment at work, with 90% saying their job is negatively impacting their health.24 According to another study in 2018, 85 percent of garment workers face verbal abuse, 71 percent face mental torture, 21 percent face physical torture and 13 percent face sexual abuse.25 A study titled "State of Rights Implementation of Women Ready Made Garment Workers," conducted by Karmojibi Nari and Care Bangladesh, says about 12.7% of workers face sexual harassment at their workplaces.26 A recent study jointly conducted by Manusher Jonno Foundation and Karmojibi Nari has shown that 22.4% of female garment workers are sexually harassed at and on their way to their workplaces. The study found that 42% of these incidents included ill-intentioned leering at female workers, 34% cases of being groped and 34.92% of their "private body parts being stared at." Some 28% of all sexual harassment incidents were of female garment workers being touched inappropriately by their supervisors at work. Around 40% were harassed and abused on public transport and sidewalks. Furthermore, one-fourth of female garment workers reported feeling unsafe working in factories.27 According to the activist, the overall legal framework for addressing sexual harassment at workplace is not equipped to effectively deal with the issue as many women still face the abuse (ibid). There is a serious lack of proper enforcement of the existing laws that the laws hardly define sexual harassment at workplace, and on the other there is a lack of enforcement of the laws.

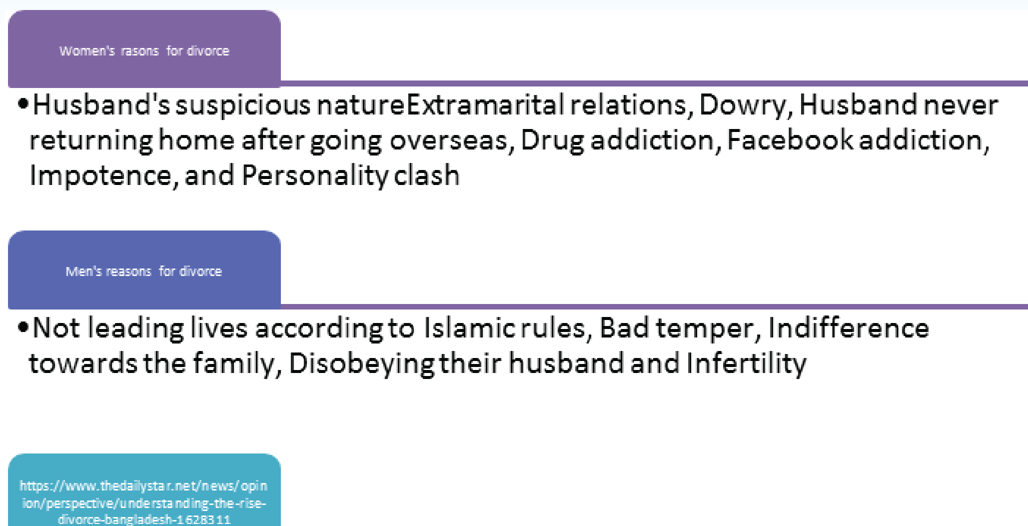
[24] *https://actionaid.org/news/2019/80-garment-workers-bangladesh-have-experienced-or-witnessed-sexual-violence-and*

[25] *https://www.thedailystar.net/frontpage/news/sexual-abuse-workplace-legal-framework-inadequate-1738840*

[26] *https://www.dhakatribune.com/opinion/special/2018/05/21/workplace-sexual-harassment-remains-unreported-ignored*

[27] *https://www.observerbd.com/details.php?id=212528*

Figure 7: Men and Women's reason for divorce



2.3 Factors behind the cases of VAWG

The cause of VAWG, is a complex one. Irrespective of society and culture it can be said that any case of VAWG is a result of multiple interlinked factors. Even though gender inequality can be identified straight way as the prime factor for VAWG, it can also be a result of such violence. Because discriminatory laws and exclusionary social norms can make women vulnerable undermining their opportunities for education, income and independence. On the other hand, when women try to move away from conventional roles due to empowerment, men might resist due to resentment about the shifting power relations within households (and communities) resulting in VAWG. Research on the causes of violence against women has consisted of two lines of inquiry: examination of the characteristics that influence the behavior of offenders and consideration of whether some women have a heightened vulnerability to victimization (National Research Council, 1996).[28]

Generally causal factors for enactment of VAWG are analyzed at various levels including individual, dyadic, institutional, and social. A systematic review[29] of researches conducted on VAWG identified several factors and accompanied study models. In the context of Bangladesh, the causes can be classified in three scales such as immediate causes of violence, intermediate causes of violence and underlying causes of violence.

Immediate causes of GBV: The immediate causes of VAWG include male ego and problems in dealing with rejection from girl/women (marriage/love proposal, dowry etc.), family dispute, greed for wealth (Hossain 2019) or even just to have "fun and entertainment" (Jahan and Imtiaz, 2017).

Intermediate causes of Gender based Violence: The intermediate causes of violence include the profiles of both victim and perpetrator and mostly identifies education, economic background, social customs, peace and conflict and law and order situation which enhance an environment to support enactment of VAWG.

Lack of education and economic opportunities: Education and good economic condition of women made them less prone to violence. Most of the studies agreed to the fact that lack of education makes women more vulnerable. According to statistics years of schooling is also associated with the prevalence of violence.

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[28]*See National Research Council. 1996. Understanding Violence Against Women. Washington, DC: The National Academies Press. doi: 10.17226/5127*

[29]*ibid*

Figure 8: Theories of VAWG

Biologic factors	such as androgenic hormonal influences
Evolutionary theories	
Intrapsychic explanations	focused on mental disorder or personality traits and profiles
Social learning models	highlights the socialization experiences that shape individual men to be violent
Social information processing theory	concerning the cognitive processes that offenders engage in before, during, and after violence
Sociocultural analyses	aimed at understanding the structural features of society at the level of the dyad, family, peer group, school, religion, media
State	that encourage male violence and maintain women as a vulnerable class of potential victims
Feminist explanations	stressing the gendered nature of violence against women and its roots in patriarchal social systems.

Social customs: Child marriage and dowry, two worst forms of violence against women and girls are reproduced by the harmful traditional practices and customs. There also lies a crucial relationship between child marriage and dowry. A girl child is treated as a burden to poor parents as in the marriage market the age of the bride is co-related with the dowry demand (Islam 2015); the demand of dowry is lesser if the bride is young.

Lack of women friendly services: Lack of security for women's travelling from the workplace, lack of women friendly public transport facilities, lack of housing facilities for migrant workers from rural areas make women vulnerable to gender based violence (Hossain, 2019). Moreover, political influence; administrative failure and lack of social resistance and implementation of laws allow the perpetrators to go free[30] which sustains the culture of violence and inspires the potential perpetrators to commit violence.

[30] *https://www.risingbd.com/english/Violence_against_women_and_girls_in_Bangladesh/14131*

Underlying Causes of Gender based Violence: Underlying causes can be the daily behaviors, social norms and values that slowly make men to be violent or to tolerate and at the same time encourages women to be submissive, to accept violence as inevitable.

Reproducing hegemonic masculine practices and behaviors: Men and boys are perpetrating almost all incidences of VAWG in Bangladesh. Traditionally men are taught to be violent, to prioritize their ego at the cost of women's life. Society also normalizes such behaviors that men may make fun out of harassing a girl sexually (Jahan and Imtiaz, 2017). The traditional socialization process in Bangladesh reproduce hegemonic masculinity in a way that teach men to remain authoritative over women. On the other hand, women are taught to be submissive and not to protest (Islam, 2015). Moreover, those men who exhibit positive masculinity and participate in so called women's work are discouraged by other women and girls by embodying complicit masculinity (Imtiaz, 2014).

Gender Division of labor: Traditionally, gender division of labor assigns household chores and care works for women and girls defining them as "feminine". These tasks do not bear any economic value and hardly recognized as "work", women-who mostly do these works also lose value and become subordinate. On the other hand, when men get involved in the income generating tasks, that gives them value, respect and power over the subordinated group "women" which pave the way to gender based violence (Imtiaz, Smith & Rabbi 2015). Toxic masculinity discourages men to participate in household chores or care works and those men who participated are also criticized even by women. Therefore, existing gender division of labor is reproduced and care works remain as feminine even though women are involved in so called productive works.

Figure 9: causes of GBV

2.4 Impacts of Gender Based Violence

Gender based violence surely has a wide range of impact and BPA sketched the impacts as such that "Acts or threats of violence, whether occurring within the home or in the community, or perpetrated or condoned by the State, instill fear and insecurity in women's lives and are obstacles to the achievement of equality and for development and peace. The fear of violence, including harassment, is a permanent constraint on the mobility of women and limits their access to resources and basic activities." High social, health and economic costs to the individual and society are associated with violence against women which is immeasurable. However, along with the above mentioned areas, there are report which tried to calculate the impacts of violence in terms of injury and economic cost.

2.4.1 Injuries due to Physical Violence

VAW report 2015 has been able to measure only the "physical" and "visible" signs of injury.

However, the report mentioned that 41.7% of ever married women who experienced physical or sexual violence sustained some form of violence where the most common form of injury were cuts, scratches, or bruises sustained by 32.3% of women. Being unable to work or move normally due to injuries was the second most common form of violence which was experienced by 11.1% women. Eye or ear injury, dislocation or burns was experienced by 8.4% "survivors". Deep wounds, broken bones, broken teeth, and internal injuries were sustained by 5.5%. Losing a body part such as hand, leg, ear, nose, eye etc. was experienced by 2%.

2.4.2 Cost of gender Based Violence

In addition to being a human rights violation, violence, particularly domestic violence has many monetary costs at all levels of society (Siddique, 2011). Individuals and family members have to pay medical bills, legal fees and relocation expenses. They mostly lose wages due to injuries and attending court. The state is also responsible for the judgment.

Only a few economic analyses on the cost of gender based violence have been conducted in developing countries, particularly in Bangladesh. The first known study in Bangladesh was conducted by Fahmida Khatun et al through the Centre for Policy Dialogue in 2010 mostly focusing on the cost of domestic violence (ibid). That study found that the average victim of domestic violence spent Taka 18,917 on healthcare, shelter, criminal justice, legal services and social services, the equivalent of 2.86% of the GDP of Bangladesh. Then CARE Bangladesh attempted to conduct a study on calculating the cost of domestic violence and the findings from that study are as follows.

2.4.2. a Loss of Income to the victim and her family

The 483 families in that survey forfeited over Taka 66 lac in wages in the year 2010, an average of 13,814 per family a year, as a result of suffering from a permanent injury that prevented them from working. The average daily income for the victim and her family was 155 Taka per day. In that survey, a total of 116 victims and 42 family members were not able to work for at least a year due to the injury sustained. The families also lost a total of Taka 99,366 in the year 2010 by attending court, an average of Taka 206 per family per year.

2.4.2. b Loss of income to the perpetrator and his family

Over Taka 11.7 lac was lost in income in the year 2010 due to the perpetrator losing the ability to work, an average of Taka 2,417 per family per year. Time spent in prison took a much great toll on the income of the family (Taka 2,142 per family per year) than time spent in hiding (Taka 276 per family per year).

According to our calculations, the total national cost of Violence against Women is at least Taka 14,358 crore for the year 2010. This is about 2.05 percent of GDP for that year.

2.4.2. c Cost of Violence against Women to the State

Five ministries were identified by the abovementioned study as providing services or undertaking activities pertaining to Violence against Women: (i) Ministry of Women and Children Affairs, (ii) Ministry of Social Welfare, (iii) Ministry of Health, (iv) Ministry of Home Affairs, and (v) Ministry of Law, Justice and Parliament any Affairs. It was found that the expenditure of the Government of Bangladesh for programmes and activities designed to combat Violence against Women for the FY2010 was Taka 137.24 crore.

This is about 0.12 percent of total government budget for that year and about 0.02 percent of the estimated GDP.

2.4.2.d Cost of Violence to Non-State Organizations

The NGOs and CBOs who were identified and willing to share their expenditures spent a total of Taka 125 crore on services and advocacy pertaining to Violence against Women. This number was increased by 20% to account for the NGOs and CBOs that were not identified or were not willing to share their Expenditures. On the basis of this assumption, the total amount NGOs and CBOs spent on services and awareness raising pertaining to Violence against Women was approximately Taka 150 crore for the FY2010 (July 2009 to June 2010). This is about 0.16 percent of the total government budget for that year and about 0.03 percent of the GDP.

2.5 Treatment seeking behavior

Tendency to seek treatment was quite low among the respondents. Among the respondents only 28.5% received treatment. Majority of the respondents (72.2%), from both rural and urban areas, who experienced partner physical or sexual violence were reluctant to reveal the incident. The most common reason was that the victim did not consider it necessary to report it, secondly they were concerned that it would bring a bad reputation to the family and some women were also afraid of what of their husbands. Only a very women (2.6%) took any legal action for partner physical and sexual violence. "Not considering it necessary" (11.5% of women) was the most common reason for not taking any legal action. Some (8.3%) were afraid of children's future. Women in urban areas were a bit more aware (3.6% women) in this regard. But it is more surprising that among the legal measures, mediation was the most common. However, the other legal measures taken were GD (0.4%), court case (0.4%), police case (0.4%) and first investigation report (0.2%). However, only 0.5% of perpetrators were punished "satisfactorily"/"partially satisfactorily". Very few women (2.4%) knew about the government telephone number for reporting violence.

2.6 Role of Education and Economic status to combat GBV

Education and Economic status seemed to play a positive role to reduce the rate of violence. Women at all level of education reported to experience any kind of violence but the rate declined as education level increased. 57.7% of "illiterate" women, as the report said, experienced partner physical and/or sexual violence compared to 26.0% of women with a degree or above. Physical and/or sexual violence was also more prevalent among poorer households. 61.4% women from the poorer households experienced violence when 18.4% women from the richest had to go through violence. The scenario was quite similar for controlling violence, economic violence and emotional violence. But another thing which is relevant here that 15.2% of respondents who earned their own income reported not to have control over their earnings.

3. Strategies for Combatting GBV: Major Initiatives

3.1 Commitments of the Govt. of Bangladesh towards Combatting Gender based violence

The government of Bangladesh is committed to ensure women's empowerment and to end violence against women in various ways. Constitution of the People's Republic of Bangladesh guarantees equal rights and opportunities for women and men in the Articles 19, 27, 28, and 29. Article 19(1) ensures equality of opportunity for all citizens. Article 27 states that all citizens are equal before law and are entitled to equal protection of law. Article 28(1) states that the state shall not discriminate against any citizen on the ground of religion, race, caste, sex or place of birth. Article 28(2) states that women shall have equal rights with men in all spheres of the state and of public life and Article 28(4) paves the way for special provision to facilitate the advancement of women and children.

3.1.1 Laws and Policies for Combating VAWG

GoB has also enacted various laws to prevent violence against women and children such as Women and Children Repression Prevention Act, 2000, Dowry Prohibition Act,1980, Acid Control Act,2002, Acid Crime Prevention Act, 2002, Domestic Violence (Prevention and Protection) Act, 2010, Prevention and Suppression of Human Trafficking Act, 2012, Pornography Control Act, 2012, Hindu Marriage Registration Act, 2012, Deoxyribonucleic Acid (DNA) Act, 2014, Child Marriage Restraint Act, 2017 and Child Day Care Centre Act, 2018 (draft). Special provisions have been incorporated in the National Women Development Policy 2011 and National Children Policy 2011 to prevent violence against women and children and to ensure supports for the victims. The High Court Division of the Supreme Court of Bangladesh has given a set of directives on 14 May 2009 for action in cases of sexual harassment of women in all academic institutions, workplaces. Steps are being taken to implement the directives of the Court.

The section 509 of the Penal Code has been included in the schedule of Mobile Court Act, 2009 to take immediate action against the perpetrators of sexual harassment. All extra judicial punishments including Fatwas are now banned as illegal as the declaration of the High Court Division.

Government is in a very strict position to end women and child trafficking. The Government of Bangladesh and India jointly formed a Taskforce regarding Rescue, Recovery, Repatriation and Integration (RRRI) of child victims of trafficking of these two countries. Monitoring Cell have been established in the Police Headquarters and district to oversee the trafficking situation. The Prevention and Suppression of Human Trafficking Rules 2017 has been formulated. A National Plan of Action 2015 -17 on Combating Human Trafficking has also been adopted that focuses on legal protection; raising awareness on trafficking; training of law enforcement agencies, support services etc.

3.1.2 Support Services for Combating VAWG

Victim Support Centres have been established in Dhaka, Rajshahi, Sylhet, Chittagong, Barisal, Khulna, Rangpur and Rangamati districts headquarters for providing various supports and services to the women and children survivors of violence. There are now women investigation and support unit established in Dhaka Metropolitan area for enhancing access to justice to the women and children survivors of violence.

There is a central cell to prevent violence against women and children in the Ministry Women and Children Affairs to monitor, supervise and follow up the efforts and initiatives to address violence against women and children. There are VAW Cells under the Department of Women Affairs and Jatiya Mahila Sanghsha to provide legal support to the women and children survivors of violence. In addition, there are 7safe custodies for women, girls and adolescents under the Department of Social Services, one such safe custody under the Department of Women Affairs (DWA), 6 women support centers under the department

of women affairs. In these safe custodies and shelters the women and children survivors can stay up to 6 months where they get legal support, psychosocial counseling and life skill training.

There are various supports and services under the Multi-Sectoral Programme on Violence Against Women (MSPVAW) of the Ministry of Women and Children Affairs being implemented jointly by the Government of Bangladesh and the Government of Denmark in collaboration of 12 ministries. Following the Beijing Declaration in 1995 to address gender based violence the programme started in May 2000, passed through various phases to 4th phase (July 2016-June 2021). The programme has established a coordinated approaches to end gender based violence that include: • One-Stop Crisis Centre (OCC) in Dhaka, Rajshahi, Chittagong, Khulna, Sylhet, Barisal, Rangpur, Faridpur and Cox's Bazar Medical College Hospitals provide health care, police assistance, DNA test, social services, legal assistance, psychosocial counseling and shelter services. • One-Stop Crisis Cells (OCCs) in districts sadar hospitals (40) and upazila health complexes (20) mobilize various services within and outside the hospitals for women and children victims of violence. • National Trauma Counseling Center (NTCC) in Dhaka provides psychosocial counseling to the women and children victims of violence and organize training for professionals and stakeholders. • Regional Trauma Counseling Centre along with 10 Mental Health Service Centres (MHSC) have been established under the Multi-Sectoral Programme on Violence against Women of the Ministry of Women and Children Affairs in Kutopalong and Balukhali camps of UkhiaUpazila for Rohingya women and children.

The main objective of this centre is to ensure a coordinated approach through MHSC in providing psychosocial counselling services to the women and children of Rohingya. • National Forensic DNA Profiling Laboratory in Dhaka ensures speedy and fair trial for the incidences of violence against women and children. • National Helpline Center for Women and Children provides various supports to the women and children through national toll free helpline 109 for 24 hours, 7 days a week. The Toll Free Helpline has been incorporated in the textbooks of secondary and higher secondary levels. • Mobile Apps "Joy" has been developed jointly with Access to Information (a2i) of Prime Minister's Office to combat violence against women and children. Women and Children victims of violence and their relatives can send quick sms to 109 by using this apps. This sms can also be sent simultaneously to the Deputy Police Commissioner of Metropolitan Area, Police Super of respective district, nearby police station and three FnF numbers of victim. • A National Action Plan to Prevent Violence Against Women and Children (2013-2025) has been formulated which included six major field for women and children i.e, (i) legal arrangement and legal facilities; (ii) social awareness and mental transformation; (iii) socio economic advancement of women and children; (iv) protective services for violence against women and children; (v) prevention and rehabilitation; (vi) institutional measures and strategies for implementing national action plan.

Ministry of Women and Children Affairs and UNICEF jointly launched a National Multimedia Campaign for Ending Child Marriage on 31st July 2017. Campaign theme is Raise the Beat which is a symbol of garnering attention, and in voicing protection to end child marriage. The campaign suggests a beat or rhythm for everyone to rally around together in order to raise their voices and report any incidents of child marriage. GBV clusters are formed in the context of humanitarian issues. MoWCA and UNFPA are co-leading the GBV Cluster. Government, Non-Government Organizations, Development Partners, Citizen's Groups are jointly conducting massive awareness programme on the eve of 16 days campaign on gender based violence.

3.1.3 Initiatives for Women Empowerment

Women empowerment is one of the 10 Special Initiatives of Hon'ble Prime Minister Sheikh Hasina. Seventh Five Year Plan (2016-2030) has prioritize the establishment of a society of gender equality and development of women. The vision of the 7FYP was to develop the country where men and women will have equal opportunities and rights and women will be recognized as equal contributors in economic, social and political development.

Since 2009 the gender responsive budget has been formulated by the Government for ensuring the participation of women in various programmes. At present all the ministries seem to adopt gender responsive budgeting and are made accountable towards spending their allocation for economic and social empowerment of women. Allocation for women development is Tk. 1,12,019 crore which is 27.99 percent of total budget Tk 4,00,266 crore in 2017-18 fiscal year.

Bangladesh has created a model in the world in the field of women leadership. The Prime Minister, the Speaker of the House, the Leader of the Opposition and the Deputy Leader of the House are women. In addition to the provision of contesting for general seats, 50 out of 350 seats in the Parliament are reserved for women. In order to promote women leadership at the grassroots level, one-third of the seats have been kept reserved for women candidates in elections to local bodies. Provision has been made requiring political parties to include one third post for women at various levels of their committees by 2020. Women Development Forum has been formed to enhance the capacity of selected women representatives at the upazila level.

Women's participation has been enhanced at the upper echelons to the Government, Judge of the Supreme Court, Vice Chancellor of a university and Ambassador.

Female soldiers have been lauded for their performance in the Army, Navy and Air Force. Along with other forces, women from Bangladesh are performing responsibly in peacekeeping missions. Ten percent quota has been reserved for appointment of women to gazetted posts and 15% to non-gazetted posts. In primary schools, 60% posts are reserved for appointment of women candidates.

Bangladesh Bank is providing collateral free loan up to Tk.25 lakh to women entrepreneurs. In addition, small and medium enterprise foundation offers special financial package for women entrepreneurs. Small women entrepreneurs are getting financial support from the volunteer women associations. Moreover, 10% industrial plots and 10% of small entrepreneurs fund are reserved by the Bangladesh Bank for women entrepreneurs. Ministry of Women and Children Affairs recently has taken the Income Generation Activities Training Project with a cost of Tk.250 crore. Under this project 217440 poor, underprivileged women of 426 upazilas will receive livelihood training on various trades as per the demand of the local community and can participate in the microcredit programme. Marketing and display facilities will be created for promoting their products. In addition, life skill and livelihood training for poor, marginalized and unemployed women for their self-employment and economic emancipation.

The Women Entrepreneurship Endeavor Programme (Joyeeta) was started to promote products and services of women entrepreneurs across the country. For the continuation of this support a non-profitable and autonomous Joyeeta Foundation has been set-up. The Vision of this foundation is to expedite the process of creating a gender based society through economic empowerment of women and the mission is to ensure economic empowerment of women by giving them special priority. Selected 180 registered women associations from the remote area of the country are allotted 139 stalls at Rapa Plaza at Dhanmondi, Dhaka for marketing their products. Almost 14000 women are engaged directly and indirectly involved with these 180 registered women associations. The 'Joyeeta Onneshone Bangladesh'

is being implemented through selection of Joyeetas in five categories from different parts of the society are to properly recognized and inspired them to make more confident and to make themselves as an entrepreneurs. Government has put utmost importance on developing a Digital Bangladesh by 2021. Tottho Apa Project of Jatiya Mahila Sanghsha makes remarkable contribution in solving day-to-day problems for grassroots woman through taking ICT services at their doorsteps.

The Ministry has established 94 daycare centres for the children of the working women. Low cost accommodation has been made for the working women in hostels. Considering the health need of working women and their children maternity leave has been increased from four to six months with full benefit. Government has introduced 142 social safety net programmes for marginalized and women with extreme poverty. The largest of the safety-net progammes is vulnerable group development (VGD) programme with 10 lakh beneficiaries where each vulnerable woman gets 30 kg of rice per month for a cycle of 2 years. Through investment component of VGD cash and fortified rice are being provided to ultra-poor women. Other programmes include allowances for the elderly, widowed and women, maternity and lactating mothers, allocation of government land to the ultra-poor and destitute women etc. All these programmes are contributing to alleviate poverty.

Ministry of Women and Children Affairs formed adolescent clubs in 379 unions of 7 districts to bring positive changes in the society. In each club there are 20 girls and 10 boys with age limit between 11 and 17 years who meet twice a week for sharing social issues. These adolescents are expected to become the change of agent in future. Initiative has been taken to establish 4880 clubs at unions (4550) and pourashavas (330).

A total number of beneficiaries would be around 2 crore marginalized women with their mainstreaming in development process through social safety net programmes, skill based training, computer and ICT training, TotthoApa project, Joyeeta initiatives, Multi-Sectoral Programme on Violence Against Women, entrepreneurship development, and microcredit programmes(MOWCA 2019).

3.2 Searching for More Scopes to work on

However, the attempts by the Government of Bangladesh is truly appraisable and GoB is actually focusing on holistic approaches. Still, hoping for more effective programs, the limitations are needed to be addressed too.

3.2.1 Gaps in Available Data and Statistics

While reviewing the secondary documents, some inconsistency among the reports were observed. In VAW Report 2015, 1838 respondents were selected from the 15-19 age group and many of them reported to experience partner violence. It refers that they had child marriage. Though the report was specifically conducted on Violence against Women, it never considered “child marriage” as a form of Violence itself.

SVRS Report 2018, while studying maternal mortality, only identified the immediate causes of death like complex pregnancy, bleeding etc. which mostly belong to medical terminologies and hence ignored the underlying causes like domestic violence or marriage at early ages. Bangladesh Demographic and Health Survey 2014 and Bangladesh Maternal Mortality and Health Care Survey 2016 also dealt with immediate causes. But there are studies revealing that in Bangladesh, 13.8% of maternal death in pregnancy occurred as a result of violence (Hossain, 2019). We have a declining trend in maternal mortality ratio, but unless the social dimensions are addressed as a cross cutting issues in such reports to understand the underlying causes, it may delay our progress towards its end.

SVRS report 2019 successfully analyzed the trend of divorce which shows that there is a tendency for the crude divorce rate to increase over time: from 0.7 in 2006 to 0.9 in 2018. This issue is relevant in the discussion of violence that it can be hypothesized that there can be crucial link. Hence, more in depth study is needed. Another major limitation was that this study only dealt with the non-mortal violence. But there are cases that leads to death, either murder or suicide. There was no data regarding that in this report. Discussion on the profile of the perpetrators, reasons for committing violence, was missing, though it should be prime concern, if we really want to end GBV.

3.2.2 Specifying the form of violence and addressing the emerging forms

Many more form of violence are yet to be discussed. VAW report 2015 mentioned "Humiliating and insulting" but this terminology does not clarify the extents. Passing bad comments while crossing roads, writing slangs in school/college buildings, taking picture without any consent, making fun on women's menstruation, forcing to watch bad pictures/movies, making trolls in social media are the emerging severe forms of violence that need to be addressed immediately.

3.2.3 Incorporating the experiences of men and boys, transgender and people of other gender and sexual identity

It should be considered that Gender based Violence does not occur against women and girls only. There are cases where men and boys fall victim to Gender Based Violence, there are transgender people, people of other gender identities whose basic Human Rights are being violated every moment, they are prone to severe forms of Gender based Violence. Many development organizations are working with them, but if large scale programs and studies on Gender based Violence by the government could include them, that would bring a holistic perspective.

3.2.4 Focusing on changing social norms that work as underlying causes of gender based violence

The person who commit gender based violence, does not become a perpetrator in a day. The lifelong learning teaches that it is okay to be violent. Our social system, where women, transgender, and people of other gendered identities belong to lower strata, society teaches men to use violence as a tool to oppress women and the marginalized ones. And women are taught to be silent, to accept it as their fate. To be violent, men are taught to be hard, to be cruel which process start as early as when they are said at childhood "boys do not cry". They get freed from the responsibilities of care works and household chores. Women, on the other hand, find no one to share their works, inevitably they go through limitless works and as society pay no value to their work, that makes them more submissive and vulnerable to violence.

Even though women strive to continue her education and job outside home, there remain threats like "Child Marriage", Dowry" in the name of customs and in addition men are never ready to welcome women in the public places. So cases of rape, sexual harassment are committed by men who cannot accept women's mobility, success and opinions (Imtiaz, 2014).

Considering all this, there is no way out of altering men's "Hegemonic Masculine Practices", turning those into "Positive Masculine Practices." Along with empowering women, men need to be sensitized to welcome that. And hoping for a sustainable change, every micro level practices, ranging from participation in household chores to not to commit violence, need to be taken under consideration. And as the learning should be a lifelong process, interventions must start at the earliest age (Imtiaz, S; Smith, B. & Rabbi, S. 2015).

4. Conclusion: Way forward to reduce Gender Based Violence and achieve SDGs

Bangladesh's success to empower women has been recognized in the world economic forum's Gender Gap Index; in 2009 the country ranked 93 whereas in 2019 it secured 49th position, highest among South Asian Countries. The visionary leadership of Prime Minister Sheikh Hasina to promote women in higher position has placed the country into the top five in the global index on the Political Empowerment sub-index in 2019. However, in terms of labour force participation the gender gap is widening. Bangladesh has closed over 72 percent of its overall gender gap. Undoubtedly, ensuring gender equality is a must if Bangladesh wants to achieve its target to be a developed country by 2030. The first step to it is to ensure a society free of VAWG. Unfortunately, unless the overall perception and attitude towards women are changed in the society, it will be very difficult to curve the overall situation with regard to VAWG. Because, there exists a culture of 'normalizing violence' with regard to intimate partner violence. It is acceptable to every corner of the society that men have the right to punish their wives. Unless such 'acceptability' is challenged there exist very little hope that overall situation with regard to VAWG will be improved.

This study discussed the present situation of GBV in Bangladesh based on available statistics. The study further focused on the available initiatives of the GoB to combat GBV. Preventing GBV is a prerequisite to achieving gender equality and the empowerment of all women and girls. Bangladesh as a signatory to the 2030 Agenda for Sustainable Development has already focus on empowering women and girls. However, such initiatives should be strengthened and other development efforts should also integrate strategies to combat GBV as among the 17 goals concerns for women were repeated in most cases. To cut GBV from its root, all the efforts for development must not consider women empowerment as an isolated issue and all the development frameworks and initiatives should reflect and identify proper strategies to ensure gender equality while focusing on preventing gender-based violence.

Poverty reduction has always been a major indicator of development and measuring development in line with SDGs. This requires concern for women together with men regarding access to basic services and ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology, and financial services. Unfortunately, due to existing gender-biased practices and a high rate of violence against women and girls many women and girls could not access these opportunities and basic services. Changing this situation requires creating sound policy frameworks and "gender-sensitive development strategies", that would support accelerated investment in gender-sensitive poverty eradication actions while also prevent GBV.

Aligning to SDGs also requires to take initiative to end hunger addressing the nutritional needs of adolescent girls, pregnant and lactating women. SDGs also set the target to double the agricultural productivity and incomes of small scale food producers especially women. Reducing the global maternal mortality ratio to less than 70 per 100,000 live births is also a prime concern of SDGs while ensuring 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 by 2030. SDG also address the issue of education setting targets of ensuring that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations, that all youth and a substantial proportion of adults, both men, and women, achieve literacy and numeracy. Unfortunately, in Bangladesh GBV is still a major issue for achieving equal access of girls to education at all levels.

Girls without any education are three times as likely to marry before 18 as girls with secondary or higher education. This hinders to eradicate extreme poverty (goal one) since child brides miss out on the educational and economic opportunities needed to lift themselves and their families out of poverty. Girls' education is the factor most strongly associated with reduced prevalence of child marriage, primary education was the most important for younger girls, many of whom marry at an early age. Therefore, the promotion of education at all levels is an effective way to prevent child marriage. A study by Girls not Bride Campaign revealed that education can be one of the most powerful tools to enable girls to avoid child marriage and to come up with their intelligence and potentials. Because the fact is that the longer a girl stays in school, the less likely she is to be married before the age of 18 and have children during her teenage years. Education also helps girls avoid the chance of getting married by empowering them, with developed skills, knowledge, and confidence to make informed decisions including if, when and whom to marry. Being in school also instills the notion that girls are still children and are therefore not ready to marry.[31]

While arguing for ensuring availability and sustainable management of water and sanitation for all in Goal 6, it required to end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations. SDGs urged for protecting labor rights and promoting safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment and to make cities and human settlements inclusive, safe, resilient and sustainable providing access to safe, affordable, accessible and sustainable transport systems for all with special attention to women. But unfortunately as we see from the data discussed in this report public space is still very unsafe for our women and girls. SDGs try to pave the way towards gender equality and hence recommend for structural changes in every possible field. Mainstreaming gender concern in every sector of development will help raise women's social status, ensure their rights making them less vulnerable to gender based violence. Following specific suggestions may help to improve GBV situation in Bangladesh:

4.1 Positive discrimination policy should be continued to empower women

The introduction of quota system and reinforcing it by the Prime Minister Sheikh Hasina at every level has ensured women's political empowerment. Prime Minister's initiatives in terms of creating equal opportunities for legislators, senior officials and managerial roles, as well as professional and technical roles have contributed a lot to empower women. Such strong leadership to empower women should be continued along with continuous allocation of resources for already taken initiatives as well as new initiatives at every level.

[31]*http://www.girlsnotbrides.org/themes/education/ accessed in March 22, 2017*

4.2 Implementation and enforcement of the law should be ensured

There exists an urgent need to ensure that existing laws are implemented and enforced whenever and wherever required without any bias. The issue of impunity for perpetrators of VAWG must end to begin curbing VAWG. Undoubtedly punishing perpetrators would act as the deterrence to future offenders and curbing the prevalence rate.

4.3 Men should be considered as partner of positive change for women empowerment

Although some people argue that empowering women would automatically ensure gender equality, the high prevalence of VAWG and increase rate of divorce suggest a bleak picture of future of gender equality in Bangladesh. It is evident at every level of the society that men are not ready to accept the change in general.

This has added an extra burden to the empowered women's lives. There should be immediate policy and accompanied programmatic interventions to help men to understand the positive impact of empowerment of women on their lives. Unfortunately, the government has failed to address it entirely except incorporating the issue in the national action plan to prevent violence against women and children 2013-2025.[32]

4.4 Boys should be targeted for generational breakthrough

Even if Bangladesh invest in this generation of men, it would be very difficult to sustain already achieved gender equality unless the next generation of men realize the importance of women empowerment. It has been observed from the experience of the Nordic country that investing in the younger generation for gender education bring positive change in the long run. Therefore, urgent initiatives should be taken to ensure that boys become better partners in future.

4.5 Deeply rooted toxic hegemonic masculinity construction should be challenged

Unless the deeply rooted toxic hegemonic masculine behavior and practices are challenged, it would be very difficult to ensure increasing antagonistic relationship between men and women at every spheres of the society. Celebration of those enactments of masculinities that prevent violence against women and girls while challenge the harmful toxic can be a way to promote positive masculine behavior.

[32]*See section 1.10.1 of National Action Plan to Prevent Violence against Women and Children 2013-2025*

4.6 Fatherhood can be used to eliminate harmful practices like child marriage and dowry

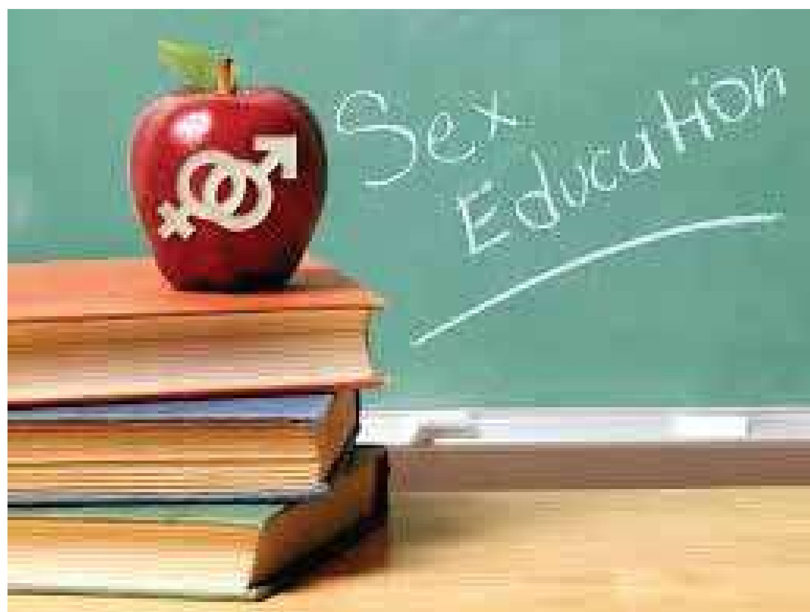
In order to ensure women's education and empowerment and to end all forms of violence against women and children including child marriage, special self-reflexive initiatives need to be designed involving the fathers. As fathers are still the sole decision makers in most of the families in Bangladesh, they are the gatekeepers for child marriage in most of the cases and fathers think they do so for the betterment of their daughters. If we can change the traditional thoughts of fatherhood and can make the fathers realize the benefits of ending child marriage following the examples of role model fathers, the situation with regard to child marriage will be changed.

4.7 Conduct study on men and masculinities to understand perpetrators perspectives

Till now all the studies to understand VAW in the context of Bangladesh were targeted at understanding victim's perspectives, there isn't any significant effort to understand perpetrators perspective. As majority of the perpetrators are men and this study finds a frightful silence among men about VAW that contribute to 'normalizing VAW', there should be an immediate study why and how few men become perpetrators while most men accept such criminal acts and remain silence. Incorporating a men and masculinity lens for such a study will allow identifying strategies to curve the violence against women involving men.

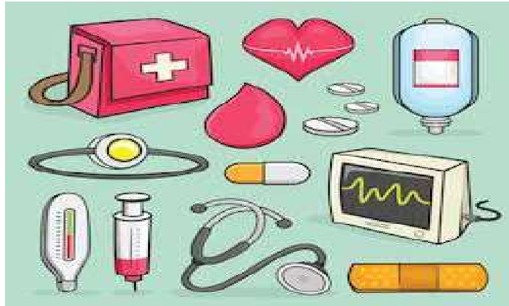
4.8 New technologies should be used to introduce 'sex education'

An action research conducted by Center for Men and Masculinities Studies (CMMS) on SRHR and VAWG involving boys in schools suggests, adolescents mainly internalize sexual behavior watching porn videos, movies and dramas over the internet that promote sexual domination by the male as an innate characteristic of masculinity. In the absence of proper mechanisms for the youth to discuss their sexual anxiety and fantasies along with relevant queries, most of them fall prey on internet sources as their only 'authentic knowledge source'. The introduction of the chapters on SRHR issues in the curriculum also could not address the issue as the traditional teacher-student relationship does not allow such 'intimate conversation'. Both the parties involved feel uncomfortable. As youth loves to use new technologies like internet and mobile phone and somehow have access to these, and face to face interaction for promoting sexual and reproductive health counseling in a classroom setting is very difficult, developing a mobile app along with the self-reflexive diaries help to fill up the gap and promote safe space for SRHR information learning and sharing.



4.9 Develop and implement standard VAW treatment protocols

It has been observed that there is no standard protocol for treatment of a VAW victim irrespective of the type of violence. This has resulted in lack of consistency with regard to the service provided to the VAW victim. For example, it has been observed that rape victims in different health care settings were not referred for any of preventive treatment including diagnosis or treatment for gonorrhoea, Chlamydia, Trichomonas, HIV test (HIV may be recommended if a victim is evaluated within 72 hours of being assaulted) and hepatitis B even though none of the victims were previously vaccinated with hepatitis B vaccines.



Preventive treatment completely depends on the doctors wish and available facilities. Moreover, as in some cases such treatment requires a prolonged period of observation, the victims also do not want to stay at the health care settings due to the fear that their identity will be disclosed. If a protocol is in place at least there will be a guideline before the heath care service providers to maintain a minimum standard and consistency while providing service to the victims.

4.10 Provide adequate logistic supports for emergency response

One of the major obstacles for VAW prevention is the lack of timely services. It has been observed that the OCCs with special mandate to deal with such cases do not have any logistic supports including Ambulance services. Therefore, they cannot take any proactive role to bring the victim in the health care setting with in a shortest possible time and provide required support services. There were many incidences that suggest how due to the lack of proper logistics the VAW victim's urgent health care needs could not be fulfilled. We have heard many stories even from the health care service providers that though there was urgent need to send a victim to the district level or in few cases to Dhaka, it could not be done due to the lack of Ambulance service. Sometime even though the Ambulance was available, the oil cost was an issue and the victim was so poor that they could not bear any cost. Thus, the victims suffered for long without any proper treatment. We heard stories of death from such incidences. Providing adequate logistic supports to the OCCs at least at the district level hospitals may help to improve the situation drastically.

4.11 Develop emergency rescue mechanism

In many cases, more specifically with regard to sexual violence and trafficking, it was found that the victims needed special support to rescue them. Rescuing a victim is the mandate of law enforcing agency and health care service providers are not included in such operations. It seemed that the law enforcing agency do not provide any special attention to such cases. If there is a coordinated mechanism between the OCCs and law enforcing agencies for such operation, situation might improve. At least at every divisional level a special rescue team with a coordinated effort between OCCs and law enforcing agencies can be deployed.

4.12 Provide adequate training to the staffs for responding to emergency crisis

Adequate training with regard to handling VAW victims should be introduced immediately. The study found that most of the nurses who were involved in the health care service providing mechanism to the

VAW victims did not have any rigorous training on how to handle the cases of violence. There can be specialized training to develop skills of the nurses as Sexual Assault Nurse Examiner (SANE) with regard to handling rape victims or sexual assault victims. Such specialized training can also be provided for acid throwing, burn cases or wife battering.

4.13 Increase number of female doctors

One major demand from the VAW victim's was to increase the number of female doctors. Almost all of the victims irrespective of types of violence expressed their uneasiness to be examined by male doctors. This issue should be taken care of immediately as experiences of examining by a male doctor especially after the sexual assault create extra psychological pressure on the victim. In order to increase the number of female doctor's special measures should also be taken. In most cases women doctors do not want to be involved in forensic department as such duty require them to go to the court as witness on a regular basis. Based on the interviews with the female doctors it seems that considering the stigma attached with such duties at the court female doctors want to avoid it. Therefore, if required special provision should be taken so that the female doctors are exempted from such duties or such witness can be taken at their duty stations.

4.14 Strengthen and expand existing psychological counselling service

Psychological counselling is an integral part of the treatment plan for any sorts of VAW cases. The victims and their relatives have overwhelmingly emphasized on the importance of such counselling. Most of the OCCs that the research team has visited as part of the study have such counselling services. But as many of the VAW victims do not come to the OCCs rather are admitted in the general bed, the counselling service should be expanded to include the patients in the general ward. Moreover, as such counselling services are not available at the community level; at least a psychological counsellor should be deployed at the Thana level.

4.15 Develop follow up mechanism with strong web based monitoring system

One major drawback of existing health care service providing mechanism for the VAW victims is that the follow up mechanism is very week. There is no system to trace whether a victim after receiving immediate treatment is following the treatment regime. One way to strengthen the follow up mechanism can be to link the community clinics with the web of Thana and District level service providers using a web based referral system. Any patients after receiving treatment at the upper level of health care facilities will be referred to the community clinics for reporting and monitoring purpose.

4.16 Create networking among GoB and civil society actors

Unfortunately, existing networking among the health care service providers with in the GoB system and civil society actors is very weak. This need to be strengthened immediately as such networking may help to initiate coordinate efforts at every level to respond to VAW. Information exchange and sharing of experiences should be a regular practice among different actors.

4.17 Engender HIS data sources

As a model for standard practice of HIS, the government of Bangladesh has accepted the Health Metrics Network (HMN) framework.[33] This framework has been used to examine HIS in Bangladesh in 2009. Unfortunately, this framework has not considered gender as a lens to identify different components. The framework should emphasize on making legislative, regulatory and planning framework of HIRS women friendly. There should be specific direction to ensure women's active participation in the formulation process of legislation, regulation and plan. There should be clear suggestion about the recruitment of women personnel to provide specialized services like VAW victim's health care (as for example OCCs and Forensic department etc). There should also be clear direction for data management with regard to women's concern like VAW victims health care needs. It should be noted here that the HNM has identified six components of which data source is one.[34]

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[33] *Before 2005 there was no global standard for Health Information System. There was no common structure of HIS for Countries. The World Health Organization (WHO) took an initiative to set a standard practice of Health Information System worldwide. WHO, as a host, launched Health Metrics Network (HMN) along with financial assistance from other donor agencies to help countries and other partners improve global health by strengthening the systems that generate health-related information for evidence based decision making. HMN dealt with mainly Health Information and Statistical Systems and Health information production and Use. Then it established the "HMN Framework" as a standard practice of Health Information System (HMN 2009).*

[34] *Health Metrics Network (HMN) has identified six components of Health Information System. These are: Health Information System Resources, 2. Indicators, 3. Data sources, 4. Data Management, 5. Information Products and Dissemination and use. The HMN has also put those six components into three broad stages: 1. Inputs, 2. Processes and 3. Outputs. According to the 'HMN framework', Health Information Resource System (HIRS) is, considered as input of overall HIS, is obligatory for a Standard HIS. The HIRS includes –1. Legislative, regulatory and planning frame work, 2. Personnel, financing and logistics support, 3. Information and Communication Technology, and 4. Co-ordination among the other components. Then, the 2nd, 3rd and 4th components are considered as processes. The 2nd component is mainly about a core set of indicators and related targets for the three domains of health information: 1. Determinants of Health (e,g socio economic and demographic factors and environmental factors), 2. Health System (e.g Policy, financing and service availability etc) and 3. Health Status (e.g Levels of Mortality and Morbidity). The third component includes Data sources especially Population based (Census, Surveys etc) and Institution based (Individual records, Service records etc). The final stage consists of the component 5th and 6th. The 5th and 6th components deal with Information products and dissemination and use respectively.*

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POLICY PAPER: 3

Addressing High Unmet Need for
Family Planning and its Subsequent Impacts on
Adolescent pregnancy and Maternal Mortalities
and Morbidities in Bangladesh

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December 2020

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Executive Summary

Recent theoretical exercise of population projection reveals that the target of achieving CPR at 75% could be met if all current unmet need (12%) were to be met (Streatfield and Kamal, 2013). However, it perhaps remains important for further investigations regarding the inconsistencies between CPR and TFR. Streatfield and Kamal (2013) also emphasized for better understanding about the program itself or reasons behind the plateauing in the uptake of contraception during the 1990s and that it again happened during 2011 – 2017/2018 (BDHS).

It has been emphasized that high fertility rates will impact woman's health, and woman's reproductive pattern may also have important effects on the health and survival chances of her children. UN is monitoring the developments across the globe. Bangladesh falls behind to meet the commitments to achieve FP 2020 goals of reducing TFR from 2.3 to 2.0; unmet need from 12% to 10%; discontinuation rate of FP methods from 30% to 20%.

Unmet need of contraceptive use is a complex factor. BDHS 2017 – 2018 tells us that overall the unmet need is 12% but unmet need is highest among young women aged 15-19 (17%) and divisions such as Sylhet and Chattogram (18% and 17% respectively) (NIPORT, 2016). Adolescent pregnancies are quite rampant and these are happening due to many reasons. One of the big reasons is that the girl after marriage has to prove her fertility by getting pregnant. In Bangladesh, more than 1 in 3 girls has started childbearing by the age of 19, and 1 in 10 girls becomes mother before the age of 15 years (NIPORT et al., 2016).

The overall objective of the assignment (TOR is in Annex 1) is to prepare a thematic paper, policy brief and factsheet based on secondary data and literature review on the topic "Addressing high unmet need for family planning and its subsequent impacts on adolescent pregnancy and maternal mortalities and morbidities in Bangladesh", which will generate knowledge and build capacity of concerned Government Officials and stakeholders including NGOs and CSOs on how to attain 3 Commitments of Bangladesh Government to ICPD25, the 3 Zeros.[1]

For developing this Policy Research document, the Scope of Work included a) In-depth review and analysis of existing FP related policies and available reports and document; b) Prepare a draft thematic paper on the above-mentioned issue and submit it to both GED and UNFPA for review, feedback and comments;c) Prepare a key note presentation, based on policy research, to facilitate a policy dialogue;d) Submit the draft final policy research report and based on the report, a policy brief & a factsheet to GED;e) Prepare and submit the print ready version of the report, policy brief and factsheet to GED.

For developing this policy research document, a mixed method approach has been followed combining desk research (literature review), quantitative research through secondary analysis of BDHS data and qualitative method comprising of key informant interviews (KII) with GOB policy makers and managers associated with family planning and health services delivery programs, international agencies and organizations, NGOS and CSOs involved in adolescent health and rights, researchers and academia. The quantitative part of the research was done using seven rounds of Bangladesh Demographic and Health Survey (BDHS) data sets (from 1993-1994 to 2017) along with population census data. Both descriptive and inferential techniques were applied as and where applicable. Triangulation of all types of information was made for deducing the conclusions and producing programmatic and policy recommendations.

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[1] *New research showing exactly what it will cost to achieve the "three zeros": zero preventable maternal deaths, zero unmet need for family planning, and zero gender-based violence. https://www.nairobisummiticpd.org accessed on 01 December 2020*

Findings documented in this research policy work gives us the existence of high child marriage prevalence, high child pregnancy coupled with relatively low CPR and high unmet need for family planning among married adolescent girls (MAGs) in Bangladesh, which in turn, leading to high pregnancy related morbidity, high PRMR and MMR.

Under the above context some recommendations of high programmatic, policy and research values have been put forward for consideration in the 8th Five Year Plan and other relevant documents. Keeping in consideration the FP law, policy and program situation the recommendations have been proposed. Given the existing coverage of FP services to MAG, the national FP strategy moving forward should dedicate more attention to the quality of sexual and reproductive health and FP in line with the ICPD+, FP2020 moving towards FP 2030 and achieving the national goals of SDGs.

The MOH&FW should propagate pertinent policy enshrining quality FP services as a right of all eligible MAGs. Given the rapid growth of the private sector in MNH services

and especially delivery service in private sector, service quality following national (including WHO standards and guidelines at these settings) has become issues of concerns. The government should establish and effectively implement a national mechanism for assuring the FP services at all steps. A specific guideline needs to be developed to facilitate district, and Upazilla FP-MCH managers monitor and supervise SRHR service coverage, adequacy and quality at respective facilities for addressing the Unmet need of SRHR services, especially unmet need of MAG to family planning services.

An appropriate quality audit toolkit should be devised to facilitate the participatory audits of FP service coverage to MAG, its' quality, effectiveness, efficiency, impact and sustainability based on the reproductive health rights-based approach enshrined in the ICPD, ICPD+, FP2020, national and/or WHO standards and the socio-cultural context of Bangladesh.

Acronyms/Glossary

ANC	Antenatal Care
ASRH	Adolescent Sexual Reproductive Health
BOT	Born on Time
CEmOC	Comprehensive Emergency Obstetric Care
CP	Child Protection
CSBA	Community Skilled Birth Attendant
DGFP	Directorate General of Family Planning
EDD	Expected Date of Delivery
FGD	Focus Group Discussion
FPI	Family Planning Inspector
FWV	Family Welfare Visitor
GBV	Gender Based Violence
GE	Gender Equity
GoB	Government of Bangladesh
HCP	Health Care Promoter
HDRC	Human Development Research Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IFA	Iron, Folic Acid
IMPAC	Integrated Management of Pregnancy and Childbirth
IPV	Intimate Partner Violence
KII	Key Informant Interview
MAG	Married Adolescent Girls
MCH-FP	Maternal Child Health and Family Planning
MDG	Millennium Development Goal
MNH	Maternal and Neonatal Health
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
NGO	Non-Government Organization
NIPORT	National Institute of Population Research and Training
PAC	Post Abortion Care
QoC	Quality of Care
RQA	Rapid Qualitative Assessment
SACMO	Sub Assistant Community Medical Officer
SBCC	Social Behavior Change Communication
SIDS	Sudden Infant Death Syndrome
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TT	Tetanus Toxoid
UFPO	Upazilla Family Planning Officer
UH&FWC	Union Health and Family Welfare Center
UHC	Upazilla Health Complex
UHFWC	Union Health and Family Welfare Centre
UNICEF	United Nations Children Fund
UP	Union Parishad
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

1: Introduction, Objectives, Research Questions, & Scope of Work

1.1 Introduction

It has been emphasized that high fertility rates will impact on woman's health, and woman's reproductive pattern may also have important effects on the health and survival chances of her children. UN is monitoring the developments across the globe. Bangladesh falls behind to meet the commitments to achieve FP 2020 goals of reducing TFR from 2.3 to 2.0; unmet need from 12% to 10%; discontinuation rate of FP methods from 30% to 20%; and increasing contraceptive prevalence rate (CPR) from 62% to 75%. In order to achieve these goals, the 4th Health, Population and Nutrition Sector Program (HPNSP) aim to reach a CPR of 75% and a reduction in TFR of 2.0 by 2022. Recent theoretical exercise of population projection reveals that the target of achieving CPR at 75% could be met if all current unmet need (12%) were to be met (Streatfield and Kamal, 2013). However, it perhaps remains important for further investigations the inconsistencies between CPR and TFR. Streatfield and Kamal (2013) also emphasized for better understanding about the program itself or reasons behind the plateauing in the uptake of contraception during the 1990s is required. This has become more important looking at the stalling of CPR and TFR during 2011 – 2017/18.

Unmet need of contraceptive use is a complex factor. BDHS 2017 – 2018 tells us that overall the unmet need is 12% but unmet need is highest among young women aged 15-19 (17%) and divisions such as Sylhet and Chattogram (18% and 17% respectively) (NIPORT, 2016). Adolescent pregnancies are quite rampant and these are happening due to many reasons. One of the big reasons is that the girl after marriage has to prove her fertility by getting pregnant. In Bangladesh, more than 1 in 3 girls has started childbearing by the age of 19, and 1 in 10 girls becomes mother before the age of 15 years (NIPORT et al., 2016). Available data suggests that the pace of decline in adolescent fertility has slowed over the last two decades (Islam et al., 2017). Lack of awareness, missing inter-spousal communication and then the non-availability of contraceptives soon leads to a pregnancy. Many of the pregnancies are unwanted and then the girl wants to get it terminated which ends up in lots of complications and sometimes leading to death. Nearly a third of pregnancies are terminated annually.

The risk of maternal death and disability is substantially higher for adolescent mothers than for mothers with ages 20 and above (Chen et al., 2007; Ganchimeg et al., 2014; Hunt, 2001; WHO, 2019). Besides, higher risks of eclampsia, puerperal endometritis, systemic infections, low birthweight, preterm delivery and severe neonatal conditions among adolescent mothers compared to adult mothers (Bacci et al., 1993; Fraser et al., 1995; Gilbert et al., 2004; Satin et al., 1994). Most of the adolescent pregnant girls stay back at home without availing the ANC services again due to many social reasons and lack of awareness. These adolescent pregnant girls are at the highest risk of running into pregnancy related complications where death is a common outcome. Many of these adolescent pregnant girls during delivery and after the birth of the babies end up having morbidities such as obstetrical fistula etc.

The country has to achieve FP 2020 goals of reducing TFR from 2.3 to 2.0 in Bangladesh; unmet need from 12% to 10%; discontinuation rate of FP methods from 30% (in BDHS 2017-2018 discontinuation has gone up to 37%) to 20%; and increase contraceptive prevalence rate (CPR) from 62% to 75%. In order to achieve these goals appropriate local level estimation is crucially needed to develop evidence-based FP program and implement that in selected and target the at-risk populations at all levels particularly Upazilla and District.

In Bangladesh, these estimates are often not available and difficult to estimate due to lack of data. Bangladesh Demographic and Health Surveys collect divisional level information; however, these are not

useful to derive reliable regional level (e.g., District/Upazilla) estimates due to small sample sizes that lead to high levels of sampling variability (Rao 2003; Johnson et al., 2010). However, an attempt has been undertaken by UNFPA using a local organization using the methodology of Small Area Estimation to determine unmet need at District/Upazilla level (Unnati et al 2020, work in progress).

1.2 Justification

Bangladesh, after almost 50 years of its independence, has started facing new challenges with a relatively large population, particularly in the wake of the recent COVID-19 pandemic. Due to COVID-19 pandemic, it is estimated by UNICEF that an additional 2.4 million babies would be born in Bangladesh in the coming months. The Total Fertility Rate (TFR) has been stagnant at 2.3 since 2011, while the wanted TFR by women is 1.6. This means that if all women had their family planning (FP) needs to be met and would get the number of children they wanted, the total fertility would be 1.6 and well below the replacement level (NIPORT, 2016). Besides, the maternal mortality ratio (MMR) is still high 196 deaths per 100,000 live births. Experience shows that FP prevents 30% maternal deaths, avert 20% new-born death, reduce 66% unintended pregnancies and reduce unsafe abortion by 40%. Reducing unintended pregnancies by meeting the current unmet need for contraception would result in a 67% decline in induced abortion and 81% decline in the number of maternal deaths due to unsafe abortion in the developing world.

Early childbearing often limits teenage girls' access to socioeconomic and wellbeing opportunities such as education, income generating activities and healthcare facilities (McQueston et al., 2012; Oyefara, 2009). Early marriage or pregnancy causes drop out of school for an estimated 5 to 33 percent girls ages 15 to 24 in some countries which in turn lower their earnings 9 percent (WB, 2017). Married adolescent girls may also need greater emotional, psychological and social support to carry the burden of childbearing than those of adult mothers (WHO, 2019).

The Bangladesh Government has committed in different international ratifications to reduce unmet need for family planning, reduce maternal mortality, prevent and respond to gender-based violence including child marriage, and harnessing the demographic dividend in conformity with the SDGs. Besides, accelerating the implementation of the ICPD POA in Bangladesh needs to come down to enough strategic investments, evidence-based plan and policy making and strong political commitment. Inputs as such are also directly relevant for the success of the SDG Agenda and FP2030 goals. Under this context, GED IPDIPP Project will prepare a policy brief titled "Addressing high unmet need for family planning and its subsequent impacts on adolescent pregnancy and maternal mortalities and morbidities in Bangladesh".

1.3 Objectives

The overall objective of the assignment is to prepare a thematic paper, policy brief and factsheet based on secondary data and literature review on the topic "Addressing high unmet need for family planning and its subsequent impacts on adolescent pregnancy and maternal mortalities and morbidities in Bangladesh", which will generate knowledge and build capacity of concerned Government Officials and stakeholders including NGOs and CSOs on how to attain 3 Commitments of Bangladesh Government to ICPD25 3 Zeros.[2] Besides, this thematic paper will also use as inputs during preparing National Plans and Policies.

[2]New research showing exactly what it will cost to achieve the "three zeros": zero preventable maternal deaths, zero unmet need for family planning, and zero gender-based violence. https://www.nairobisummiticpd.org accessed on 01 December 2020.

The specific objectives of the policy research are as follows:

(i) to investigate the state of unmet need for family planning among the married adolescent girls,
(ii) to explore the contributing factors of unmet need for family planning among the married adolescent girls,
(iii) to examine the state of maternal morbidity among the married adolescent girls,
(iv) to identify MMR among the married adolescent girls,
(v) to produce policy and programmatic recommendations for reducing unmet need of family planning, maternal morbidity and mortality.

1.4 Research Questions

The overall research question of the assignment is to find out that addressing high unmet need for contraceptive use will impact on adolescent pregnancy, leading to stopping of untimed termination of many of those pregnancies which leads to maternal mortalities and morbidities in Bangladesh.This will generate knowledge on how to attain Commitments on 3 Zeros of Bangladesh Government toICPD25.The 3 Zeros include zero unmet need; zero gender-based violence; and zero preventable maternal deaths.

1.5 Scope of Work

For developing this Policy Research document, the Scope of Work includes the following:

a. In-depth review and analysis of existing FP related policies and available reports and documents like- Fourth Health, Population and Nutrition and Sector Program (4th HPNSP), Strategic Plan of HPNSDP, HPNSDP (2011-2016), PIP, Mid-term review report, priority action plan (PAP),operational plans (OPs), perspective plans 2021 and 2041, national social security strategy (NSSS), 8th Five Year Plan,national health, nutrition and population policies along with maternal, neonatal and child health strategies,health financing strategy (2012-2030), essential service package (ESP), universal health coverage (UHC), primary health care (PHC) services, Census reports, BDHS reports, MICS reports, SVRS reports, BMMS reports, relevant research reports, study reports, monographs, etc.; to understand the current programmatic challenges and future priorities.
b. Prepare a draft thematic paper on the above-mentioned issue and submit it to both GED and UNFPA for review, feedback and comments;
c. Prepare a key note presentation, based on policy research, to facilitate a policy dialogue titled "Addressing high unmet need for family planning and its subsequent impacts on adolescent pregnancy and maternal mortalities and morbidities in Bangladesh"to be organized by GED for policy makers and concerned stakeholders;
d. Briefing/debriefing meeting with the Project Director, GED IPDIPP Project and UNFPA for conceptual clarification of the assignment;
e. Submit the draft final policy research report and based on the report, a policy brief & a factsheet to GED by incorporating all feedback and comments received from policy dialogue, GED and UNFPA; and
f. Prepare and submit the print ready version of the report, policy brief and factsheet to GED.

2. Methodology

2.1. Methodology

For developing this policy researchdocument, a mixed method approach has been followed combining desk research (literature review), quantitative research through secondary analysis of BDHS data and qualitative method comprising of key informant interviews (KII) with GOB policy makers and managers

associated with family planning and health services delivery programs, international agencies and organizations, NGOS and CSOs involved in adolescent health and rights, researchers and academia. The quantitative part of the research was done using seven rounds of Bangladesh Demographic and Health Survey (BDHS) data sets (from 1993-1994 to 2014) along with population census data. Both descriptive and inferential techniques were applied as and where applicable. Triangulation of all types of information was made for deducing the conclusions and producing programmatic and policy recommendations.

2.2 Limitations

Above all the resource and time scarcity are the prime limitations of this research. Among others knowledge gap on adolescent SRHR, lack of absolutely dedicated comprehensive research papers and articles on the subject, and unavailability of access to specifically designed adolescent SRHR survey data sets are also mentionable limitations of the accompanying research.

3. Findings

3.1. Reconciliation of Findings

Triangulation of findings reveals that Family Planning after 50 years of glorious history of being near miracle, there is no scope for feeling satisfied, still it is long way to go for attaining FP2020 goals. This chapter is a compilation of the findings generated for addressing the objectives of this policy research. The quote of a Key Informant Interviewee is a good start of this chapter (Box –1).

Box 1: Family Planning Program in Bangladesh, stalled, temporary decline in contraceptive use during COVID-19 pandemic, high Unmet Need among adolescents, with probabilities of increase in maternal mortality &morbidity.

The findings chapter comprise of ten (10) sections pertinent to the objectives of the policy research and a reconciliation section (instead of introduction). Section 3. 2 presents married adolescent girl (MAG) population doing secondary analysis of available data. Section 3.3 depicts analysis of age and education distribution of MAG and following section (section 3.4) explores wealth quintile and employment of the MAGs and their husbands. Section 3.5 examines contraceptive use issues pertinent to CPR, method mix, source of supply along with information on source of family planning.and unmet need of MAGs, the historical analysis of unmet need for family planning among MAG along with factors influencing the same. Section 3.6 investigated age of first marriage, age at first pregnancy along with number of living children etc. Section 3.7 presents information on maternal mortality and morbidity, and is followed by the Discussion and Recommendation chapter.

3.2 Overview of married adolescent girl population in Bangladesh

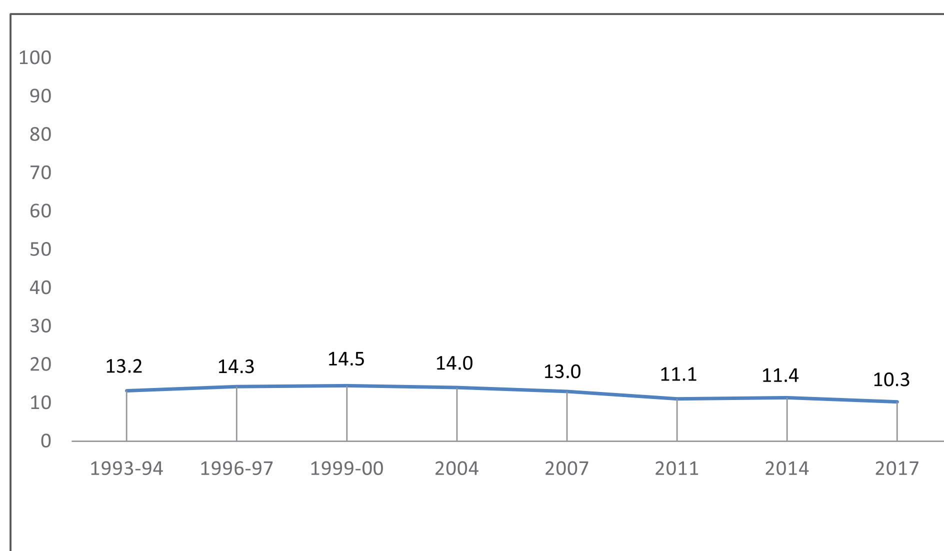
In Bangladesh, according to law child marriage is not permissible, except certain especial circumstances. However, marriage under 18 years is quite a frequent phenomenon in the country. All seven rounds of Bangladesh Demographic and health surveys held between 1993-94 and 2014 reveal that a notable female population ranging between 11.1 percent and 14.5 percent are married. During the first round of BDHS (1993/94), 13,2 percent of the under nineteen women was in marital union. The consequent BDHSs identified the same as 14.3 percent (BDHS 1996/97) and 14.5 (BDHS 1999/00). The proportion gradually declined to 14.0 percent and 13.0 percent respectively during BDHS 2004 and BDHS 2007 (Table 1). The next two rounds of DHS in Bangladesh recorded further downsizing of the proportion. However, it remained notably as high as around one-ninths of currently married women belongs to under 19 age group (11.1 % in 2011 and 11.4 % in 2014).

Table 1: Percentage of married adolescent girl aged 15-19 years, BDHS 1993-2014

	1993-94		1996-97		1999-00		2004		2007		2011		2014		2017	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Married adolescent girl	1271	13.2	1301	14.3	1514	14.5	1598	14.0	1424	13.0	1970	11.1	2029	11.4	2134	10.3

The overall total population of the adolescent girls remained at a linear level over the years (Fig.1).

Figure 1: Percentage distribution of currently married adolescent girls by years 1993 to 2017



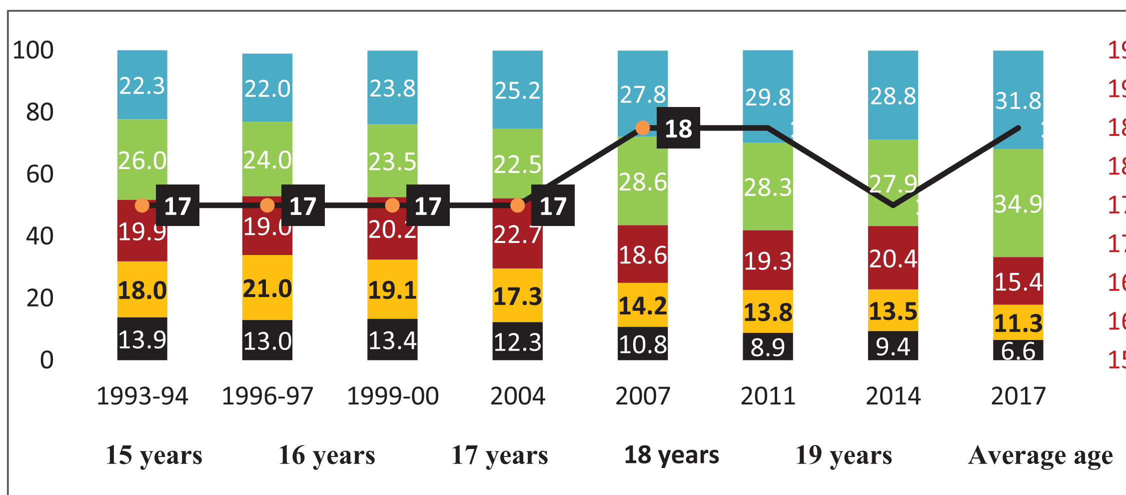
In terms of absolute numbers, the married adolescent girl population in Bangladesh surpasses many countries of the world. In 1993/94 the number of married adolescent girls constituted around 4.3million and the same in 2014 was 5 million.

[3]*Estimated using data available at https://www.worldometers.info/world-population/bangladesh-population/and http://origin.searo.who.int/entity/child_adolescent/topics/child_health/fp-ban.pdf*

3.3. Age and Education of Married Adolescent Girls

Mean age of married adolescent girls (MAG), irrespective of duration of marital union, is 17 years. Age specific proportion of MAG over past two decades varies widely. It is important mentioning that the proportion of girls aged 15 declined over time. In 1993, the proportion was around 14 percent (13.9%) which in 2014 dropped to 9.4 percent in 2014 (Fig. 2). Similar trend is identified for girls aged 16 years. On the contrary, the proportion of MAG during the same period increased to around 28.8 percent from 22.4 percent in 1993. It is worth mentioning that the proportions of MAGs aged respectively 16 and 17 years also increased in 2014 to 20.4 percent (from 19.9 % in 1999) and 27.9 percent (from 22.1%). However, there were some upward and downward movements in individual years of observations.

Figure 2: Distribution of currently married adolescent girls by their age



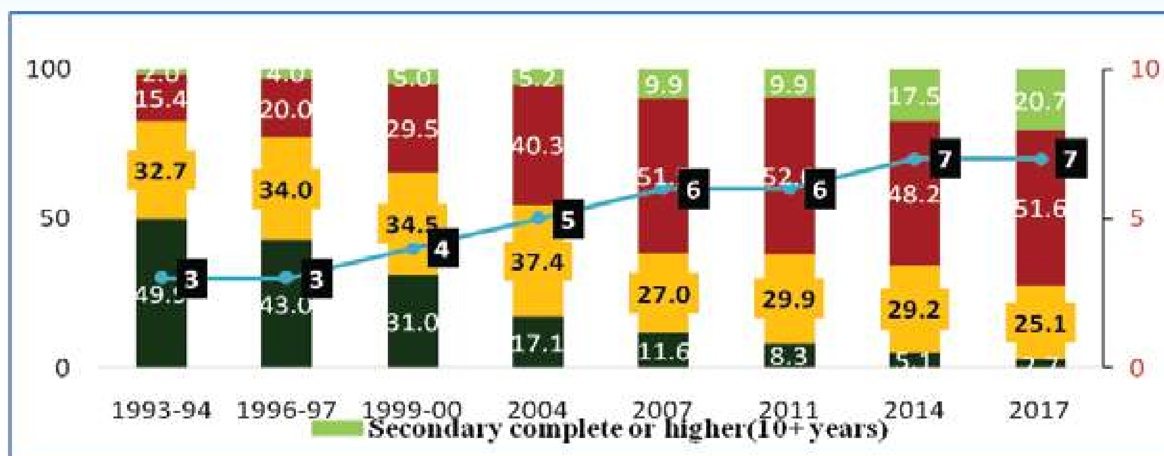
It is revealed that mean age of husbands is around higher than that of the MAGs (Table 2). In 2014 the mean age was 26 years, while in 1996/97 the same was 27 years. Importantly, over two-thirds of MAGs have husbands 25 years and above.

Table 2: Distribution of Husbands of MAGs in Bangladesh by age

Age	Survey Year													
	1993/ 1994		1996/1997		1999/2000		2004		2007		2011		2014	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Husband Age														
<25y			305	23.0	372	24.6	490	30.7	495	34.8	726	36.9	697	34.4
25-29			589	45.0	643	42.5	650	40.7	601	42.2	773	39.3	802	39.5
30+			343	26.0	444	29.3	394	24.6	280	19.6	423	21.5	482	23.8
Missing/other			64	5.0	55	3.7	64	4.0	49	3.4	48	2.4	48	2.4
Total			**1301**	**100**	**1514**	**100**	**1598**	**100**	**1424**	**100**	**1970**	**100**	**2029**	**100**
Mean (SD)			**27**	**(5.0)**	**27**	**(5.0)**	**27**	**(5.0)**	**27**	**(6.0)**	**26**	**(6.2)**	**26**	**(4.7)**

Average years of schooling of MAGs has increased to 7 years in 2014 from 3 years in 1993/94 (Fig. 3). The proportion of MAGs having no education during this period reduced substantially from 49,9 percent (1993/94) to 5.1 percent (2014). Proportion of the MAGs with secondary education and above increased by over eight folds, from 2.0 percent in 1993/94 to 17.5 percent in 2014. Similarly, the proportion of same with secondary education also increased substantially.

Figure 3: Distribution of currently married adolescent girls by education level



In terms of educational attainment, the state of the husbands is close to that of the MAGs (Table 3).

Table 3: Distribution of husbands of adolescent girls in Bangladesh by education status: 1993 - 2014

Level of education	Survey Year													
	1993/1994		1996/1997		1999/2000		2004		2007		2011		2014	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
No education (0 years)	625	49.2	588	45.0	597	39.4	501	31.4	394	27.6	362	18.4	287	14.1
Primary education (1-5years)	307	24.2	302	23.0	387	25.6	518	32.4	444	31.2	662	33.6	703	34.6
Secondary incomplete(6-9 years)	202	15.9	234	18.0	273	18.0	373	23.4	339	23.8	648	32.9	632	31.21
Secondary complete or higher(10+ years)	127	10	156	12.0	204	13.5	205	12.8	239	16.8	297	15.1	407	20.0
Missing/others	9	0.7	22	2.0	53	3.5	1	0.1	8	0.6	2	0.1		
Total	**1271**	**100**	**1301**	**100**	**1514**	**100**	**1598**	**100**	**1424**	**100**	**1970**	**100**	**2029**	**100**
Mean(SD)	**4(7.2)**		**5(12.0)**		**7(17.5)**		**5(4.8)**		**6(6.7)**		**6(5.0)**		**6(3.9)**	

3.4. Married Adolescent Girls by wealth quintile and working status

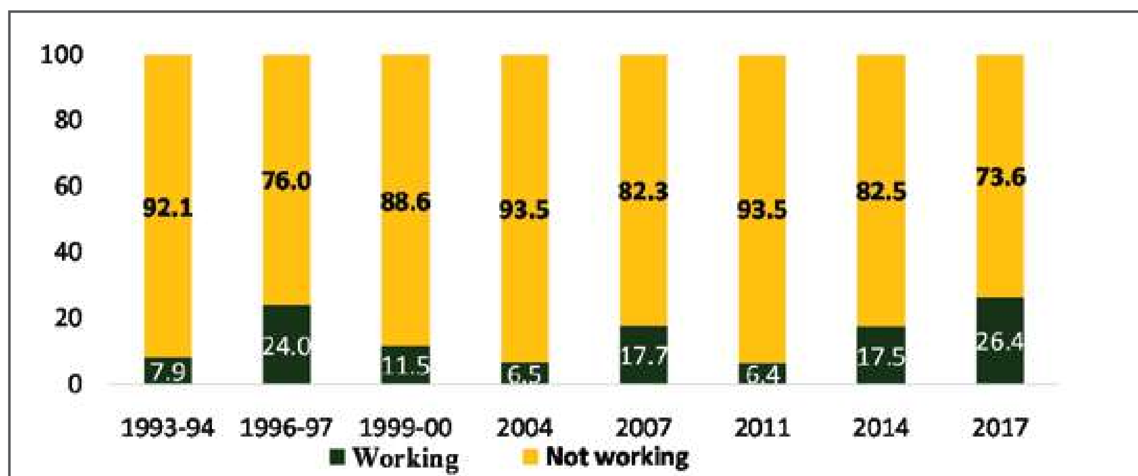
About one-sixths (16.1%) of the MAGs belong to richest quintal, while about one-fifths (19.8%) are from the poorest quintal. 22.6 percent and 21.7 percent MAGs belong to rich and middle quintal (Table 4). The proportion did not change substantially over time.

Table 4: Distribution of MAGs in Bangladesh by wealth quintile: 1993- 2014

Wealth quintile	Survey Year													
	1993/1994		1996/1997		1999/2000		2004		2007		2011		2014	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Poorest							313	19.6	238	16.7	328	16.6	402	19.8
Poorer							357	22.3	323	22.6	469	23.8	400	19.7
Middle							377	23.6	325	22.8	453	23.0	441	21.7
Rich							306	19.1	305	21.4	437	22.2	459	22.6
Richest							246	15.4	234	16.4	282	14.3	328	16.1
Total							**1598**	**100**	**1424**	**100**	**1970**	**100**	**2029**	**100**

Investigation about occupation of MAG shows that most of them are not involved in any type of income earning activities (Fig. 4). Less than 4 percent of them are engaged in service and/or sales related works. The share of skilled and/or unskilled labor among MAGs is low. In 2014, the same was 8.5 percent while it was 3.9 percent in 1993/94.

Figure 4: Distribution of currently married adolescent girls by working status



3.5. Contraceptive use and unmet need for family planning

Examination of data collected in 2014, on age at first sexual intercourse reveals that over one-thirds (33.7%) of MAG had their first experience with their husbands before attaining 15 years and 90.4 percent before attaining 18 years. The similar proportions in 2011 respectively were 3.7 percentage points and 1.5 percentage points' higher (Table 5).

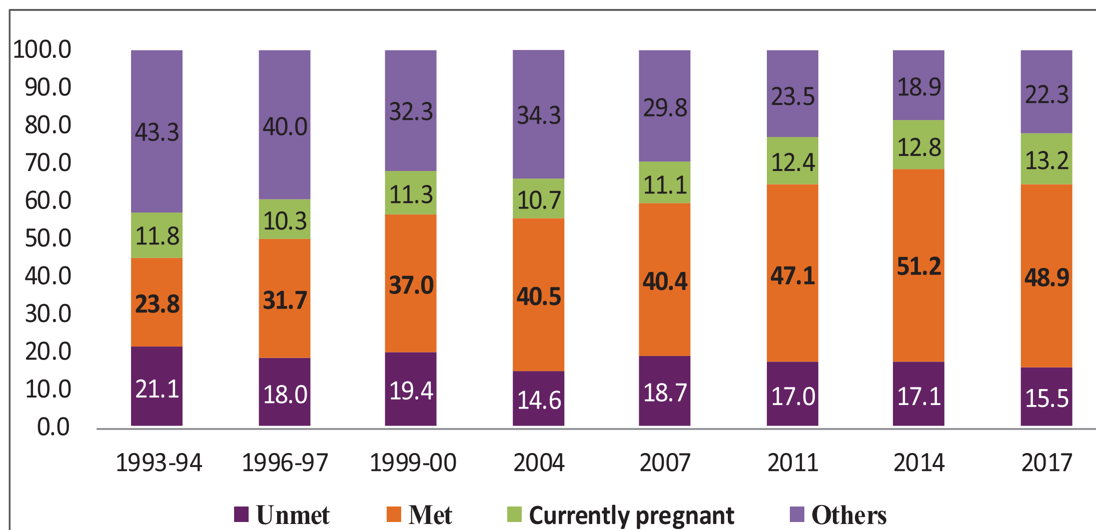
Table 5: Distribution of married adolescents by age first sexual intercourse

Age	Survey Year													
	1993/1994		1996/1997		1999/2000		2004		2007		2011		2014	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Not had sex	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	16	0.8	9	0.4
10	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	6	0.3	3	0.1
11	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	7	0.4	9	0.4
12	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	52	2.7	47	2.4
13	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	276	14.2	267	13.4
14	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	385	19.7	346	17.4
15	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	429	22	399	20.1
16	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	377	19.3	410	20.7
17	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	237	12.2	277	14
18	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	138	7.1	187	9.4
19	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	29	1.5	33	1.7
Total	Na	Na	Na	Na	Na	Na	Na	Na	Na	Na	1953	100	1985	100
Mean(SD)											**15(2.2)**		**15(1.5)**	

This research work portrayed that the unmet need among eligible MAG varies in reverse manner over time ranging between 21.1percent (in 1994) and 17.1 percent (in 2014) and 15.5 percent in 2017 (Fig. 5). However, depending upon variables the proportion was observed as changing. For example, according observation in 2017 the share of unmet need for family planning in relation to age cohort vary between 12.4 percent (for applicable MAG of 18 years) and 20.5 percent for applicable (MAG aged 16 years).

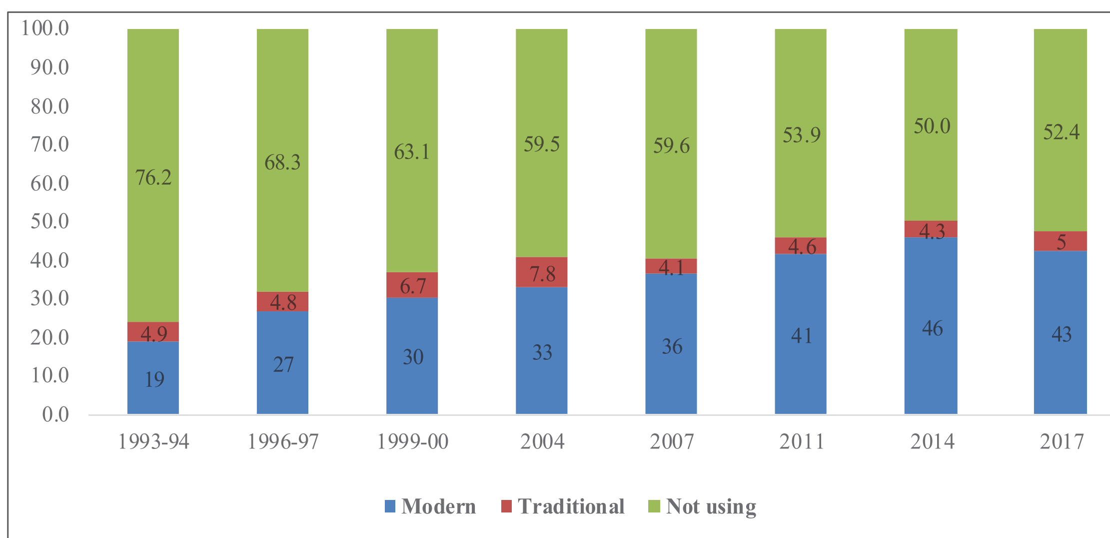
The proportion of MAG who reportedly met need for family planning need during the study period ranged between 23.8 percent in 1993 and 51.2 percent in 2014.It was also revealed than a considerable proportion of MAG belonged to currently pregnant category. About 10.3 percent MAG belonged to such category in 1993 and in 2017 the same proportion was 13.2 percent.

Figure 5: Distribution of currently MAGs by their met/unmet needs



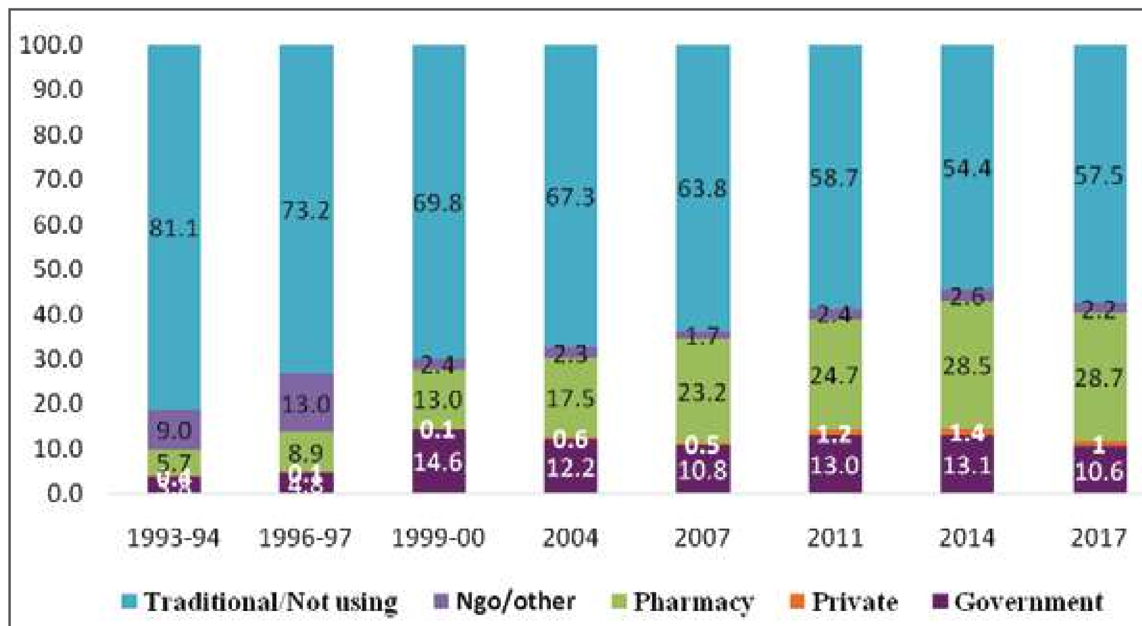
In 2017, contraceptive prevalence rate (CPR) among eligible MAG was 48 percent. While, in 2014 the same had increased to 50.3 percent from 24.8 percent in 1994. The prevalence of modern method use at the reported time points were respectively 43, 46 and 24.8 percent. However, there is ample scope further increase of the shares in line with FP 20-21. Figure 6 presented below revealed that the CPR as well as modern method use among MAG sharply increased from 1993 to 2014. However, in 2017 the same (overall CPR) decreased 2.3 percentage points, and modern method use showed a decline 3 percentage points. It is worth mentioning that during the same period share of traditional method use increased by 0.7 percent and proportion of non-users increased by 2.4 percentage points between (2014 and 2017). Such phenomena need in depth attention of not only program managers and policy makers, but also of the research community.

Figure 6: Distribution of currently MAGs by types of contraceptive method



Relevant surveys (like, BDHS, BMMS, BHDS, etc.) revealed that the sources of contraceptives are: (i) GOB FP services, (ii) pharmacies, (iii) NGO services, and (iv) private clinics. These sources also supply to MAGs. It is necessary to point out that over time pharmacies (Fig. 7) had become the prime source for FP method supply. The share of pharmacies in this regard was 28.5 percent in 2014 and 28.7 percent in 2017. The same in 1993 was 5.7 percent. Government sources supplied FP methods to 3.8 percent MAGs in 1993 which increased to 13.0 percent (2011) and 13.1 percent (2014). However, it was 10.6 percent in 2017. NGOs in the second half of 90s supplied methods to around 13 percent eligible MAGs. At present their share became limited to 2.2 percent only.

Figure 7: Distribution of currently MAGs by sources of contraceptive methods



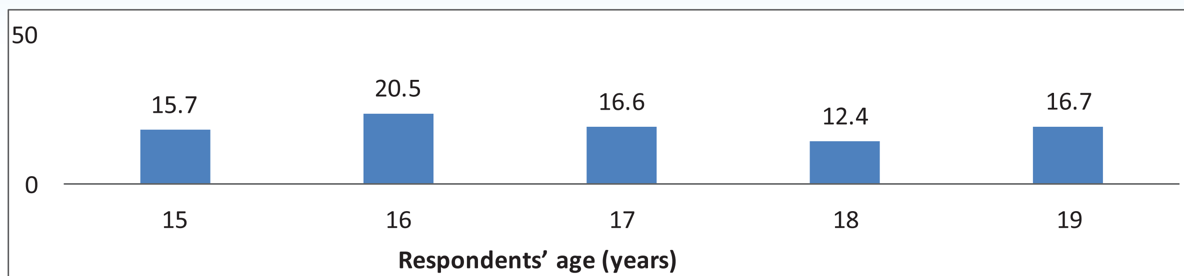
Sources of information

Source of adequate information is an important aspect of family planning program. Absolute majority of MAGs receive such information from GOB sources (ranging between 80.7% and 88.2% in depending upon year of observation. NGO sources act as supplementary channel for the same (ranging between 9 percent and 11.1 percent.

3.5.1 Characteristics of MAGs having Unmet Need

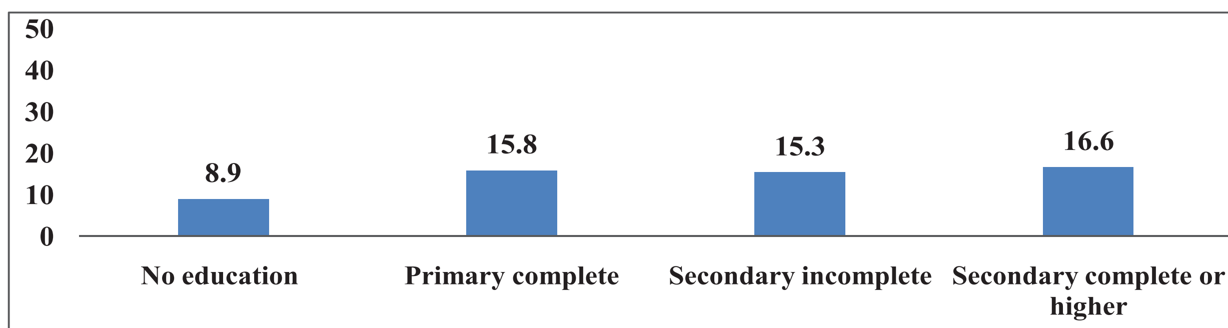
The study examined pertinent characteristics of MAGs who expressed unmet need for family planning. Highest proportion of unmet (20.5%) need was expressed by girls aged 16 years (Fig. 8) which was followed by girls aged 19 years (16.7%) and girls aged 17 years (16.6%). It is quite a natural that over one-five married girls felt unmet need at the age of 16. A substantial proportion of adolescent girls were married by 15 years and cohabitation with husbands made them vulnerable to pregnancy. The national FP programme usually do not reach them immediately after the marriage. Moreover, the adolescent girl had to face a social pressure to prove herself as fertile as early as possible. In this context, the reader needs to recall that age at first birth is as low as 16 years, it can easily be presumed that many of those who expressed unmet need did not delay the first child birth and/or for spacing.

Figure 8: Distribution of currently MAGs who had unmet need by their age



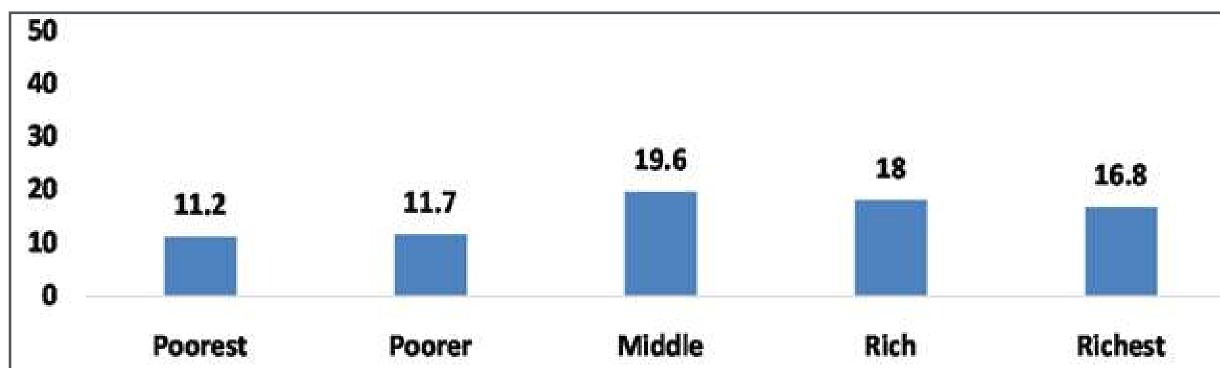
Attempts to analyze MAG with unmet need by their educational attainment revealed that unmet need for FP among girls having completed primary education and above is almost two-fold higher compared to those who did not have any education. The unmet need among MAGs having secondary and above education was found to some extent higher (Fig. 9) compared to those have primary education (16.6% vs. 15.8). Similar scenario was observed during comparison between secondary completed and secondary incomplete level of education (16.6% vs. 15.3%).

Figure 9: Distribution of currently MAGs who had unmet need by their educational status



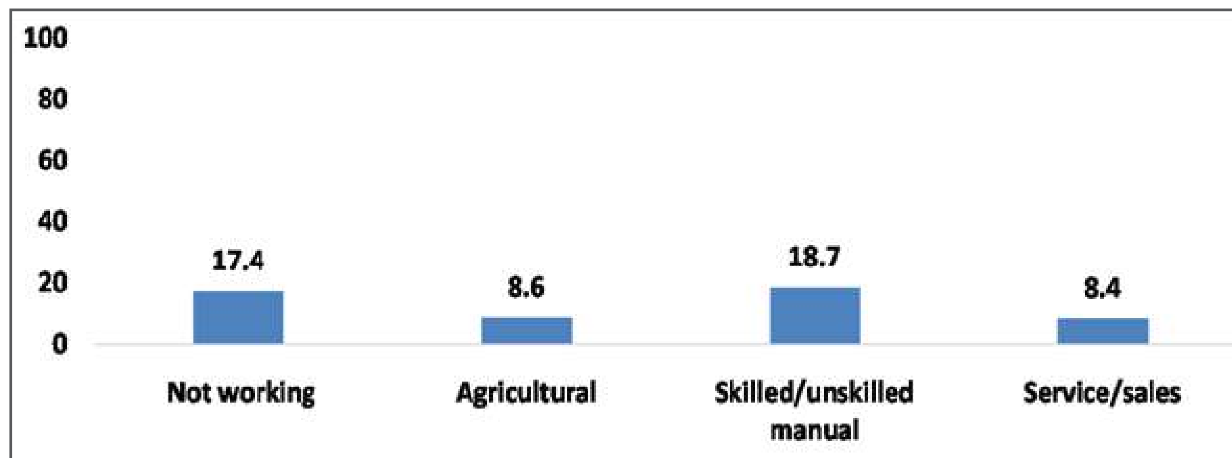
The research unveiled that the MAGs belonging to middle and above socio-economic quintiles, had expressed unmet need for FP methods more than poorest and poorer quintiles. Among all such categories, middle quintile had highest proportion of MAG (19.6%) closely followed by rich (18.0%) and among the richest 16.8% mentioned the same (Figure 10).

Figure 10: Distribution of currently MAGs who had unmet need by wealth quintiles



Among occupational categories, highest proportion of MAG belonging to labor (skilled/unskilled) expressed their unmet need for family planning (18.7%) followed by not working category (17.4%). The share of other two categories (agriculture and service sector workers) respectively 8.6 percent and 8.4 percent (Fig. 11).

Figure 11: Distribution of currently MAGs who had unmet need by their occupation



3.5.2 Factors Influencing Unmet Need for FP

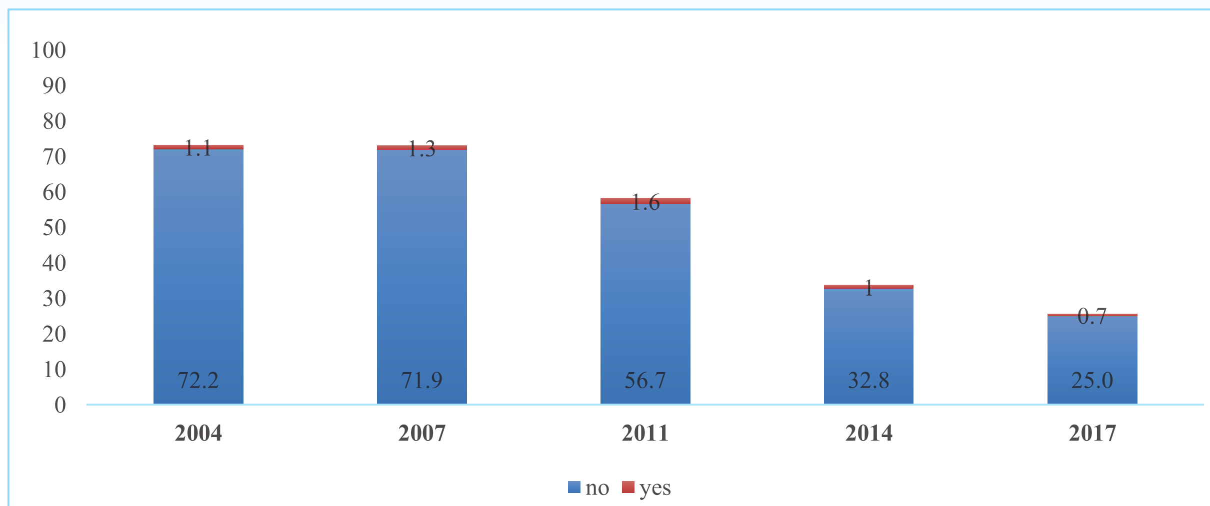
Analysis presents the determinants of the adolescent with unmet need for family planning among currently married adolescent age 15-19 years using logistic regression. Proportionately adolescents live in rural areas with unmet need for family planning is higher (18%) compared to adolescents living in urban area (14%), but this difference does not statistically significant (OR:1.3, 95%CI:0.98,1.70). The unmet need of Adolescents is likely 2 times higher in Chittagong division (24%; OR: 2.0, CI:1.3,3.1) and 1.7 times higher in Sylhet division (24%; OR: 1.7, CI:1.04,2.9) compared to Rajshahi division (11%).

The likelihood of having unmet need for family planning of adolescents age 15 is 1.9 times higher than oldest 19-year adolescents. Adolescents whose husbands work in skilled/ unskilled manual are likely to be more unmet need (OR:1.6, CI:1.1,2.3) compared to husbands who work in agriculture. We have observed the crude associations between adolescents with unmet needs and other covariates. For instance, Region, age, occupation, and husband's occupation are associated with unmet need. We have found the determinants of adolescent with unmet needs are region, age, and husband's occupation after adjusting the covariates and possible known confounders.

3.5.3 Menstrual Regulation among Married Adolescent Girls

The policy research divulged that the prevalence of induced menstrual regulation therapy for getting rid of unwanted pregnancy – as a right of women enshrined in ICPD and ICPD+ documents – is still low. The same in 2014 is as low as 2.1 percent of applicable MAG (Fig. 12), 1.3 percent in 2004, 1.6 percent in 2007, 1.1 percent in 20011 and 2.4 percent in 2014. It implies that there is a strong need for proactive consideration of issues related to MR policy by taking urgent policy decisions and programmatic steps towards attaining relevant decisions ICPD plus and ‘three Zero’ targets.

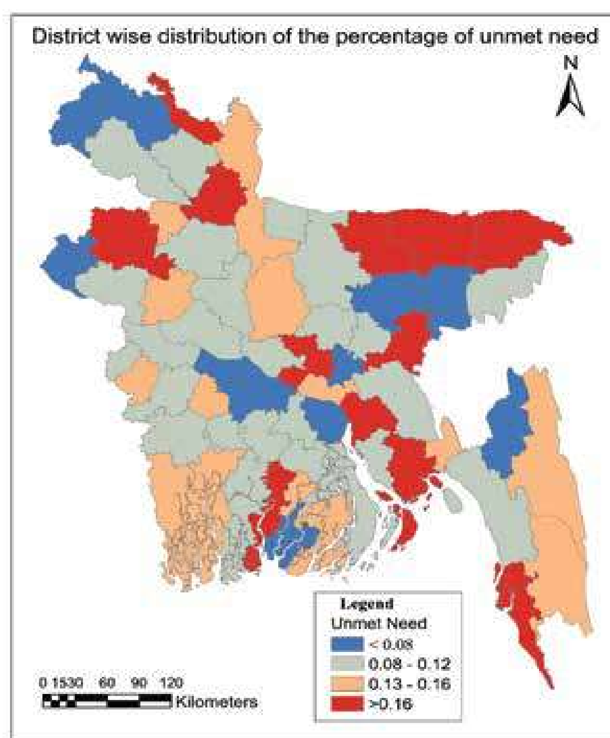
Figure 12: Distribution of currently married adolescent girls by their MR status



3.5.4 Review of the overall Unmet Need of Contraceptive Use in the country

In the country according to BDHS 2017/2018 the overall unmet need of contraceptive use is stagnant at 12 since 2011. Unmet need is never analyzed at lower levels such as the Districts and or Upazillas. In 2020 an attempt has been undertaken to estimate unmet need by Districts using the Small Area Estimation (SAE). In some 8 Districts the unmet need is 8 which is much lower than the national figure (Fig. 13). There are several Districts where the unmet need is 13 – 16 and above. This issue needs a deeper look where the unmet need among the Married Adolescent Girls (MAGs) could be significantly higher.

Figure 13: Spatial analysis using small area estimation methodology: Unmet need for contraceptive use



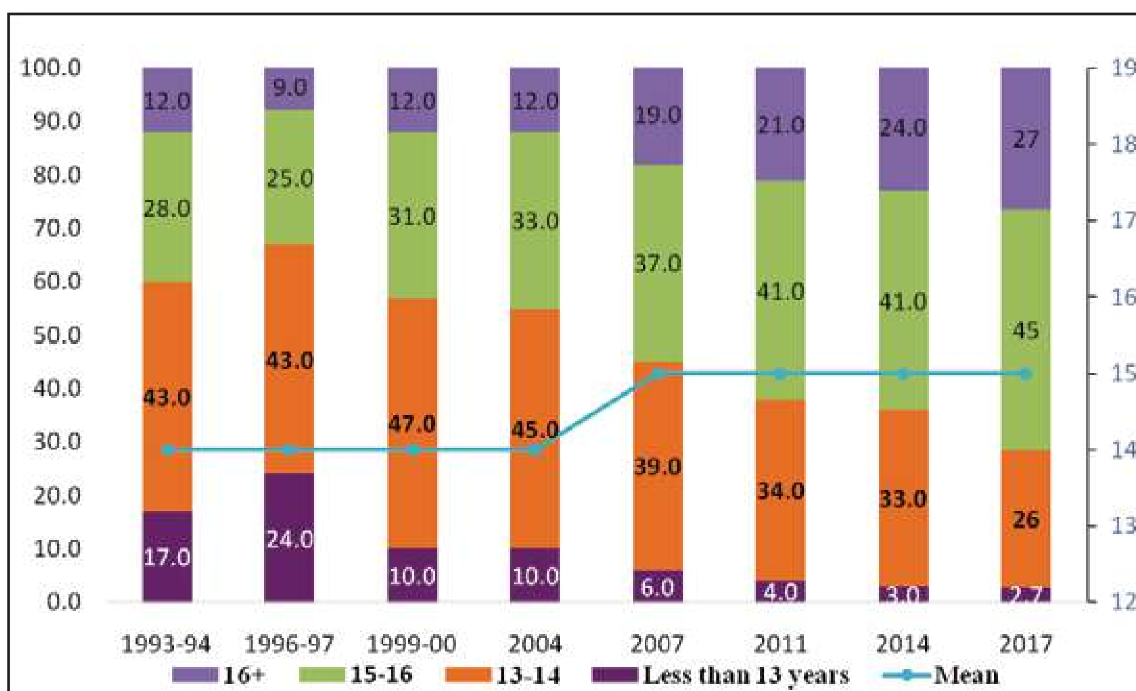
Ref. An unpublished document on Small Area Estimation and determining Unmet Need of Contraceptive use by Dr. Unnati Rani Saha, 2020 (work in progress).

3.6. Different aspects of Adolescent pregnancy and outcome

3.6.1 MAG by first marriage, age at first birth, birth categories etc.

Investigation depicts that mean age at first marriage (AFM) of the MAGs is low. During 2007 to 2017, the same was 15 years, while since 1993 to 2004 it was 14 years (Fig. 14). Analysis of AFM reveals that, in 1994, around 17 percent MAG (16.9%) was married before reaching their 13 birthdays. About 43 percent MAG was solemnized at the age between 13 and 14 years and 28 percent between 15 and 16 years. The state of affair regarding the same in 2017, has changed towards positive direction. The proportion of under 13 years MAG is only 3.1 percent, the same in the age group between 13 and 14 years is around 33 percent and 40.5 percent in the age group between 15 and 16 years.

Figure 14: Distribution of currently MAGs by their age at first marriage

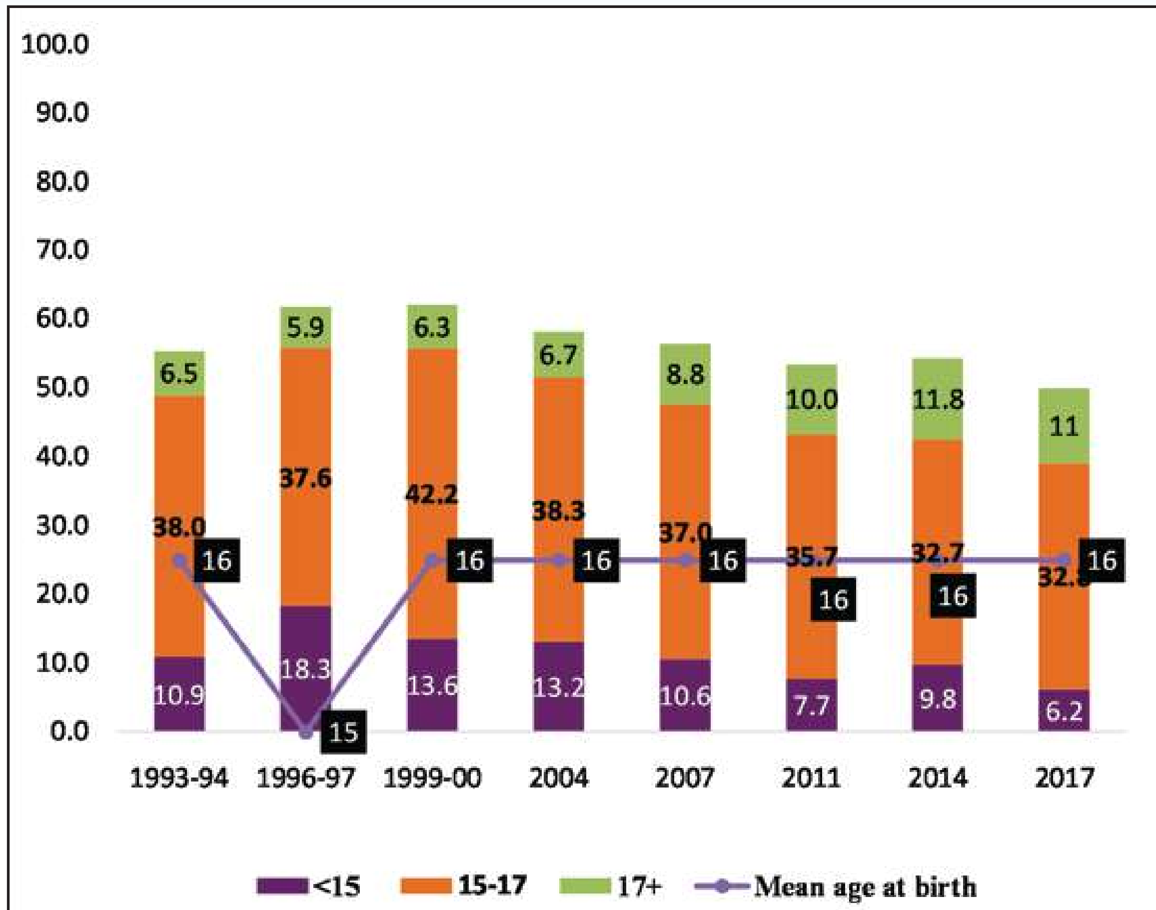


Age at First Birth

The mean age at first birth remained as low as 16 during the study period (1994 – 2017), however, in 1996 it dropped by one year (i.e. 15 instead of 16). For MAGs with 17 plus age group, the year specific age mix of age at first birth showed a trend with ups and down during the study periodand was ranging between 6.5 percent and 11.8 percent (Fig. 15). A going up and down trend was also observed among other age groups. For age group between 15 and 17, the same was ranging between 32.6 percent (in 2017) and 42.2 percent (in 2000), and among under 15 age group, it is ranging between 7.7 (in 2011) percent and18.3 (in 1997).

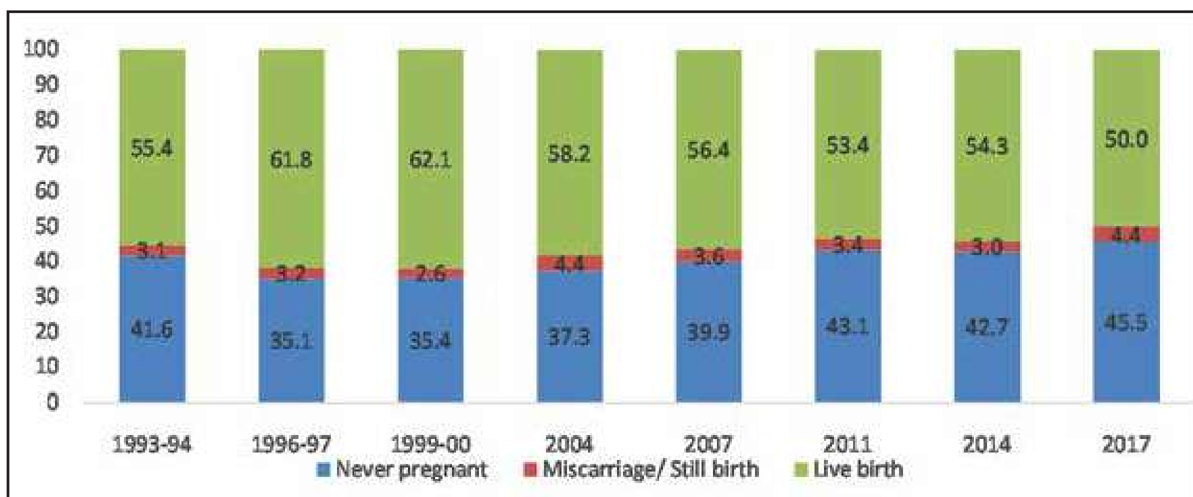
It is noteworthy that over the years, the share of delivering first child below 15 years reduced, but the same in the age bracket 15 – 17 years remained predominant throughout the period (ranging between 32.2% and 42.2%). It should me mentioned in this context that rest share (except those shown in the figure) belonged to MAGs who were never pregnant, or currently pregnant.

Figure 15: Distribution of currently MAGs by their age at first birth



This policy analysis work revealed that majority of the MAG were ever pregnant. The proportion of ever pregnant ranged between 54.4 percent and 65.0 percent. In 1994, 55.5 percent MAG had live birth(s), and 50 percent in 2017 (Fig. 16). During the rest of the research coverage period this proportion ranged between 53.3 percent and 61.8 percent. In this context, it is important to highlight that during this period, the proportion MAG who had miscarriage or still births were between 2.6 percent and 4.4 percent.

Figure 16: Distribution of currently married adolescent girls by birth categories

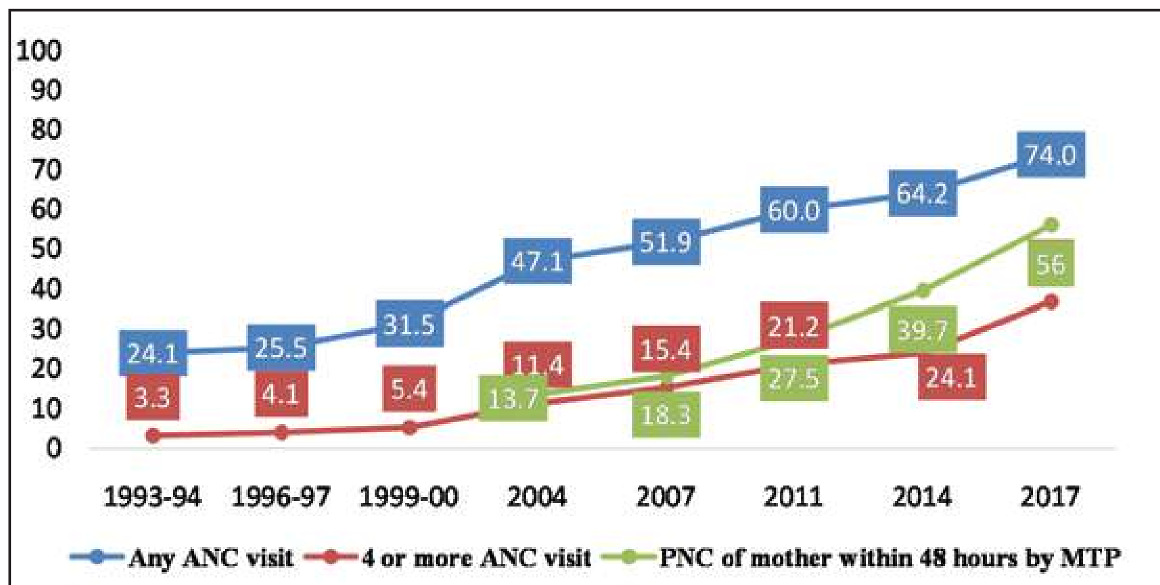


3.6.2. ANC & PNC, place of delivery and person assisting deliveries among MAGs

The analysis presented below divulged that there was an upward trend in utilizing ANC services. For example, the proportion MAG who had at least one ANC, was ranging between 24% in 1993 and 74% in 2017 (Fig. 17). However, during same time interval, share of those who had 4 or more ANC ranged between 3.3 percent (1993) and 37 percent (2017).

Moreover, the same for those who had PNC services from medically trained providers (MTP) within 48 hours of delivery increased from 3.5% in 2004 to 39.7 percent in 2014 and afterwards declined to 37 percent in 2017.

Figure 17: Percentage distribution of current MAGs by status of ANC &PNC visit

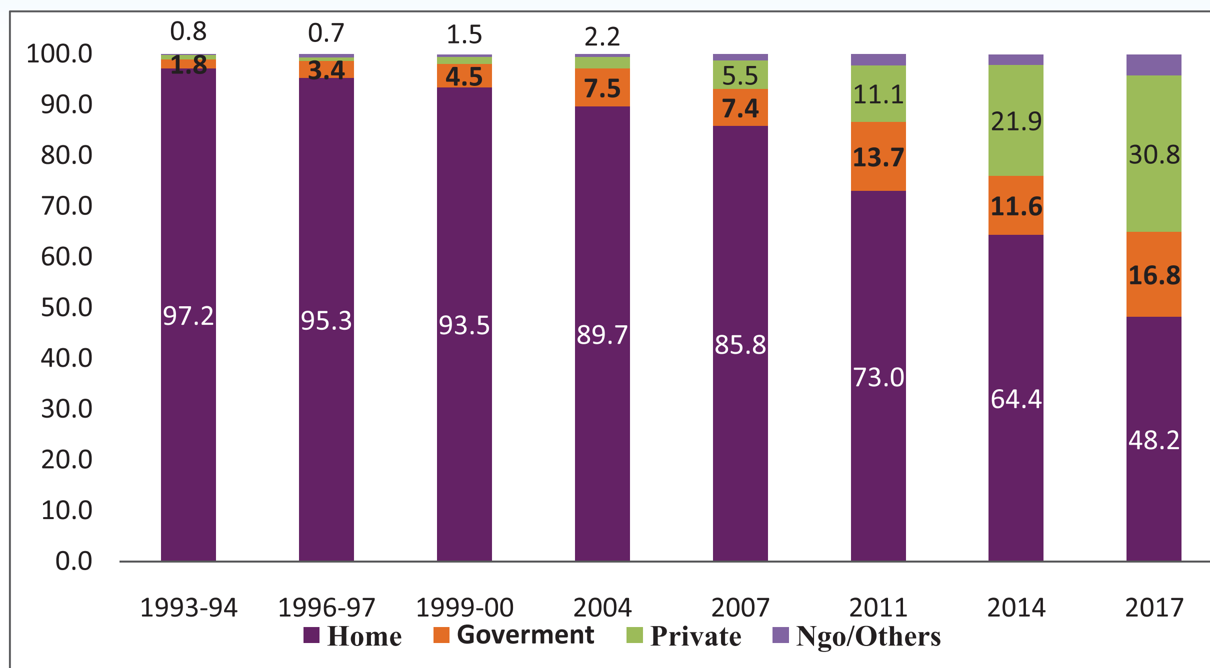


3.6.2. a. Place of Delivery

The research divulges that despite declining trend of home delivery over time, most of the deliveries are home deliveries. In 2017, the proportion of home deliveries among eligible MAG constituted 48.2 percent and in 2014 the same was 64.4 percent and the same in 1994, 1997 and 2000 respectively were 97.2 percent, 95.3 percent and 93.5 percent. The proportion of institutional delivery among MAGs in 2017 was 51.8 percent and 35.6 percent in 2014 against 3.6 percent in 1993. The share of GOB facility delivery among eligible mothers increased to 16.8 percent (in 2017) and13.7 percent (in 2014) from 3.4 percent (in 1994).

The private sector share of deliveries among eligible MAGs rose with a faster pace compared to GOB facilities. The proportion of private sector deliveries grew from 0.7 percent in 1994 to 21.9 percent in 2014 and further increased to 30.8 percent in 2017 (Fig. 18). According to knowledgeable sources most of the deliveries in private sector facility deliveries are C-sections (EMoCs incidences) irrespective of necessities of the eligible MAGs.

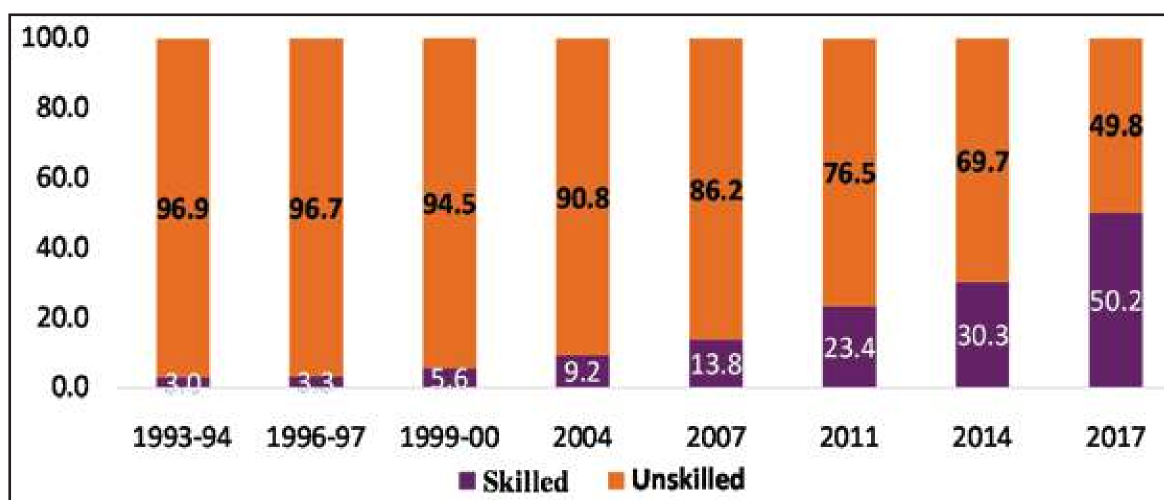
Figure 18: Distribution of currently married adolescent girls by place of delivery



3.6.2. b. Delivery assistance among the MAGs

The research shows that likewise home delivery, share of labor for applicable MAG conducted by medically untrained persons (MUTP) is gradually decreasing (Fig. 19) over time (97% in 1994 and 76.5%) and the same by medically trained persons (MTP) showing an increasing trend (from 3.0% in 1994 to 30.3% in 2014 and 50.2 % in 2017).

Figure 19: Distribution of currently MAGs by assistance during delivery



3.7. Pregnancy Related Morbidity and Mortality

Each and every pregnancy bear to some extant risk elements to the mother as well as child (WHO, Adolescent Pregnancy, 31 January 2020[4]). The accompanying section presents findings related to morbidity and mortality. BMMS 2010 and 2015 reports as well as BMMS data set acted as the sources of information for this section. In this research, in line with the BMMS methodological approach, pre-eclampsia, obstructed/prolonged labor, severe/heavy bleeding, retained placenta, and high fever with smelly discharge were considered as pregnancy related morbidity among the MAG.

Literature revealed that all of maternal health hazardous conditions are medically manageable if adequate care [emergency obstructed care (EmOC) is sought from appropriate facilities. Otherwise, in most of the cases, these would lead to maternal and perinatal-neonatal deaths. The following tables (Table 6 & Table 7) were prepared on the basis of BMMS 2010 data set released by Measure Evaluation. As these conditions may happen at any stage of pregnancy, the findings were presented accordance with pregnancy and related stages.

It was revealed that 46.6 percent women do not faced complication at any stage of pregnancy. However, 38.1 percent of MAG had one or more complication during pregnancy (prenatal), 30.1 percent during delivery and 18.8 percent after delivery. Among all types of complication, eclampsia was faced by 31.7 percent, 12.9 percent and 10.9 percent respectively during pregnancy, delivery and after delivery. Obstructed/prolonged labor was experienced during delivery 17.2 percent, and 8.9 percent reported the same during delivery. Sever bleeding was reported by lesser proportion of MAG. The respective proportions were (i) 1.2 percent during pregnancy, (ii) 2.9 percent during delivery, and 6.0 percent after delivery. Less than 1 percent MAG reportedly had retained placenta (0.9%) during delivery and 1.6 percent after delivery. High fever with smelly discharge after delivery was reportedly experienced by 1.2 percent.

It is important that if appropriate care for any of complications is not taken, it may turn into a fatal incidence of maternal mortality.

Table 6 : Adolescent reporting recent maternal complications at last birth

Type of complication	Complications			
	During pregnancy	During delivery	After delivery	Any stage
No complication	61.9	69.9	81.2	46.6
Had one or more complication	38.1	30.1	18.8	53.4
Symptoms of pre-eclampsia	31.7	12.9	10.9	35.8
Obstructed/Prolonged labor	8.9	17.2	-	22.8
Severe/heavy bleeding	1.2	2.9	6.0	8.5
Retained placenta	-	0.9	1.6	2.2
High fever with smelly discharge	-	-	1.2	1.2
Convulsion/fits	2.1	2.0	3.8	7.1
N	**2892**	**2892**	**2892**	**2892**

[4] *https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancyaccesses on 5 January 2021.*

It is important to analyze the care seeking practices of the MAGs (including their households) having any of the pregnancy related complications. BMMS 2010 reported that among those who suffered from symptoms of preeclampsia, 61.3 percent MAGs sought treatment, 76.8 percent of those suffering from severe bleeding, 64.4 percent having high fever with smelly discharge, 82.5 percent with convulsions, 78.9 obstructed/prolonged labor and 72.2 percent with retained placenta sought treatment.

The proportion of urban and rural MAGs with any of these complications sought treatment are 69.7 percent and 66.9 percent. Division wise disaggregation of data showed that MAGs or their households from Khulna, Chittagong and Rajshahi were more careful compared to those in other divisions. The care-seeking practices for maternal emergencies for MAG were higher among those who have higher level of education than those who have completed primary and below educational attainments. Similar is the practice among middle and above quintiles compared to those who are below.

Table 7 : Care seeking by type of maternal complications

Type of complication	Sought Treatment	Number of women with complication
Symptoms of preeclampsia	61.3	1034
Excessive bleeding	76.8	246
High fever with smelly discharge	64.4	36
Convulsion/fits	82.5	205
Obstructed/prolonged labor	78.9	659
Retained placenta	72.2	64
Residence		
Urban	69.7	366
Rural	66.9	1178
Division		
Barisal	67	72
Chittagong	71.5	395
Dhaka	64.3	580
Khulna	73.4	120
Rajshahi	70.1	277
Sylhet	57.4	99
Mother's education		
No education	55.6	179
Incomplete primary	57.9	275
Completed primary	64.6	273
Higher	74.4	817
Household wealth index		
Poorest	65.9	306
Poorer	60.1	320
Middle	69.7	358
Richer	70.4	308
Richest	72.5	252

It needs to observe that despite many achievements, Bangladesh still occupies one of the lowest positions among 172 counties in the world in terms of maternal morbidity and mortality. The overall pregnancy-related mortality ratio (PRMR) is 206 per 100,000 live births (95% confidence interval [CI]: 169–244) in BMMS 2016. The PRMR among the youngest women (15–19 years) is higher in BMMS 2016 (144 deaths per 100,000 live births) than in BMMS 2010 (75 deaths per 100,000 live births). The overall MMR is 196 per 100,000 live births (95% CI: 159–-234) in BMMS 2016. This is similar to the BMMS 2010 estimate of 194 per 100,000 live births (95% CI: 153–-236). The MMR is among women ages 15–19 years is 134 per 100,000 live births (BMMS 2016).

4. Discussion and Recommendations

This report has been prepared keeping in mind the rights-based approach adopted by the International Conference on Population and Development (ICPD) 1994 in Cairo[5], United Nations Fourth World Conference on Women (Beijing Declaration of 1995)[6], United Nations Convention on the Rights of the Child (UNCRC 1989)[7], UN Joint Statement on Adolescent Girls (2010)[8] Nairobi Summit onICPD25 declarations, UN Agencies Executive Board Joint Declaration on Adolescents (2015)[9] and Bangladesh Population Policy. All these vital documents were enshrined in high level commitment of Government of the understanding that “educated, healthy and skilled adolescent girls will help build a better future.”

Adolescent girls are a vital section of the population; their empowerment and protection have broad ranging effects. Girls who stay in school, marry later and delay childbearing often have healthier children, are able to earn better incomes that benefit themselves, their family, community and nation. However, adolescent girls face specific vulnerabilities and challenges. This policy research work explored the state of unmet need for family planning among the married adolescent girls and its subsequent impact on adolescent pregnancy and maternal mortalities and morbidities in Bangladesh in line with the defined objectives of the work.

This section is devoted to summarizing the mainfindings of the research work along with the corresponding references, sharing of key conclusions and provide recommendations for senior program managers, policy makers and researchers.

[5]*https://www.unfpa.org/events/international-conference-population-and-development-icpd#:~:text=International%20Conference%20on%20Population%20and%20Development%20(ICPD),-5%20September%201994&text=The%20Programme%20of%20Action%2C%20adopted,than%20on%20achieving%20demographic%20targets. accessed on 4 January 2021.*

[6]*https://www.un.org/en/events/pastevents/pdfs/Beijing_Declaration_and_Platform_for_Action.pdf accessed on 25 December 2020*

[7]*https://www.savethechildren.org.uk/what-we-do/childrens-rights/united-nations-convention-of-the-rights-of-the-child#:~:text=The%20United%20Nations%20Convention%20on,their%20race%2C%20religion%20or%20abilitie accessed on 25 December 2020.*

[8]*Accelerating Efforts to Advance the Rights of Adolescent Girls (2010) – A Joint UN Statement*

[9]*https://docs.wfp.org/api/documents/e059c9bf290448898fd4b821e570a6cf/download/ accessed on 10 January 2021.*

4.1 MAG Population Size, Age and Education

The absolute number of married adolescent girl (MAG) population in Bangladesh was 5.6 million in 2017. Mean age of married adolescent girls (MAG), irrespective of duration of marital union, is 17 years. (in Nepal proportion of MAG in 2016 was 27.1%) 15-19 yearsHas been 72.5%. Average years of schooling of MAGs in 2017 was 7 years. Every year, an estimated 21 million girls aged 15–19 years in developing regions become pregnant and approximately 12 million girls aged 15–19 years and at least 777,000 girls under 15 years give birth each year in developing regions (WHO 2020).[10] These are the issues which requires discussion at the policy level to determine ways and means to address the problem.

4.2 Occupation

Most of the MAGs are neither involved in any type of income earning activities nor attending schools. A 7.9 percent were employed in 1993 and 26.4 percent were found employed in 2017. In many places' girls choose to become pregnant because they have limited educational and employment prospects. Often, in such societies, motherhood is valued and marriage or union and childbearing may be the best of the limited options available.[11]

4.3 Age at First Marriage

During 2007 to 2017, the mean age at first marriage has been 15 years, while since 1993 to 2004 it was 14 years. About 29.5 percent MAGs were married before they reached 14 years and over 50 percent married before 15 years. Nepal DHS 2016 the proportion of women age 15-19 years who were married by age 15 declined by 10 percentage points from 1996 (14%) to 2016 (4%).[12] In least developed countries, at least 39% of girls marry before they are 18 years of age and 12% before the age of 15years[13] . This is a social factor which is based on age old norms and practices. This is an area where we have not been able to make much of a dent. It takes years on to make societal change and for that sustained multifaceted efforts shall have to be under taken.

4.4 Age at First Birth

Mean age at first birth during 1993 to 2017 has been16 years. Proportion of child birth before 17 was almost 39 percent of total MAG population. Half of the MAG population had their first child before reaching adulthood (<19 years). In many places' girls choose to become pregnant because they have limited educational and employment prospects. Often, in such societies, motherhood is valued and marriage or union and childbearing may be the best of the limited options available.[14] The other subtle factor of the MAGs getting pregnant soon after marriages is to prove her fertility. In the society still infertility is always contributed to the girls.

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[10]*https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy*

[11]*ibid*

[12]*Nepal DHS 2016*

[1]*3https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy*

[14]*ibid.*

4.5 Trends of ANC and PNC

Almost three-fourths (74%) of MAG had at least one ANC by medically trained provider (MTP) during their first pregnancy in 2017 while, 24 percent had the same in 1993. According to DHS of 2011, a 63.5 percent of MAG received any ANC by MTP. A 37 percent of MAG had 4 or more ANC in 2017 while the same proportion was merely 3.3 percent in 1993. The proportion of MAG who had PNC services from medically trained providers (MTP) within 48 hours of delivery increased from 3.5 percent in 2004 to 37 percent in 2017.The antenatal and postnatal care is an indication of how the MAGs are taken care during pregnancy and after delivery. These are critical time periods in the life of the MAGs which is definitely linked with the long-term illnesses (morbidity) and also mortalities.

4.6 Institutional delivery of babies

The proportion of institutional delivery among MAGs in 2017 was 51.8 percent and 35.6 percent in 2014 against 3.6 percent in 1993. This has improved a lot which is a good indication. In 2011, a 41.2 percent of MAG in Nepal had their delivery at any health facilities.[15] The private sector institutions' share of deliveries among eligible MAGs in 2017 was 30.8 percent against 0.7 percent in 1993. BDHS 2011 revealed 6.1 percent MAGs delivered in private facilities. To reduce maternal mortalities having safe deliveries at health facilities is one of the interventions followed worldwide.

4.7 Assistance during Delivery

The share of assistances during delivery by medically trained persons (MTP) in 2017 was 50.2 percent against 3.0 percent in 1994. Information in this regard are not available of the home deliveries which is becoming more and more critical. All program people shall have to think seriously all the steps that need to be taken in this regard.

4.8 Contraceptive Prevalence Rate (CPR)

The contraceptive prevalence rate (CPR) among eligible MAG was 48 percent in 2017 which has increased from 24.8 percent in 1993. In Nepal, 17.6 percent MAG used any FP method in 2011 and 14.4 percent used any modern method.[16] The share of modern method in 2017 in Bangladesh was 43 percent against 19 percent in 1993. This gives us the information that a large proportion of the MAGs are resorting to traditional methods where the failure rates are very high leading to unwanted pregnancies. Early age marriage of the girls followed by an early unwanted pregnancy without using any modern contraceptives leading to an attempt to get rid of it and finally lot of many untoward consequences.

4.9 Sources of Contraceptive Supply

In 2017, the prime source for contraceptive modern method was pharmacy 28.7 percent (against 5.7% in 1993) and was followed by GOB with 10.6 percent (in 1993, it was 0.3%). NGOs in 1993 were among one of the major sources of contraceptive supply with 9.0 percent share for MAGs and they lost their position with 2.2 percent share in 2017. Contraceptive procured from the pharmacies is a positive indication of the societal environmental change that is happening. The GOB share of contraceptive supply is shrinking which would require some policy change. Similarly, the decrease of the NGO share of contraceptive supply should encourage these organizations to act in different ways. The accessibility and availability of contraceptives is a major element in the contraceptive use dynamics.

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[15] *ibid.*

[16] *Nepal DHS 2011, available at https://dhsprogram.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf accessed on 11 January 2021.*

4.10 Menstrual Regulation (MR) Services

The utilization of MR services among MAG for discontinuing unwanted pregnancies had been at a low level between 0.7 percent in 2017 and 1.1 percent in 1993. This is another sensitive aspect where the MAG always tries to hide the fact and as such end up in not utilizing the MR services. Besides this the other issues connected with MR services is the availability of skilled providers and facilities. The MR statistics available in BDHSs does not reflect the MR nowadays being done using medicines called MRM. Overall the Health system has to look into the depth of this very socially sensitive issue. MRs done by untrained providers in clandestine places may risk the life of the MAG.

4.11 Unmet Need for Family Planning/contraceptive use

Despite the declining trend over time of unmet need for family planning methods, the proportion of MAG who expressed their unmet need in 2017 was as high as 15.5 percent against 21.0 percent in 1993. The highest proportion of unmet need (20.5%) was expressed by girls aged 16 years which was followed by girls aged 19 years (16.7%) and girls aged 17 years (16.6%). In the unpublished work of Dr. Unnati Saha it is found that are big variations of overall unmet need by Districts. In the Family Planning program the issue of unmet need overall in the country and then focusing the MAGs needs special attention.

4.12 Pregnancy related Morbidity and Mortality

A 46.6 percent of MAG did not face complication at any stage of pregnancy. However, 38.1 percent of MAG had one or more complication during pregnancy, 30.1 percent during delivery and 18.8 percent after delivery. Early pregnancies among adolescents have major health consequences for adolescent mothers and their babies. Pregnancy and childbirth complications are the leading cause of death among girls aged 15–19 years globally, with low- and middle-income countries accounting for 99% of global maternal deaths of women aged 15–49 years.[17]

The proportion of urban and rural MAGs with any of these complications sought treatment are 69.7 percent and 66.9 percent. Division wise disaggregation of data showed that MAGs or their households from Khulna, Chittagong and Rajshahi were more careful compared to those in other divisions. The care-seeking practices for maternal emergencies for MAG were higher among those who have higher level of education than those who have completed primary and below educational attainments. Similar was the practice among middle and above quintiles compared to those who were in poorer and poorest.
The PRMR among the MAG (15–19 e 1years) as reported in BMMS 2016 was as high as144 deaths per 100,000 live births. It has been said by the experts that maternal mortality among the MAGs are under reported as the overall MMR has been reported to be 196 per 100, 000 live births. This has been almost the same situation in 2011 (194 per 100, 000 live births). Vital statistics collected regularly by BBS called SVRS reports the same figure in 2019 to be 165 per 100, 000 per life births. We all need to acknowledgethat the MMR has still remained at three digits in spite of many achievements in the country. The Health and Family Planning statistical information systems (DHIS2 and DGFP MIS) does not collect any data related to maternal morbidities. Back in 1993 and beyond data were used to be collected on obstetrical fistula which has decreased due to change in the maternal health care systems. New kind of fistulas are occurring called ‘iatrogenic’ fistula which happens with many surgical procedures.
Findings documented in this research work has shown us theexistenceof high child marriage prevalence, high child pregnancy prevalence coupled with relatively low CPR and high unmet need for family planning among the MAGs in Bangladesh, which in turn, leading to high pregnancy related morbidity, high PRMR and MMR.

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[17] *https://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy*

Under the above context following recommendations having high programmatic, policy and research values have been put forward for consideration. These after further careful examination could be incorporated in the 8th Five Year Plan and subsequent documents.

5. Recommendations

5.1 Given the existing coverage of FP services to MAG, a national FP Policy Framework/Strategy needs to be developed which moving forward should dedicate more attention to the quality of sexual and reproductive health and FP in line with the ICPD+ (Nairobi Conference), commitments of FP2020 leading to FP2030 goals and addressing the means and ways of contributing to the achievements of SDGs number 3 and 5.

5.2 The MOH&FW should propagate pertinent policy(ies) enshrining quality FP services as a right of all eligible MAGs. The quality services will ensure some of the aspects of upholding sexual and reproductive rights as a part of the overall human rights. This an opportunity of setting FP information and services on a rights basis. An appropriate quality audit toolkit should be devised to facilitate the participatory audits of FP service coverage to MAG, its' quality, effectiveness, efficiency, impact and sustainability based on the reproductive health rights-based approach enshrined in the ICPD, ICPD+, FP2020, national and/or WHO standards and the socio-cultural context of Bangladesh.

5.3 Given the rapid growth of the private sector in MNH services and especially delivery service in private sector, service quality following national (including WHO standards and guide-lines at these settings) becomes an issue of concern, where the government should establish and effectively implement a national mechanism for assuring the FP services at all steps through setting up a National Accreditation Board. This Accreditation body can set up specific guideline to facilitate district, and Upazilla FP-MCH managers monitor and supervise SRHR service coverage, adequacy and quality at respective facilities for addressing the Unmet need of SRHR services, especially unmet need of MAG to family planning services.

5.4 The proposed FP Policy Framework/Strategy mentioned earlier should set up local level systems of undertaking planning involving multi-stakeholders to address the social challenge of bringing an end to child marriages, delaying the first pregnancy among the MAGs by raising the awareness among the newly married couples through use of modern contraceptive methods. Awareness efforts shall have to be carried out among the family gate makers particularly the guardians, socials leaders and religious influencers.

5.5 The local area planning authority and managers should undertake estimating the level of unmet need of contraceptive use by applying easy methodologies such as Small area Estimation (SAE) and then plan the contraceptive service delivery accordingly. The most important element that will have to be instilled in the service delivery is 'counseling' or one-to-one communication with the prospective users and ongoing acceptors at all places by all concerned.

5.6 Much attention by all concerned has to be paid to the accessibility, availability and affordability of contraceptives in all places. Contraceptive supply chain has to be strengthened and to be made more versatile. Besides the pharmacies some kind of depot holders and use of non-formal providers should be planned and implemented for contraceptive distribution. All kinds of societal barriers regarding the contraceptive use by the MAGs needs to be addressed through assertive advocacy with the gatekeeps and social behavioral change communication (SBCC).

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3 Policy Study on The Probable Impacts of Climate Change on Poverty and Economic Growth and the Options of Coping with Adverse Effect of Climate Change in Bangladesh (May 2009)
4 Steps Towards Change: National Strategy for Accelerated Poverty Reduction II (Revised) FY 2009 -11 (December 2009)
5 Millennium Development Goals: Bangladesh Progress Report-2009 (2009)
6 Millennium Development Goals: Needs Assessment and Costing 2009-2015 Bangladesh (July 2009)
7 এমডিজি কর্ম-পরিকল্পনা (৫১টি উপজেলা) (জানুয়ারি-জুন ২০১০)
8 MDG Action Plan (51 Upazillas) (January 2011)
9 MDG Financing Strategy for Bangladesh (April 2011)
10 SAARC Development Goals: Bangladesh Progress Report-2011 (August 2011)
11 Background Papers of the Sixth Five Year Plan (Volume 1-4) (September 2011)
12 6th Five Year Plan (FY 2011-FY 2015) (December 2011)
13 Millennium Development Goals: Bangladesh Progress Report-2011 (February 2012)
14 Perspective Plan of Bangladesh 2010-2021: Making Vision 2021 a Reality (April 2012)
15 Public Expenditure for Climate Change: Bangladesh Climate Public Expenditure and Institutional Review (October 2012)
16 Development of Results Framework for Private Sectors Development in Bangladesh (2012)
17 ষষ্ঠপঞ্চ বার্ষিক পরিকল্পনা (২০১১-১৫) বাংলা অনুবাদ (অক্টোবর ২০১২)
18 Climate Fiscal Framework (October 2012)
19 Public Expenditure for Climate Change: Bangladesh CPEIR 2012
20 First Implementation Review of the Sixth Five year Plan -2012 (January 2013)
21 বাংলাদেশের প্রথম প্রেক্ষিত পরিকল্পনা ২০১০-২০২১ রূপকল্প ২০২১ বাস্তবে রূপায়ণ (ফেব্রুয়ারি ২০১৩)
22 National Sustainable Development Strategy (2010-2021) (May 2013)
23 জাতীয় টেকসইউন্নয়ন কৌশলপত্র (২০১০-২০২১) [মূল ইংরেজি থেকে বাংলায় অনুদিত] (মে ২০১৩)
24 Millennium Development Goals: Bangladesh Progress Report-2012 (June 2013)
25 Post 2015 Development Agenda: Bangladesh Proposal to UN (June 2013)
26 National Policy Dialogue on Population Dynamics, Demographic Dividend, Ageing Population & Capacity Building of GED [UNFPA Supported GED Project Output1] (December 2013)
27 Capacity Building Strategy for Climate Mainstreaming: A Strategy for Public Sector Planning Professionals (2013)
28 Revealing Changes: An Impact Assessment of Training on Poverty-Environment Climate-Disaster Nexus (January 2014)
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30 An Indicator Framework for Inclusive and Resilient Development (January 2014)
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