

Landscape Analysis | 2020

# Gender-Based Violence and Current Family Planning and SRHR Programs



Shukhi Jibon



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# The Situation of Gender-Based Violence (GBV) including a Review of Current Family Planning (FP) and Sexual and Reproductive Health and Rights (SRHR) Programs

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## LIST OF ACRONYMS

A&E	Accident and Emergency
ASK	Ain O Salish Kendra
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BIGD	Brac Institute of Governance and Development
BLAST	Bangladesh Legal Aid & Services Trust
CCSDP	Clinical Contraception Service Delivery Program
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
DFID	The Department for International Development
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DPM	Deputy Project Manager
DV	Domestic Violence
FGD	Focus Group Discussion
FP	Family Planning
FWA	Family Welfare Assistants
FWC	Family Welfare Center
FWV	Family Health Visitor
GBV	Gender Based Violence
HNP	Health nutrition and population
ICD	Intrauterine Contraceptive Device
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
Jhpeigo	international non-profit health organization affiliated with Johns Hopkins University
KII	Key Informant Interview
MJF	Manusher Jonno Foundation
MOHFW	Ministry of Health and Family Welfare
NAP	National Action Plan
NCGBV	National Centre on Gender Based Violence
NGO	Non-Government Organization
NSV	Non-Scalpel Vasectomy
NTCC	National Trauma Counseling Center
NVD	Normal Vaginal Delivery
OCC	One-Stop Crisis Centre
OGSB	Obstetrical and Gynecological Society of Bangladesh
PAC-FP	Post Abortion Care
PPE	Personal Protective Equipment
PPFP	Postpartum Family Planning
RGA	Rapid Gender Analysis
SACMO	Sub-assistant Community Medical Officer
SDG	Sustainable Development Goal
SGBV	Sexual and Gender Based Violence
SH	Sexual Health
SID	Statistics and Informatics Division
SMC	Social Marketing Company

SRHR	Sexual and Reproductive Health and Rights
SRHE	Sexual and Reproductive Health Education
SSC	Secondary School Certificate
SWAP	Sector-wide approach
TFR	Total Fertility Rate
TOT	Training of Trainers
UH&FWC	Union Health and Family Welfare Center
UNFPA	United Nations Population Fund
USAID	The United States Agency for International Development
UP	Union Parishad
VAW	Violence Against Women

## EXECUTIVE SUMMARY

Gender-Based Violence (GBV) is closely connected with the inequality in accessing and utilizing Family Planning (FP) and Sexual and Reproductive Health and Rights (SRHR) services. The USAID Shukhi Jibon project integrates gender and GVB-responsive service delivery in FP and SRHR as a mechanism to take a notable step towards ensuring family planning for all in Bangladesh.

The scope of this report was to depict the landscape by analyzing existing laws and policy provisions, examining service provisions, incorporating experts opinion and, finally, to come up with a set of recommendations that the Project could utilize towards its goal. Data were gathered through a review of existing documents on GBV and FP/SRHR services. In addition, more information was collected through phone discussions with representatives of service providers of Union level Health and Family Welfare Centers, and Key Informant Interviews (KII) with two high officials of Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) as well as with the representatives of NGOs providing SRHR services and support to female survivors of GBV.

Over the past few decades, many government implemented initiatives have improved diverse aspects of the lives of women. However, the subordinate position of women and girls under the patriarchal social structure of Bangladesh is very clear is persistent and remains pervasive. Though, As a result, GBV incidents persist and have increased in rate over the past year as a secondary consequence of the COVID-19 pandemic and related economic and social shocks, as well as isolation and family confinement.

There are complex and intrinsic dynamics between access to and capacity to exercise one's right to FP/RH *and* patterns of SGBV with its underlying gender-based inequity. Rates of women experiencing a form of GBV in the preceding 12 months are highest among 18-30 year olds. The same demographic group most likely desire or seek FP/RH services. According to research conducted in Bangladesh between 2015-2017, 48% - 55% of women experience physical violence by a domestic partner in their lifetime. These data also indicate that at least of quarter of women (27% - 30%) experience sexual violence by an intimate partner during their lifetime—with nearly 60% of women undergoing child marriage before the age of 18.

The percentage of ever-married women experiencing emotional violence by their Husband during their lifetime is 29.7% in rural areas and 25.4% in urban areas. Of lifetime experiences, controlling behavior is most common, reported by more than half of ever-married women (55.4%).

Social norms dictate that the responsibility for reproduction is shouldered by women. Furthermore, while women biologically carry the child and hold virtually 100 percent of social expectation and responsibility for childrearing; family planning decisions are dominated by men.

The landscape analysis reveals significant opportunity for FP/RH services to significantly contribution to addressing GBV in Bangladesh. Beyond the demographic and gender-



commonalities of SGBV and FP/RH needs, the evidence review found strong commitment on the part of the GOB to responding and preventing GBV. The GOB has implemented several national initiatives and passed a series of legislative policies; the human resources of legal and justice sector, and other respective departments and ministries have been provided with gender awareness orientations; and a National Center for GBV was established for strengthening coordination to eliminate GBV. At the beneficiary level, FP/SRHR service providers are witnessing GBV; they are well-informed about numerous confidential and exposed GBV incidents at family and community levels; and are frequently the only non-family, private and confidential contact women has on a regular basis.

However, the evidence review also found that FP/RH frontline workers do not have the necessary guidelines nor needed skills to address GBV. Though health service provider training includes a session on GBV, its influence on staff competency is not at all visible. Service providers themselves feel that they need intensive training on GBV including understanding of the patriarchic society, process and drivers of harmful social and gender norms, and how to respond to disclosures of SGBV from their clients. They also do not know what they could do for local level coordination with other relevant authorities active in GBV prevention. The senior officials of the DGFP, Ministry of Health and Family Welfare (MOHFW) also recognize the need to provide training for FP service providers. However, they are concerned with the lack of coordination among different departments, complexity in the decision-making process, and inadequate budgetary allocation which constrain the implementation of national plans to address GBV across sectors. It is worth mentioning that there is very little understanding about how GBV can be addressed through the FP services at service agency management level and above.

Primary recommendations to strengthen existing FP/SRHR services and make them more effective in dealing with GBV issues include:

- Improving coordination and policy alignment amongst the DGFP, MOHFW, and the National Center for GBV.
- Mainstreaming in-service training (long-term mainstream into pre-service training) for FP/RH providers and facility managers on GBV-responsive service provision such as first line response; effective, confidential referral; and gender-equitable counseling and informed consent.
- Establishing a national monitoring system for GBV response in the health system, particularly in SRH services such as FP.
- Increasing awareness and knowledge of GBV as a pervasive health threat and a significant barrier to individuals exercising their right to FP/RH services.
- Developing and disseminating information and behavior change messages to men and boys, as well as other norm holders around the prevalence, negative impact, and illegality of GBV, including intimate partner violence.

A full discussion of policy and programmatic recommendations based on the SGBV and FP Landscape Analysis is presented in Chapter Five of this report.

# ABOUT THE REPORT

## Purposes of the Desk Review

To review the current situation of Gender-Based Violence (GBV) in Bangladesh and explore how GBV can be addressed in FP/SRHR services. The Objectives of the Desk Review were -

- Review the current situation of Gender Based Violence (GBV) in Bangladesh considering country perspective, social norms
- Examine services that identify, treat and/or refer clients
- Examine rights to access and use of health services
- Identify areas requiring advocacy, policy dialogue, and
- Provide recommendations for future programming

## The Methodologies Followed

**Desk Review.** This assignment included collecting and reviewing GBV and FP/SRHR related documents through them using the lens of Substance, Structure and Culture:

- International and national frameworks including laws and policies regarding GBV and SRHR
- Research and studies on quality of the functional systems and access to services; and
- Academic and literary books and scholarly articles which can be found in the in the references section

**Virtual Interview.** Twelve people from the GOB and NGOs were interviewed virtually by following a prescribed questionnaire. The questionnaires and the list of the interviewees are attached as Annex 4 and 5.

## Report Structure

This report has discussed the issue of GBV in relation to FP and SRHR in Bangladesh in five chapters. The **first chapter** focused on the conceptual clarification of GBV definition, how GBV has been perceived, the existing legal provisions, contemporary situation, and State's initiatives in responses. The **second chapter** focused on establishing relationships between Family Planning/SRHR services and GBV. The **third chapter** scopes out the family planning services in Bangladesh including service provisions and process, progress and challenges and service providers' behavior and attitude. The **fourth chapter** detailed out the SRHR and FP service provisions from relevant GBV perspectives, explaining the social contexts, plans and provisions within the system that could be activated for necessary responses. The **final chapter, chapter five**, depicted recommendations and suggestions for way forward.

## Limitations and Overcoming Strategies

The COVID-19 pandemic required a change in modality of getting information while avoiding in person meetings. Instead of conducting FGDs, telephone interviews were made. It was difficult to get the appointments for the interviews, especially with GOB officers so the time of the assignment was extended. The team worked online to communicate, and through virtual meetings. The excellent cooperation from the Shukhi Jibon Project in getting necessary information and the name of the interviewees, providing times for meeting and calls helped the team to get the interview done over telephone amidst the crisis of COVID-19.

# CHAPTER 1. INTRODUCTION AND BACKGROUND

## Gender-Based Violence as a Concept

This report follows the WHO definitions: **Gender-based violence** victimizes an individual based on his or her biological sex or gender identity. It includes physical, sexual, verbal, emotional, and psychological abuse, threats, coercion, and economic or educational deprivation, whether occurring in public or private life.

The term is generally used to define violence that occurs as a result of the normative role expectations associated with each gender, along with the **unequal power relationships** between the two genders, within the context of a specific society.

In December 1993, the Declaration on the Elimination of Violence against Women, recognized that **violence against women violates women's rights and fundamental freedoms** and called on states and the international community to work toward the eradication of violence against women. That same year, the Vienna Declaration and Program of Action recognized that **the elimination of violence against women in public and private life is a human rights obligation**.

The Declaration on the Elimination of Violence Against Women (*Proclaimed by General Assembly resolution 48/104 of 20 December 1993*) defines “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 deprivation of liberty, whether occurring in public or private life.”

In 1992, the CEDAW Committee in its General Recommendation No. 19, asserted that **violence against women is a form of discrimination**, directed towards a woman because she is a woman or that affects women disproportionately. This violence seriously inhibits women’s ability to enjoy rights and freedoms on a basis of equality with men.

The above definition and statements recognize that GBV is enabled when women hold an established subordinate position in the patriarchal society. Moreover, we can add that patriarchy is the major obstacle to women’s advancement and development. Though women face domination on many levels, the wide-ranging principles remain the same - i.e., men have the controlling power. The nature of this control may differ. To understand the subordinate situation, it is necessary to see the system, which keeps women dominated and subordinate, and to untie its workings in order to work for women’s development in a systematic way. Patriarchal institutions and social relations are responsible for the inferior or secondary status of women. Patriarchal society gives absolute priority to men and to some extent limits women’s human rights also. Patriarchy refers to the male domination both in public and private spheres.

### **Gender-Based Violence includes:**

**Physical Violence.** Any act which causes physical harm as a result of unlawful physical force. Physical violence can take the form of, among others, serious and minor assault, deprivation of liberty and manslaughter (European Institute for Gender Equality, n.d.).

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."(Violence Prevalence Alliance, WHO 2020)

**Sexual Assault.** Any type of sexual activity or contact that you do not consent to. Sexual assault can happen through physical force or threats of force or if the attacker gave the victim drugs or alcohol as part of the assault. Sexual assault includes rape and sexual coercion (UN Women, 2017).

**Sexual Violence** is any sexual act, attempt to obtain a sexual act, or other act [*verbal, physical, or visual*] directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, and trafficking or sexual exploitation. (WHO, 2012)

**Psychological Violence.** Any act which causes psychological harm to an individual. Psychological violence can take the form of, for example, coercion, defamation, verbal insult or harassment (European Institute for Gender Equality, n.d.).

**Economic Violence.** Any act or behavior which causes economic harm to an individual. Economic violence can take various forms including of property damage, restricting access to financial resources, education or the labor market, or not complying with economic responsibilities, such as alimony (European Institute for Gender Equality, n.d.).

It is also important to recognize that GBV may be normalized and reproduced due to structural inequalities, such as societal norms, attitudes and stereotypes around gender generally and violence against women specifically. Therefore, it is important to acknowledge **structural or institutional violence**, which can be defined as the subordination of women in economic, social and political life, when attempting to explain the prevalence of violence against women within our societies – see Annex 1 for details (European Institute for Gender Equality, n.d.).

## Gender-Based Violence as Violation of Human Rights

It has taken decades of struggle by the women's rights movement to persuade the international community to view gender-based violence against women as a human rights concern and not just as a private matter in which the State should not interfere. In 1992, the CEDAW Committee in its General Recommendation No. 19, asserted that violence against women is a form of discrimination, directed towards a woman because she is a woman or that affects women

disproportionately. This violence seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men. In 2017, the CEDAW Committee, marking 25th anniversary of its General Recommendation No. 19, further elaborated international standards on gender-based violence against women in its General Recommendation No. 35. In General Recommendation No. 35, the CEDAW Committee recognized that the prohibition of gender-based violence against women has evolved into a principle of customary international law, binding all States.

Framing GBV against girls' and women as a human rights violation implies an important conceptual shift. It means recognizing that women are not exposed to violence by accident, or because of an in-born vulnerability. Instead, violence is the result of structural, deep-rooted discrimination which the state has an obligation to address. Therefore, preventing and addressing GBV against women is a legal and moral obligation requiring legislative, administrative and institutional measures and reforms, and the eradication of gender stereotypes which condone or perpetuate GBV against women and underpin the structural inequality of women with men. The GOB also recognizes GBV as human rights violation. The Statistics and Informatics Division of Planning Ministry (SID) and the Bangladesh Bureau of statistics (BBS) published gender statics in 2018, where GBV is mentioned as a human rights violation (BBS, 2019) – see Annex 1 for more details.

## GBV in Bangladesh

### Position of Women in the Society

There are persistent patriarchal attitudes and discriminatory stereotypes about the roles and responsibilities of women and men in the family and in society. Almost all the conditions that play a catalytic role for continuation of the subservient state of women exist in the social and institutional systems of Bangladesh. Prejudices, orthodox outlook, under-enforced law, poverty, socio-economic inequality, patriarchic family arrangement, and so many other push-and-pull factors have been and are being the protagonist forces to shape and sustain the overall Bangladeshi attitude and behavior towards women. On the other hand, the post-liberation initiatives of rebuilding the country included the target of achieving women's economic self-reliance. Such a target positively influenced the women rights movement and stirred the conception of women's human rights. Consequently, political decision has been taken to eliminate all kinds of discrimination against women. As a result, law and policies were adapted for addressing violence against women, women's education, and women's health; and programs for increasing women's participation in economic activities and women's quota in jobs and equal opportunity in the employment sector became institutionalized. Yet, the deep-rooted patriarchy at family and social levels continue to slow down the process of decreasing violence against women.

### Statistics of GBV in Bangladesh

Gender-Based Violence is the most pervasive form of human rights violation that women and girls are regularly facing in Bangladesh. The VAW Survey 2015, jointly conducted by UNFPA and the BBS, revealed that 73% of ever-married women in Bangladesh have experienced any kind

violence by their current husband, 55% reported any type of violence in the past 12 months, and 50% reported physical violence in their lifetime (The Daily Star , 2016).

In Bangladesh, GBV persists largely due to deep rooted patriarchal social norms. The worst manifestation of such social malaises as well as the existing forms of GBV is child marriage which is widely prevalent in the country. According to BDHS 2014, about 59 percent of women aged 20-24 marry before they turn 18. Child marriage puts girls at particular risk of sexual, physical and psychological violence throughout their lives (Ministry of Health and Family Welfare, 2016).

While data around intimate partner violence is challenging to validate. Between 2014-2017 multiple large-scale survey's including the 2014 DHS, the 2015 BBS Report on VAW, and an independent survey by BRAC in 2017 indicate that 48% - 55% of women experience physical violence by a domestic partner in their lifetime. These data also indicate that at least of quarter of women (27% - 30%) experience sexual violence by an intimate partner during their lifetime— with nearly 60% of women undergoing child marriage before the age of 18.

The percentage of ever-married women experiencing emotional violence by their Husband during their lifetime is 29.7% in rural areas and 25.4% in urban areas. Sexual violence by the husband is higher in rural area (29.2%) than urban area (23.7%) and by Non-Partners is higher in city corporations at 3.8%, followed by urban area at 3.4% and, rural area at 2.8%. Physical violence by non-partners was the highest for age group 15-19 - it stood at 30.9% and 11.2% for lifetime and 12 months prevalence of physical violence by non-partners respectively. Women aged 20-24 represent the highest percentage of sexually violated women by non-partners for both lifetime and 12-month prevalence. Almost two third (72.6%) of ever married women experienced one or more such forms of violence by their husband at least once in their lifetime, and 54.7% experienced violence during last 12 months.

Of lifetime experiences, controlling behavior is most common, reported by more than half of ever-married women (55.4%). This was followed by physical violence (49.6%), emotional violence (28.7% of women), sexual violence (27.3%) and economic violence (11.4%).

A large proportion (41.7%) of women experiencing lifetime partner physical or sexual violence suffered from injuries as a result of that violence, while 12.9% reported injuries during the last 12 months. A higher proportion of women reported cuts, scratches, bruises or aches (32.3% in lifetime and 9.8% in the last 12 months), whereas other injuries were reported by a lower proportion of women.

Regarding domestic abuse, the Bangladesh Bureau of Statistics (BBS) Violence Against Women Survey 2015 found that 72.6% of ever-married women experienced one or more forms of violence (physical, sexual, economic, and emotional abuse, and controlling behavior) by their husband at least once in their lifetime. Most women did not report incidents of violence for reasons including family honor, fear of the perpetrator and shame or embarrassment. The report noted that in comparison to 2011, the 2015 survey showed a lower occurrence of all form's

violence (aside from physical violence) though accepted this could be due methodological differences rather than a true reduction in violence against women (Dhaka Tribune, 2016).

A total of 7,489 women and girls reported experiencing violence in 2016. Most frequently reported type of violence is (highest to lowest): physical violence (67%), sexual (19%) and mental/psychological (14%). The most frequent form of violence is physical assault at 58% followed by rape and gang rape at 12%, suicide 11%, murder 6%, and attempted rape 4%. Around 82% of violence occurred in the domestic sphere and 18% in public sphere (BRAC, 2017).

Women, fetus in utero, and infants are particularly vulnerable to the negative impacts of GBV. Physical assault, chronic stress, denial of access to food, health, or other resources, and/or emotional violence all contribute to higher rates of poor MNH outcomes among women living with intimate partner violence. Furthermore, contrary to common belief, women and girls continue to experience GBV during pregnancy and the postpartum period. The 2017 BRAC survey findings show that 4.7% of women experienced physical violence during pregnancy at the national level. Such percentages were 4.9% in the rural area, 4.3% in the urban area, 3.6% in the city corporation area and 4.6% in urban areas other than city corporation areas. The prevalence of sexual violence during pregnancy is higher than for physical violence. Almost one in ten women experienced sexual violence during pregnancy. Such percentages were 10.0% in the rural area, 6.2% in the urban area, 3.8% in the city corporations and 7.3% in the urban areas outside city corporations (Ministry of Planning , 2016).

## Legal Context /Country Legal Perspective: Bangladesh

There have been several legislative advances in Bangladesh in the last decades.

### Constitutional Guarantee, Policies, and Laws Related to GBV

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.

### **Policies**

The Gender Equity Strategy, in 2014; The Climate Change and Gender Action Plan, in 2013; The National Action Plan for Implementation of the National Women Development Policy, in 2013; The National Action Plan to Prevent Violence against Women and Children (2013-2025); The Domestic Violence (Prevention and Protection) Rules, in 2013; The National Plan of Action on Combating Human Trafficking (2012-2014); The National Action Plan for Adolescent Sexual and Reproductive Health (2011-2016); the Domestic Workers Protection and Welfare Policy, which provides legal protection, including access to social benefits, maternity leave and establishes the minimum age of employment in domestic work at 14 years, in 2015.

## Laws

Since GBV is not limited to VAW, domestic violence and sexual harassment, and since it is very related to the social attitude towards women, we note that there is no comprehensive law to address GBV. We also should mention that legislative action alone is not enough to fully address GBV. Further, existing laws to address GBV as a crime are facing several challenges in their proper implementation.

- The Domestic Violence (Prevention and Protection) Act, 2010 (“the Act of 2010”) was enacted to address domestic violence in Bangladesh. The Act is preventive and protective in nature. In the preamble of the Act, it is stated that the Act is enacted to establish equal rights for women and children guaranteed in the Constitution of the People’s Republic of Bangladesh. More precisely it was enacted to prevent domestic violence and to protect women and children from domestic violence.
- The Dowry Prohibition Act of 1980 and its 1986 amendment make the practice of dowry an offence punishable by fine and imprisonment. Dowry Prohibition Bill, 2018 states that the offender will be awarded maximum five years and minimum one year in jail or Tk 50,000 fine or both.
- The Prevention of Women and Child Repression Act 2000 (amended in 2003) provides for effective and efficient way of dealing with cases of violence against women such as rape, acid attacks, forced prostitution and trafficking.
- The Family Court Ordinance 1985 provides for the exclusive jurisdiction of the court on matters relating to marriage, dowry, maintenance, and custody of children.

However, these laws hardly challenge the traditional subordinate position of the women. Rather, some of the laws contribute to sustaining the lower socio-economic position of women - for example, Property Law (inheritance law), Evidence Act (Law of Witness), and Citizenship Act. The 2003 amendment to the Prevention of Women and Children Repression act of 2000 states that survivors should be provided immediate services at hospitals, however, access to quality, timely care remains unequitable across communities and districts—and across socio-economic groups. Furthermore, enforcement is inconsistent and subject to individual bias and beliefs.

*“The laws remained largely unimplemented and cited the reasons were due to corruption in police investigations, inefficient prosecutorial systems, absence of modern forensic medicine infrastructures, delay in criminal justice system, non-judicial mind-set of the judges, lack of public awareness, and impunity to the perpetrators having ruling political party affiliation. “A joint NGO submission to the UN Human Rights Committee” Data related to VAW is inadequate, the collection methodology is weak and there is no comprehensive data base. Only cases launched with police are recorded and maintained”.*

*Citizen initiative on CEDAW (CIC-BD) Alternative Report, 2016*



## [Remedy from the existing legal system and Knowledge of the VAW-related services](#)

Regardless of challenges within the existing legal framework, much progress could be made by strengthening application and integration of the GBV protective laws that have been enacted. Despite high rates of partner violence, most women (72.7%) never reported their experience to others. A low proportion of women reported their experience to a formal authority (Ministry of Planning , 2016).

"Only 2.6% survivors took legal action after being subjected to physical violence (Ministry of Planning , 2016). The statistics regarding GBV/VAW also shows that, "Few ever-married women (2.4%) know about the government telephone helpline for reporting violence. However, 41.3%of women reported they knew about other places where they could report experiences of violence. The most well-known service responsible for dealing with reports of violence were Police/Thana (identified by 27.8% of women), and the Union Parishad/Upazila Parishad/Paurashava (12.1%). The village leader or mediator and village court were known as places to lodge reports by 11.0% and 7.5% of these women respectively. Other services such as courts (4.2%), NGOs or private organization (2.4%), government organizations (0.8%), and the one stop crisis center (0.3%) were known to relatively few of the respondents. Knowledge of the Police/Thana ranks the highest in all geographic areas, the second highest was union/upazila/paurashava, and third highest was village leader or mediator (United Kingdom: Home Office , 2018).

The CEDAW Committee is concerned “The high levels of maternal mortality often due to child marriages and subsequent early pregnancies...” Annex 1 includes statistics on legal action, treatment received due to physical or sexual violence, state treatment and attitudes, implementation of the law, health care, access to justice and the police, assistance available to women such as support centers and shelters, other institutional initiatives, National Centre on Gender Based Violence Multi-Sectoral program on violence against women, One-Stop Crisis Centre and Cell (OCC), and the National Trauma Counseling Center (NTCC).

## [Covid-19 Impact on Gender Based Violence](#)

In response to the COVID-19 pandemic, the GOB declared a public holiday, shut services, and asked the population to stay home. The long period of staying home is causing psycho-social disruptions within domestic boundary as well as across social interactions, which are mostly affecting women and their physical, mental and sexual security and degrading their dignity, as exposed through media feeds and a few recent studies. These include surveys by the Bangladesh Legal Aid and Services Trust (BLAST) and Manusher Jonno Foundation (MJF) in Bangladesh as well as the cyber-crime status in the COVID-19 context. Details will be found in Annex—1 Gender Based Violence /Violence against women/Domestic Violence is on the rise in Bangladesh amid the COVID-19 lockdown. “Those who were at the risk of domestic violence are now in more danger as the COVID-19 pandemic has pushed people into their homes”—*Sara Hossain, Executive Director, BLAST (Dhaka Tribune, 2020).*

Around 50% of BLAST's cases are related to domestic violence, which indicates that women are now coming forward to put an end to the problem. "But, COVID-19 had changed the situation. As the lockdown continues, women are now forced to keep silent as they know they must continue with their partners and stay home," as pointed out by the *BLAST lawyer Nusrat Meraji* (Dhaka Tribune, 2020). The complaints are being received but further procedures could not be taken due to the lockdown.

During the month of April 2020 alone a total of 4,249 women reported violence (848 women were physically abused by their husbands, 2,008 were mentally abused, 85 were sexually abused, and 1,308 were economically abused) with an additional 456 reports of violence against children. Of these, 1672 women and 424 children had never been abused before. Ninety-two percent of children have been abused by their parents and relatives. A global survey conducted by UNFPA, indicates that domestic violence has increased globally by 20 percent during the COVID-19 pandemic.

Out of 4,259 respondents, 424 children fell victims of domestic violence. During this period, a total of 33 incidence of child marriage occurred. Out of 42 violent incidents, four children were raped, 16 fell victims of attempted rape, two were abducted, 10 were sexually assaulted and 10 fell were raped while collecting relief material (MJF, 2020).

As per Peace graphics - a BPO e Newsletter published in 24 July 2020, in Bangladesh during Jan - Jun 2020, Sexual assault increased 2% during COVID-19 time (8 Mar to 30 Jun) compared to Pre COVID time (14 Nov- 7 Mar). It was 345 in pre-COVID-19 time and 353 in the COVID time. 474 Incident 33 Death Top 3 reported incidents in June 2020. Domestic and Dowry related violence increased 6% during COVID-19 period (with 166 cases) compared to pre-COVID-19 period (with 176 cases). Violence against children increased 35% during COVID time with 347 cases compared to pre-COVID period with 536 cases (Bangladesh Peace Observatory, 2020).

As per Phase-III-Media-Tracking-of-Domestic-Violence Research Update (RAPID RESEARCH RESPONSE TO COVID-19 SERIES: GENDER 06 03 JUNE 2020 ) by Brac Institute of Governance and Development (BIGD), UN Women organized a webinar on "Gendered Impacts of COVID-19 in Bangladesh" on 19 May where key findings from a Rapid Gender Analysis (RGA) during COVID-19 were presented. Acknowledging Bangladesh's high prevalence of violence against women and girls during the pandemic, Dr. Abul Hossain, Deputy Secretary, Ministry of Women and Children Affairs (MOWCA) and Director for Multi-sectorial Program on Violence Against Women, discussed how the services of MOWCA as the One-Stop Crisis Centers and Cell (OCC) and National Trauma Counselling Centers and National Help Line for GBV are continuously providing support to women during the crisis. The National Help Line has been receiving approximately 10,000 calls a day, an increase from the average of 6,000 calls a day before the COVID-19 outbreak (Institute of Governance and Development, 2020).

Violence against women increased globally during the pandemic, in parallel with a marked decrease in services available for survivors. In Bangladesh, there is less access to legal support with physical courts closed during much of the pandemic, and fewer places for women to go with

the services of One-Stop Crisis Centers and women's shelters being limited. People are also less willing to seek medical support in cases of rape because health facilities are overburdened, transport is limited, and people are scared about catching the virus. Chillingly, these facts are not unknown to perpetrators (Sarah-Jane, 2020).

## Background for Formulating Recommendations to End the Gender Based Violence

We already have mentioned that laws and legal steps alone are not enough to eliminate GBV. The less discussed causes are deep rooted in our social and family structure. Therefore, initiatives need to include a vast social education, in addition to the application of the existing laws and policies. See Annex 1 for more details on the recommendations by the Survey Report on GBV status in Bangladesh of Bangladesh Bureau of Statistics in 2015.

A comprehensive strategy needs to be developed from national to grassroots levels to address GBV, ensuring basic support like medical treatment, legal support, psycho-social counseling, life skills training for rehabilitation, and shelter need to be made available at divisional, district and upazila levels. To fulfill this, a comprehensive network between the government and NGOs is required to strengthen and consolidate the social forces for combating the GBV. A National Centre on Gender-Based Violence was established in 2004 in the Department of Women Affairs Building of the Ministry of Women and Children Affairs.

The major objectives for networking and coordination are to prevent violence against women and children as well as assist survivors of GBV through coordination among government entities, NGOs, development partners, and civil society organizations.

### Activities for Enhanced Coordination

- Mobilize efforts and initiatives of different organizations at national, regional and international level for preventing violence against women and children.
- Coordinate activities and develop policy on violence against women and children of different ministries, divisions and organizations.
- Build networks with the international organizations to prevent GBV.
- Establish referral system among the networking organizations.

## CHAPTER 2. RELATION BETWEEN GENDER-BASED VIOLENCE AND FAMILY PLANNING/SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

As per our information of the investigated 5 unions in Chattogram and Mymensingh divisions, we found that 90% of FP/SRHR service clients are women. Specifically, we can mention that more than 80% of the FP clients are aged 18 to 35 years old and more than 90% of the survivors are girls and women aged 20 to 35 (Ministry of Health and Family Welfare, 2016).

Therefore, FP/SRHR clients and GBV survivors are within the same population demographic. At the same time, the patriarchic social system, which pushes the position of the women down to subordinate level, is contributing to the imbalanced sexual and reproductive role of men and women. The patriarchal power has been maintaining the secondary social position of women. Further, FP/SRHR services strengthen the sexual and reproductive role of every human being, but women's SRHR is also controlled socially. This is an issue to be addressed properly and without delay.

Despite gender inequity and patriarchal systems that limit women's agency and power explicitly and implicitly, FP/RH is understood and viewed as a women's realm and rates of ANC care, skilled delivery attendance, and post-natal care are high. While there is much work to be done, FP services, including post-partum FP, do reach large numbers of women (mCPR is above 50%). This provides a valuable entry-point to reach couples and women who may have little other exposure to formal government systems or services.

Underlying gender norms and power dynamics that contribute to GBV are complex and require leadership and modeling by respected community members in order to change. Health providers enjoy a high level of respect and status in Bangladesh and the ways they provide care, expect joint decision making, and model gender equitable norms is a valuable lever in the social norm change process.

GBV can play a direct role in limiting access and hindering uptake and/or continuation of modern contraception – for example, women who are afraid of experiencing violence if they seek or use contraception often will not use contraception. Women who select a method and are subject to sabotage may not use it effectively if they live with a controlling partner. Without proper couple-based counseling, some women may experience increase in violence due to selection of one method over another.

Worldwide, it is estimated that VAW is a serious cause of death and incapacity among women of reproductive age. GBV is a major but preventable public health problem. The health care system is the most common to only institution that interacts with almost every woman at some point in her life. International research has consistently shown that women exposed to violence visit health services more frequently than non-abused women. Health service providers – especially

those serving in accident and emergency wards and in women's health settings such as reproductive and sexual health, maternal child health and prenatal settings – have a critical role to play in detecting, referring and caring for women living with violence. Interventions by health service providers can potentially mitigate both the short- and long-term health effects of GBV against women and their families.

Despite the increasing evidence of the serious health consequences of GBV, health systems in many countries are not geared towards addressing the issue. Studies show that health professionals in many countries have not received training or professional development on GBV and responding to violence is not seen as part of their role. Service providers are members of a given society and reflect the dominant socio-cultural attitudes within the community that may contribute to GBV. Within the health system, like anywhere else, there will inevitably be both victims and perpetrators of GBV. There is therefore a great need to sensitize service providers about gender and GBV and enhance the capacity of health systems to respond effectively and sensitively to GBV.

Recognizing that GBV is a public health issue does not mean that the health sector can be expected to deal with it alone. Reducing and responding to GBV takes concerted and coordinated effort from a range of sectors including social services, religious organizations, the judiciary, police, media and business. The health sector therefore needs to play an important role within a multi-sectorial framework. GBV has a wide range of physical, mental and Reproductive Health consequences which often last long after the abuse has ended (UNFPA, 2010).

## CHAPTER 3. FAMILY PLANNING

In chapter 3, we have discussed how Family Planning can be related with GBV. Before seeing how the FP service delivery mechanism addresses and responds/ works to prevent GBV, we have to have a look at the range the Bangladesh context of FP concepts, objectives of the national FP Program, and what services are available.

As Bangladesh's constitutions and the policy dictates, everyone relevant has the right to decide the number and timing of children without discrimination, violence and oppression, to have the necessary information and facilities for it, to access sexual and reproductive health services at the highest standard. Family planning is defined as having the freedom and responsibility of all couples and individuals to decide the number of children they desire and having the knowledge, education and tools for this purpose. In other words, family planning is a service that allows married couples and individuals to achieve their desired number of children and decide the spacing of pregnancies according to their economic opportunities and personal wishes, and to ensure that the births are at appropriate intervals for the mother and child health. In addition, FP can enable higher levels of education, better employment opportunities, higher socioeconomic status and empowerment.

### Bangladesh Family Planning Context

#### [Article 15 of the Constitution of the People's Republic of Bangladesh 1972](#)

**Provision of basic necessities.** It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens:

- a. Provision of basic necessities of life, including food, clothing, shelter, education and medical care;
- b. Right to work, that is the right to guaranteed employment at a reasonable wage having regard to the quantity and quality of work;
- c. Right to reasonable rest, recreation and leisure; and
- d. Right to social security, that is to say, to public assistance in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age, or in other such cases.

With other development goals, the GOB shifted from a focus on family planning to a more broad-based reproductive health approach to respond in a holistic manner. Thereby, in 1998 the government introduced a sector-wide approach (SWAP) through a series of multi-year strategies, programs and budgets for management and development of the health, nutrition and population sector (HNPS), with support from both domestic and international financing. To achieve the

development goals, the government is implementing its Fourth HPNS Program (January 2017 to June 2022) with an estimated cost of US\$14.8 billion. The Program’s overall objective is “to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable healthcare in a healthy and safe living environment.” The Ministry of Health and Family Welfare (MOHFW) considers the Program as a first, foundational, program towards the achievement of the following Sustainable Development Goals by 2030:

- Reduce Total Fertility Rate (TFR)
- Increase the use of family planning methods, among eligible couples
- Ensure adequate availability and access of Reproductive Health Services, especially family planning services to all including information, counseling and services for adolescents,
- Improve maternal health with emphasis on reduction of maternal mortality
- Develop the human resource capacity of planners, managers and service providers, including improved data collection, research and dissemination
- Ensure coordination among relevant Ministries in implementing the FP program in a comprehensive manner

## Accesses to Family Planning Services

### Regular Family Planning Services

The Bangladesh family planning program is designed to cover every corner of the country – every Union Health Facility (UH&FWC) as well as every Union level Community Clinic should include FP services by trained service providers. They provide the following services: a broad choice of FP methods (pills, injectables, condom, IUDs, implant, non-scalpel vasectomy and Tubectomy), including PFP and PAC-FP, as well as FP counseling during ANC and PNC, and breastfeeding assistance, and among other health services.

The human resources at each UH&FWC includes one Sub-Assistant Community Medical Officer (SACMO), one Family Welfare Visitor (FWV), one Family Welfare Assistant (FWA), one Family Welfare Coordinator (FWC), one Pharmacist, and one Support Staff. Moreover, the Upazila Health Office organizes Satellite Health Clinic as part of their outreach services. We contacted five UH&FWCs and found no more than four out of the expected six staff were available at each of the centers due to vacancies.

Based on our interviews, we have found no direct service that addresses GBV. One service provider mentioned: “In our country, unfortunately, gender perspectives are hardly seen in FP services. Even the definition of gender or GBV is not mentioned in any FP related policies and strategies. There are no FP services that mentioned clause for the survivors of GBV. Commonly we know through several statistics that, due to our patriarchal society, a lot of women and girls are facing discrimination and becoming the victim of gender-based violence. The services relating

to the FP have developed targeting women and girls but nowhere in these services have mentioned anything about them who are the victim of GBV.”

The policies and implementation plan are also not pro-women and girls. As an example, when many women do not want to give birth at their early age for their career or any other reason, their in-laws force them to conceive and they cannot go against their will. Due to societal norms it is not possible for a woman to opt for a FP method without consulting with her husband's family. “Privacy is one of the most important criteria to provide quality FP services and which is mostly ignored by the service provider.” **Manager, Advocacy and Communication, Marie Stopes Bangladesh.**

*“In fact, we are not clear about that to what extent we can address GBVs through FP services. I still think that FP service is not comprehensive enough to address GBVs. What we can do is to work in coordination with the other related service providers. But, thinking deeply I can comment that we can reduce GBVs by preventing unexpected pregnancy and helping the girls to build up their own self-reliant life. Practically, we have a departmental gap. The major decisions have taken by the Department of Health. There is severe lack of internal coordination. We often think that only FP Services can independently address GBVs. Actually, no legal service is under our authority. Our workers may be oriented on related legal issues – where the victims should be referred to and which government agencies are responsible for taking necessary steps etc. The government should have right initiative to build required capacity of our field level workers equipped with all respective information.”*

*DD and PM, CCSDP, DGFP*

### [Access to FP](#)

It has been found that FP Services are available to the target clients, to a great extent drive by the commitment of Bangladesh government and its SDG goals that the state it will ensure FP Services for all by 2030. The National Action Plan of the Health sector complies with this goal. Any eligible citizen can receive these required services without any condition. The union level health service providers informed us that they have been given concrete direction to ensure FP services to every service seeker and to take special care of checking so that none get deprived of necessary service. They also mentioned the effectiveness of the satellite clinics in serving hard-to-reach populations.

Though services are available, there are other factors that limit women and girls’ access to them. Our desk review did not cover the client perspective and we recommend that a separate study be undertaken to know clients’ reflection. The study could identify GBV survivors, identifying those who received FP services, their satisfaction level about accessibility and quality of the services.



## Women's Freedom of choice to FP service

One of the factors driving women risk of exposure to GBV is her limited independent decision making related to family planning service. Based on informant opinions, women bear the responsibility of using an FP method, and therefore bear the after-effects of adapting family planning method. Furthermore, with the exception of one or two, FP methods are for use by women. Our informants believe the reason behind this fact is not only biological, but they believe there is limited research on inventing FP methods that can be safely applied to men, and it is assumed that the patriarchic outlook places the family planning burden on women. In case of any side-effect of a particular method, the woman alone must bear the responsibility. A social awareness program is necessary to engage male partners.

*“A few men are taking the responsibility of family planning method, and they are supportive to their wives by sharing the responsibility of adopting a family planning method. Institutional action is required to remove the challenges on the way of advancement of the men to take a family planning method.”*

*One of the respondents (while stating that the situation is changing slowly)*

In the case of some women, their husbands neither accompanied them nor provided any cooperation. Many of these husbands never agree to use condoms. It is also believed that men cannot visit the family planning service center. On the other hand, men rarely agree to non-scalpel vasectomy (NSV), because they believe that NSV may turn them into impotent person.

*“A woman took family planning method independently but for some unknown reason she conceived. In such situation, the husband brought his wife to the service center and openly scolded the woman and even was about to beat her. He held her throat brutally!”*

One of the informants mentioned during the interview.

“No woman dares to take family planning method without husband’s permission. We often suggest some women to stop taking pill and opt for alternative method, but they refuse to do so because they feel afraid that the husband would kick her out of house!”

One informant mentioned during interview.

Another informant interviewed stated, “Many women keep taking family planning method concealed, especially, they do not feel free to expose themselves during taking IUD method. In case of requirement, they are unwilling to take hormonal injection. Some of them take hormonal injection in sly but bear husband’s repression due to their getting overweight. We witnessed that husband brutally beat his wife because of her little bleeding for taking IUD method.”

“The women are afraid of choosing family planning method independently”

An informant commented

That informants also said that the complete dependence on husband, women’s economic dependence, traditional concept of women’s taking family planning methods etc. are the causes of such acute condition.

Interviews with frontline FP service providers indicate that while GBV may be covered in brief during in-service training, providers continue to feel unprepared to handle the significant power imbalance present in most of the couples they serve. FP providers stated that they need to

*If we do not take their cultural and conceptual context into our account, we will not be able to give them proper advice*

provide counseling to the husbands as a preventive measure for saving the couple from consequent risk. One of them said, “If we do not take their cultural and conceptual context into our account, we will not be able to give them proper advice”. It’s found that they do not apparently see any relation between FP and GBV. They think, “*The reciprocal attitude towards husband and wife is a private family matter, overpowering husbands is normal and it’s not possible to change.*” So, they require careful orientation on equal dignity about providing FP services. Few providers mentioned any training, guidance, or job aids for couple-based counseling; women-led method selection; or addressing coercive behaviors when demonstrated by a man toward his partner during an FP visit.

### Violence Witnessed by the Service Provider

All informants stated they have witnessed violence against women from their childhood. Many of the girls are married early and when they have little idea of the responsibilities of family life. One of the respondents said: “Most of the men of poor rural families are addicted to gambling, drinking and smoking cannabis. While the women must work outside home for earning to manage family food. These types of husbands threaten us over phone not to provide family planning services to their wives. There are instances of inhumane occurrence. For example, recently a woman came to us just 40 days after her delivery. We gave her an IUD. Unfortunately, after one month of her taking IUD, she started bleeding. We could not believe that the husband brought the woman to our center and physically tortured her in front of us!”

A service provider informed: “Many clients have shared their stories of being helpless survivors of domestic violence. For example, a girl, who did very good results in her SSC exams, was married off by force. Immediately after marriage she became pregnant and came to us. She told us that she had to do all the household chores of the extended in-laws family despite of her pregnancy. She was not willing to take a child at that age but she was undone under extreme pressure from the in-laws family members.”

Considering the occurrences of GBV, we can say that most women face violence at some point in their lifetimes. **Two of the respondents informed, “The domestic violence is in most cases not talked about”.** The differences of the opinions of the respondents means that frontline service providers need a common understanding about GBV.

## Family Planning Service Provided to Unmarried Women

The Union level frontline service providers informed that they provide FP services to all women and girls who come seeking services. The MOHFW Family Planning Manual mentions that unmarried women are not eligible to receive contraceptive methods.

All the interviewed frontline service providers informed that they have experience providing services to unmarried girls since they received guidance to provide services to anyone regardless of marital status, but nobody was able to recall any written order to this effect. Further, they believe there is no legal barrier to providing FP services to unmarried girls. A service provider informed: *“There is of course complexity in all such cases. I never give suggestion to any girl who comes alone. I ask them to come along with their parent”*.

## Frontline Service Provider View on Confidentiality

All respondents informed that confidentiality is maintained very strictly, and there is enough space at the 5 UH&FWCs covered in this investigated. It was further learned that the service provider training covers the importance of confidentiality. But providers feel a dilemma since they also believe the decision should be discussed with the husband. The effectiveness of the family planning services to a certain extent depend on the mutual relationship and understanding of the two parties.

However, analyzing the experiences of the respondents recognize very few men visit health facilities for FP services. The very few men who do come to the facilities do not feel free to openly discuss the matter as data reflects. Non-participation of men in the FP procedures not only degrades the effectiveness of the program but also can cause a negative impact, especially on women’s life. For example, in case of permanent method, it is a mandate for the service provider to obtain the consent of the client (clients are also asked about the consent of his/her partner). But sometimes women do not like to share their decision to take a method with her husband or any other member of her family. And, they earnestly ask service providers to keep their information strictly confidential. Thus, the process of open consent of the husband and wife and the demand of women to keep the matter confidential appear as conflicting. And unfortunately, the client often fails to convince her husband and family members to agree with her taking an FP method.

We have come across two opinions regarding husband’s permission for taking family planning services. First, there is the obligation to take the husband’s consent and second there is no obligation to take the husbands’ consent. Some service providers indicated there is no official order to obtain the husbands’ consent while others do not provide FP services without husband’s consent. Thus, we understand that there are conceptual differences among service providers on husband’s consent in providing family planning services.

It is a limitation of this review that it has not been possible to highlight GBV from the point of views of the client. However, we have accomplished KIIs with frontline service providers and thus obtained (partial) field scenario of the range of the process of addressing GBV. Since there are different in opinions among service providers about service requirements, there is a need for clarification so that women have access to services. There are laws, policies, directives, and official orders but there are also gaps in their execution. The FP program should ensure the same standard of clarity among providers and clients on the equal and indiscriminate application of the framework irrespective of race, sex, disability, and economic status.

## **Men's Participation in FP: Big Challenges and a Long Way to Go Forward**

Reproduction is a dual commitment but is often seen as the sole responsibility of women, and many FP programs have focused mainly on women. Men are often described as forgotten reproductive health clients in FP services.

The role of men in family planning has received more interest in recent years as policymakers begin to recognize the importance of male influence on reproductive decisions. Up to this point, many activities focus on determining the knowledge and attitudes of men on family planning. While men play a direct and major role in deciding on contraception, they play an indirect role as a dominant factor in women's economic, social and family needs. The role of men in decision-making on women's fertility and birth is always dominant (Nazli Sensoy, 2017, p. 41).

One of the biggest obstacles to men's participation in reproductive health is the inadequacy of information. There is a dearth of information about contraception that is targeted to men. Various studies have examined how cultural and social organizations influence contraceptive patterns (Nazli Sensoy, 2017, p. 42). Yet, men's positive approach makes it easier for women to access and use FP services and it ensure continuity of method use. Participation of men in family planning involves using more male-oriented methods and supporting their partners in using the eligible method she prefers. It is important for men to support which method to use and for the couple to decide together to ensure satisfaction with the method and continuation of use. Positive attitudes of men toward FP can enable their spouses to use a method. They can also play an important role in the prevention of sexually transmitted diseases through the regular use of condoms.

Men's attitudes guide women's reproductive health decisions and family planning method choices. Many factors affect women's use of a method including their educational status and that of their spouses, the number of children they have, their family structure, the point of view of men toward family planning and the disapproval of spouse or family elders.

“Most of the methods of FP are targeted to the woman, and the notion of men selecting the use of methods for him, men and women act together during the selection use of contraceptive and follow-up of methods and positive attitudes of men in family planning to use the methods and go to the health institution regularly are missing and for this woman is bound and expected by the society to avail the methods which is also restricts women and exploit women's life.” **Manager Advocacy and Communication, Marie Stopes Bangladesh**

“In our country, women or adolescents have restrictions on expressing her choice. Women do not want to have children right now but the husband will fix or decide which is better, even the contraceptive measures too. Most of the contraceptive methods women have to take while men mostly use condoms (even they do not want to use that too). Pills, Copper T, Injection, tubectomy, etc., women have to accept. Men decide when they do not want to have a child and force wife for tubectomy, in this patriarchal system women do not have a voice. This COVID 19 period, child marriage has been increased, the general health system is failing, so whether want to have a child or not is a negligent matter.” In my experiences, I have seen the husband create pressure to have sex in an unwanted way after seeing the blue film and wife sought a divorce after having so many children, the wife becomes sick and the husband used to go brothel and infected the wife with diseases. The wife did not have the idea of SRHR at all. This interview gives me an idea, I will check how we could help our clients who are facing GBV due to family planning issues, we see how we can include in our process. ” **Coordinator, Faridpur Unit, BLAST**

## Integration of Gender Based Violence at SRHR and FP

Though globally there have been significant achievements since 1994's International Conference on Population and Development in Cairo, the Cairo commitments remain far from reality for millions of girls and women, boys and men, and families who have been left behind. Globally:

- 214 million women want to prevent pregnancy but cannot obtain modern contraceptives
- 830 women die every day while giving life, mostly from preventable causes
- 33,000 girls are forced into child marriage every day
- Nearly 1 in 5 women or girls will be assaulted by their partner this year
- 5 million pregnant women have been displaced by conflict or disaster and need medical care

The follow up ICPD+25 Summit in 2019 in Nairobi Summit ended with a clear path forward to transform the world for women and girls. The Summit opened with the release of new research rallying participants to achieve “three transformative results” -- **zero maternal deaths, zero unmet need for family planning, and zero gender-based violence and harmful practices** -- within the next decade (UNFPA, 2019).

The 1994 ICPD was a turning point for the future of women and girls while the Nairobi Summit will be remembered as a watershed moment that set in motion actions that will save lives, lift millions of women and girls, their families and communities from exclusion and marginalization, and enable nations to harness the demographic dividend to grow their economies. See Annex 2 for a summary of the Summit Way Forward.

## CHAPTER 4. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

### The Social Context of SRHR

Many women, including adolescent girls, in Bangladesh are not provided with optimal conditions to develop their full potential and ensure their overall health. Adolescent girls also face gender-based discrimination, evident in the practice of child marriage, the high rates of adolescent fertility, the high prevalence of domestic violence, the increasing incidence of sexual abuse and higher drop-out rates from secondary education. Adolescent boys also face pressure to comply with prevailing norms of masculinity, which drives them to risky behaviors such as unsafe sex, violence and substance use. All these factors have a direct as well as indirect influence on the health and well-being of adolescents and form an essential component of the context within which health issues of adolescents should be understood. *Details on social context is attached Annex 3.*

#### Adolescent Sexual and Reproductive Health:

- Adolescents in Bangladesh, both unmarried and married, have low levels of knowledge and limited access to information and services on sexual and reproductive health and rights (SRHR)
- Bangladesh does not have nationally representative data which assesses knowledge levels on SRHR among adolescents.
- A significant concern in Bangladesh is the prevalence of child marriage and the corresponding high levels of adolescent fertility. With the highest adolescent fertility rate in South Asia, at 113 live births per 1000 women aged 15-19 years, there is a critical need for Bangladesh to ensure the availability of interventions to reduce adolescent fertility levels (BDHS 2014). These interventions need to start before marriage, so that young girls have adequate knowledge on SRHR and can better plan their pregnancies. According to the BDHS (2014) contraceptive prevalence (CPR) among married adolescents is 51 percent and the unmet need for family planning is 17 percent – the former lower than the national average by 11 percentage points and the latter higher than the national average by 5 percentage points.

“Adolescents do not have a clear understanding of SRHR. Very early age they used to get married, do not want to conceive but face threats by the husband and in-laws. If they do not agree, they face violence. During the Corona period, it has increased a lot, especially sexual violence. Unwanted pregnancies have increased.”

**Coordinator, Faridpur Unit, BLAST**

In BDHS surveys, current use of contraception is defined as the proportion of currently married women who report using a family planning method at the time of the survey. **In the 2017-18 BDHS**, 62% of currently married women age 15–49 reported using a contraceptive method.

## Accesses to SRHR Services

### SRHR Services addressing GBV

SRHR services are regularly provided at every UH&FWC located across Bangladesh integrated with other health services. The Government has taken the initiative to open Adolescent Health Centers at the UH&FWCs, but it is available in a very limited number of unions. These Centers provide services on the changes during the adolescent period, including menstruation related issues, lower abdominal pain and anemia, less appetite, hormonal changes and white discharge. These services could play a part in reducing GBV, especially for adolescents, but still the services do not include trained providers who can inform adolescents on concepts of GBV, provide counseling, and make referrals for GBV response.

### GOB Commitment to Eliminate GBV through FP/SRHR services

The Directorate General for Family Planning under the MOHFW is responsible for FP/SRHR services. Though family planning has been a priority for the GOB for the last four decades, there are funding constraints with almost all the budget allocated for FP and very little for other SRHR interventions. It is essential to set aside a space for GBV interventions at the UH&FWC level, but the allocated budget is too small to run even less than 50 adolescent corners.

### Adolescent Girls and Boys' access to SRHR and its impact on GBVs

Approximately 90% of SRHR clients are girls while only 10% of clients are boys. Some of the service providers said that the ratio of girls and boys receiving SRHR services is 95:05. They believe the health needs of adolescent girls is greater than that of the boys, but also adolescent boys and their guardians neglect their SRHR needs - they even acutely lack minimum information. Even with a small client load, it would still be useful to have information tailored to boys which also includes messages on prevention of GBV.

### Reflection of SRHR to reduce GBV in the SDGs and Bangladesh 7th Five Year Plan 2016-2020

DPM, ASH, DGHS: "The plan to address GVB through FP/SRHR was included in the 5th national strategy. Remarkable progress happened in FP though there was no advancement in the SRHR. Very recently, a few efforts are visible to strengthen SRHR such as: trainings, Upazila level activity monitoring, and billboard display. Moreover, the education curriculum on SRHR is being implemented. As part of cleanliness practice, 100 schools were provided with mugs, buckets, soap, nail-cutters, toothbrushes, and toothpaste. Many schools started distributing sanitary napkins free of cost or at very marginal price. The government targets to cover 1000 schools with this program. Such initiative will promote women's sexual and reproductive health, which will surely reduce GBVs."



The Center on GBV under the multi-sector program of VAW did not establish any coordination with FP or SRHR.

**Deputy Director, CCSD, DGFP:** “There is a little coordination in rural areas but no coordination has been possible in urban areas. We must establish better coordination mechanisms. Our service providers are not prepared to serve the men and boys. We still cannot serve the men and when they come, we are discouraging them. We are ready only for women. We are taking proper care of our adolescent girls, not the boys yet.”

### [COVID-19 to Change Women’s Lives in Bangladesh](#)

The COVID 19 pandemic is having potentially catastrophic secondary impacts on the health of women and girls around the world. Decisions made at every level of the response to the pandemic are resulting in women being further cut off from SRHR services, threatening sharp rises in maternal and neonatal mortality. A total of 56% of women faced obstacles in accessing contraceptives. And 63% of respondents reported a shortage in the market and 53% said that the price of contraceptives had increased. Combined with less access to safe abortion services, it would not be surprising if COVID-19 heralded a rise in unintended pregnancies. For women who are already pregnant, the reduced access to food because of the pandemic is a concern. And 68% of pregnant and lactating women surveyed are not receiving sufficient nutritious food (Sarah-Jane, 2020).

A group of stakeholders convened a Task Force to forward recommendations to DGFP for continuing FP services during the pandemic. The Task Force recognized that during natural disasters and other emergencies, SRHR needs are easily overlooked – yet these needs are often staggering. In crisis situations, one in five women of childbearing age is likely to be pregnant. Without access to health services, these women face an increased risk of life-threatening complications. Many women also lose access to FP, exposing them to unwanted pregnancies in perilous conditions. Women and young people also become more vulnerable to sexual violence and exploitation. And the hygiene needs of women and girls are often neglected (UNFPA Bangladesh, n.d.).

The Multi-Sectoral Anticipatory Impact and Needs Analysis of April 2020 indicates that the GOB has mobilized significant resources to support communities impacted by COVID-19. However, it is likely that a coordinated humanitarian response over a 12-month period will be needed to supplement these efforts, especially to ensure that the most vulnerable receive targeted support. The analysis looks at identifying risks for vulnerable communities due to their geographical locations and socio-economic conditions providing the basis future planning, including where activities need to be focused, who is most in need, and how the programs can be best delivered.

Table 1: Sexual and Reproductive Health Education

<b>Sexual and Reproductive Health Education (SRHE) (NAWG, 2020)</b>	
<p><b>Anticipated impact</b></p> <ul style="list-style-type: none"> <li>• Maternal mortality and morbidity are expected to increase, along with unmet need for FP, along with a decrease in clinical management of rape.</li> <li>• Lack of PPE may result in reduced availability of midwives; and worries of infection will lead to pregnant women avoiding hospitals, resorting to home deliveries without access to skilled care.</li> </ul>	<p><b>Key Statistics</b></p> <ul style="list-style-type: none"> <li>• 43% of healthcare workers heard of mothers dying in their areas within the last week</li> <li>• 25% of healthcare workers noted women are not coming to health facilities</li> </ul>
<p><b>Needs and Priorities</b></p> <ul style="list-style-type: none"> <li>• Ensuring access to evidence based SRHR services, and inclusion of pregnant women to triage and case management at health care facilities</li> <li>• Procurement of PPE to increase their accessibility to midwives and provide required training on their use</li> </ul>	
<b>Gender/ GBV (NAWG, 2020)</b>	
<p><b>Anticipated impacts</b></p> <ul style="list-style-type: none"> <li>• Global evidence shows disease outbreaks increase GBV incidences due to loss of livelihoods and increased unemployment and food insecurity, intensifying intimate partner violence, domestic violence and vulnerabilities of sexual and gender minorities</li> <li>• Restrainer social distance order has affected prevention measures and access to information and availability of adequate support services</li> <li>• Disproportionate impact on female-headed households</li> <li>• With women being primary caregivers and all family members bound to stay at home, the increased workload can lead to additional mental pressure on women</li> </ul>	<p><b>Key Statistics</b></p> <ul style="list-style-type: none"> <li>• Intimate partner violence among unmarried women between 20-24 years is 28%</li> <li>• Female headed households are identified as facing the greatest challenges in meeting their daily needs</li> <li>• 50% identified that safety/security of girls was an issue in the lockdown</li> <li>• 33% did not know where to seek help in cases of abuse</li> </ul>
<p><b>Needs and Priorities</b></p> <ul style="list-style-type: none"> <li>• Dignity Kits with COVID-19 IPC items to women and girls for enhancing safety and providing life-saving information for potential GBV survivors</li> <li>• Access to multi-sectoral services for GBV survivors including psychosocial support, and GBV risk mitigation for most vulnerable groups</li> <li>• Integrated GBV response services in priority sectors</li> <li>• Support to GOB case management and psychosocial support</li> <li>• Innovative interventions for women’s livelihood and promote awareness on equal sharing of household work through engaging men and male family members.</li> </ul>	

## CHAPTER 5. RECOMMENDATION AND CONCLUSION

### Recommendations

According to our above observations and findings, we are sharing herewith our suggestions and recommendations for the Shukhi Jibon Project to intervene at both policy and operational level to address GBV through FP-SRHR services.

#### Advocacy

To bring about changes in recognizing and addressing GBV, first step should be to mainstream awareness of issues and relevant laws and policies. In this regard, we are recommending advocacy with select policy makers and high officials of DGFP and DGHS with the following agenda and activities:

- I. Analyze the relation between FP/SRHR services and GBV and explain FP/SRHR services can contribute to the reduction of GBV.
- II. Clarify how GBV impedes the ultimate outcomes of FP services. Attention should be drawn to the fact that access to FP services is a human right and GBV is a serious barrier to exercising this right. Decision makers should prioritize protecting maternal health including women's access to family planning methods. They should be sensitized to how the lack of mutual understanding about FP at family and societal levels contributes to GBV, and so GBV should be addressed through FP/SRHR services.
- III. Realize that it is very important to enhance knowledge and sensitivity of service providers on the norms and customs set by a patriarchal society which hinders women and adolescents to exercise freedom of choice and initiatives needed to be ensured for all the service providers.
- IV. Establish coordination mechanisms between service providers and relevant Government agencies and NGOs for meaningful comprehensive initiatives against GBV and VAW.
- V. Duly consider that FP services, to which girls and women are getting more and more access, have the capacity to incorporate services to address GBV.

#### Program Interventions

A survivor-centered approach is needed and the below interventions can be added to the current program initiatives:

- A. Gather data on GBV and FP services to adapt evidence based good practices to the Bangladesh context.
- B. Develop a comprehensive work plan indicating the parties among whom coordination is essential, issues that require coordinated efforts, and coordination among the programs and

projects implemented in the field. The Outline must include 5W and 1H theory (What, Whom, Where, Why, When, How) at every stage – from field to the national level.

- C. Develop practical training manuals and job aids on human rights, gender and GBV and the coordination mechanism among the GOB services.
- D. Support DGFP to organize trainings for service providers. In this respect, Shukhi Jibon may develop a number of Model Unions where after-training service standard and GBV situation can be documented.
- E. Design a national awareness raising program through both offline and online tools. The main aim of such awareness program will be bringing change in men's reproductive role.
- F. Tailor messages directly to boys.
- G. Initiate or join networks to address GBV with national and international networks and organizations.

A list of organizations and potential collaborators are attached in Annex 6.

## Conclusion

We conclude this report by restating the great necessity and importance of addressing GBV through FP/SRHR services. But this is not enough. To avail this opportunity, we need to scrutinize and understand the perspective of the survivors, perpetrators, social opinion leaders, and other stakeholders. A survivor-centered approach is needed; and it will aim to create a supportive environment in which a survivor's rights are respected and in which the survivors are treated with dignity and respect. A survivor-centered approach to GBV seeks to empower the survivor by prioritizing her rights, needs, and wishes and this approach will empower the survivor to bring out the GBV issues when they avail of the FP/SRHR services.

We know that GBV is one of the most prevalent human rights violations in the world, and has no social, economic or national boundaries. Worldwide, an estimated one in three women experiences physical or sexual abuse in her lifetime – this figure is around 70% in Bangladesh. The negative impact of gender-based violence on individuals and on families is universal and has direct links to the overall development of the country.

A good place to start is to improve quality FP/SRHR services, strengthening collaboration among the Government of Bangladesh and NGOs to create a space so that adolescents and women survivors can discuss the issue of GBV when they avail the FP/SRHR services. This will contribute to strengthening women's agency to exercise their rights and help eliminate GBV.

## REFERENCES

- Bangladesh Peace Observatory. (2020, July). Retrieved from [https://infogram.com/peacegraphics-a-bpo-enewsletter-july-2020-1h0n2579gojl6pe?live&fbclid=IwAR0hDwhjh6Qfvv2K2LN\\_84SJtnfwfsJczqOMxquo99OhgXeXcpzxtlAOTA](https://infogram.com/peacegraphics-a-bpo-enewsletter-july-2020-1h0n2579gojl6pe?live&fbclid=IwAR0hDwhjh6Qfvv2K2LN_84SJtnfwfsJczqOMxquo99OhgXeXcpzxtlAOTA)
- BBS. (2019). *Gender Statistics of Bangladesh 2018*. Dhaka: Reproduction, Documentation & Publication (RDP) Section Bangladesh Bureau of Statistics.
- BRAC. (2017, March 15). Retrieved from <https://www.brac.net/>: <https://www.brac.net/latest-news/item/1031-7489-incidents-of-violence-against-women-in-2016>
- Dhaka Tribune. (2016, October 3). Retrieved from <https://www.dhakatribune.com/>: <https://www.dhakatribune.com/bangladesh/2016/10/02/survey-70-married-women-face-marital-violence/>
- Dhaka Tribune. (2020, May 17). Retrieved from <https://www.dhakatribune.com/>: <https://www.dhakatribune.com/bangladesh/2020/05/17/blast-perpetrator-use-emotional-psychological-tools-to-control-victims>
- European Institute for Gender Equality. (n.d.). *Gender Based Violence*. Retrieved from <https://eige.europa.eu/>: <https://eige.europa.eu/gender-based-violence/forms-of-violence>
- FP 2020. (2020, May 14). Retrieved from <http://www.familyplanning2020.org/>: <http://www.familyplanning2020.org/resources/bangladesh-recommendations-contraceptive-use-during-covid-19-pandemic>
- Institute of Governance and Development. (2020, June 3). Retrieved from <https://bigd.bracu.ac.bd/>: <https://bigd.bracu.ac.bd/wp-content/uploads/2020/06/Phase-III-Media-Tracking-of-Domestic-Violence.pdf>
- Ministry of Health and Family Welfare . (2016). *National Strategy for Adolescent Health 2017-2030*. Dhaka: MCH Services Unit DGFP.
- Ministry of Health and Family Welfare. (2016). *BANGLADESH DEMOGRAPHIC AND HEALTH SURVEY, 2014*. Dhaka: Ministry of Health and Family Welfare.
- Ministry of Planning . (2016). *Report on Violence Against Women (VAW) Survey 2015*. BBS.
- MJF. (2020, May 6). Retrieved from <http://www.manusherjonno.org/>: [http://www.manusherjonno.org/latest\\_stories/amid-lockdown-4249-women-and-456-children-became-victims-of-domestic-violence-in-april-mjf/](http://www.manusherjonno.org/latest_stories/amid-lockdown-4249-women-and-456-children-became-victims-of-domestic-violence-in-april-mjf/)
- NAWG. (2020). *COVID-19: Bangladesh Multi-Sectoral Anticipatory Impact and Needs Analysis*. Dhaka: NAWG.
- Nazli Sensoy, Y. K. (2017). Factors Affecting the Attitudes of Women toward Family Planning. *IntechOpen*, 34.
- Sanaiyya Faheem Ansari, M. A. (May 2018). *Sexual Harassment Against Female Workers at Workplace: Strategy to Combat and Wayforward*. Dhaka: MJF.
- Sarah-Jane, S. S. (2020). *COVID-19 to change women's lives in Bangladesh*. Dhaka: Prothom Alo.

- The Daily Star . (2016, December 19). Retrieved from <https://www.thedailystar.net/https://www.thedailystar.net/round-tables/gender-based-violence-and-its-impact-bangladeshs-development-1331872>
- UNFPA. (2010). *Health Sector Response to Gender-based Violence : An assessment of the Asia Pacific Region*. UNFPA.
- UNFPA. (2019, November 14). <https://www.unfpa.org/press/>. Retrieved from <https://www.unfpa.org/https://www.unfpa.org/press/nairobi-summit-icpd25-ends-clear-path-forward-transform-world-women-and-girls>
- UNFPA Bangladesh. (n.d.). Retrieved from <https://bangladesh.unfpa.org/https://bangladesh.unfpa.org/en/topics/humanitarian-emergencies-1>
- United Kingdom: Home Office . (2018). *Country Policy and Information Note Bangladesh: Women Fearing Gender Based Violence* . United Kingdom: Home Office .



## ANNEX I, ANNEX II, ANNEX III

There three (3) annexes are the deep dive within the concepts and elaborative presentation of the key concepts briefly discussed in the report. Those annexes are -

- Annex I: Relevant concepts and constructs of Gender Based Violence (GBV)
- Annex II: Family Planning (FP)
- Annex III: Sexual and Reproductive Health and Rights (SRHR) services

In order to keep the report precise and short, those annexes have been removed from here; but they are readily available on request. To get those Annexes, please write to – [info@shukhijibon.org](mailto:info@shukhijibon.org)



## ANNEX IV: QUESTIONNAIRES FOLLOWED IN INTERVIEW

### For Frontline FP Service Providers at Health Facilities

<b>Name of the Service Providing Institutions</b>	
<b>Address of the Institution</b>	House no ____ Road no: _____ Block no ____ Thana ----- District-----
<b>Name and Designation of the interviewee</b>	
<b>How long engaged with the service</b>	
<b>Date of the interview</b>	
<b>Name of the Interviewer</b>	

1. By family planning services we mean not only services related to birth control methods for small family formation, but also services related to maternal health, etc. What family planning services are provided by your organization?
2. Who gets services from your organization? Do the clients have to fulfill any conditions for receiving the service? If yes, what are they?
3. Do you provide Sexual and Reproductive Health care for adolescents? On average, how many people receive this service per month?
4. We know that women cannot express their opinions because of our social & family practices, norms, and culture. For the same reason, in your opinion do women have an independent opinion when it comes to choosing an FP method? If so, why? If not, why not?
5. The study shows that 72.6 percent of women in our country are survivors of various forms of violence. This is what we call Gender-Based Violence. Does this Gender-Based Violence have any relation to or connection with the services you provide? If so, what are they?
6. Do you think FP frontline service providers need to have some understanding of GBV? If so, why do you think so?

7. If you have noticed violence during your service provision, what types of violence were they?  
Can you share some examples with us?
8. Did you serve any unmarried pregnant women during your service period? Are there any systemic complications in providing services to unmarried pregnant women?
9. What are the requirements for confidentiality in providing FP services? What role do you play in protecting the privacy of clients?
10. Does the husband/partner have any role when women want to maintain privacy and in choosing a method – that is, is there any role that makes it difficult for the woman to receive services? If yes, what are the challenges?
11. Considering above, what do you think are the roles needed to be taken care of in providing or ensuring services?
  - What can service delivery organizations do?
  - What can service providers do?
  - What does the Government can do?
  - What can the NGOs and donor organizations do?

### For Supervisors/Managers of FP Services at health facilities

<b>Name of the Service Providing Institutions</b>	
<b>Address of the Institution</b>	House no ____ Road no: _____ Block no ____ Thana ----- District-----
<b>Name and Designation of the interviewee</b>	
<b>How long engaged with the service</b>	
<b>Date of the interview</b>	
<b>Name of the Interviewer</b>	

1. Does your organization have any training for service providers on Gender-Based Violence?
2. Do you record any specific information or number of clients who are the sufferers of Gender-Based Violence? Where do you send this information?
3. Do you refer the clients who are suffers from gender-based violence elsewhere to make sure to get proper services? Can you tell me more about the procedure?
4. Do you think gender-based violence in relation to FP and SRHR is a public health issue? If so, do you have/engaged with any advocacy activities? If so, what are they?
5. What are the issues covered in adolescent sexual and reproductive health? What problems do you usually have to address?
6. What are the perceptions of adolescents who come for services about their sexual and reproductive health?
7. Do teenagers come to you for services; and if so for what kind of services? Can you provide information on their profile in terms of age, gender, education, economic situation, town-village, and occupation?
8. Marginalized and disadvantaged adolescents might engage in sex work, there are adolescent children of sex workers, working adolescents - are there any separate services for them? And if so, what is the type of services provided?
9. Are there any joint activities with Government or other agencies to make ensure the sexual and reproductive health of adolescents?
10. As a signatory to the Convention on the Rights of the Child, cosignatory of the International Conference on Population and Development (ICPD), the Beijing Platform for Action, and most recently the SDGs, Bangladesh is committed to prioritizing Sexual and Reproductive Health of adolescents.
  - Do you think your organization's work and/or service provision contributes to the commitments made by the Bangladesh Government? If so, what are they and how do you report them to GoB?
  - Does your organization offer any information through reports that have to be provided in the international arena in light of all these commitments?

- Do you store information about the number of clients, type of services, client profile, and check for repeated clients or continuation of services?
11. Along with the Government, various development partners' organizations and NGOs are working on adolescent sexual and reproductive health. Do you know of any in your area? Does your organization have any collaboration with those organizations?
12. A young woman who has been the survivor of child marriage, but at this moment is not willing to have children. In this case, when she arrived at facility to seek FP services, she was informed that she would need her husband's permission. But the client does not want to tell her husband. The service provider informed her that it would not be possible for her to offer services without her husband's signature on this permission form. In this situation, the client wants to make her own decision, but due to her social background, she has to rely on her husband's permission. Do you think that woman has the right to receive services that she wants about family planning?
- How will your organization help that client?
  - As a service facility, is there a system of couple counseling for both husband and wife keeping in mind the social context? If so, could you share ideas about arrangements.
13. Is there any Code of Conduct for your organization's service providers on how in serving clients or what kind of language to use in any situation? Do you believe this code of conduct is Gender sensitive? Are service providers following this code of conduct as they serve client; and how do you ensure this?

## For the high-ranking officials of the Department of Family Welfare under MOHFW

<b>Name of the Service Providing Institutions</b>	
<b>Address of the Institution</b>	House no ____ Road no: ____ Block no ____ Thana ----- District-----
<b>Name and Designation of the interviewee</b>	
<b>How long engaged with the service</b>	
<b>Date of the interview</b>	
<b>Name of the Interviewer</b>	

Say, we are doing research work on behalf of **Pathfinder International**. This research activity is being conducted to find out the social and family position of women in providing family planning services and Sexual and Reproductive Health services in Bangladesh, (which has led to gender-based violence), the target group for providing family planning and sexual and reproductive health services, and the extent to which gender-based violence is being considered. At the beginning of the research work, through desk review, the overall findings are; -----

The understanding of Gender-based violence in providing family planning and sexual and reproductive health services in Bangladesh demands thoughtful consideration. Over the past decade, various steps have been taken to improve family planning and sexual and reproductive health services. On behalf of the state, the government has participated in initiatives to set standards in the international arena and has adopted ideas from there to formulate various laws and policies at the national level.

In this context, the things we want to know from you -

1. Is gender-based violence being considered highly in family planning services and sexual and reproductive health services in Bangladesh? If so, what are the indicators of this importance gravity? If not, what do you think could be the reasons?

2. The Government's recently committed at the International Conference on Population and Development (ICPD), hosted by UNFPA, is to promote social, including gender-based violence for women and adolescents through family planning services and sexual and reproductive health services. All the harmful practices in the family will be tackled and eliminated by 2030. Can you tell us what action has been taken against this promise?
3. There is a big difference between men and women in the use of contraceptives - research says the ratio is 1: 6.
  - Why do you think this is so?
  - Is there any specific program plan to change this situation?
4. Family welfare and sexual and reproductive health care have been included in the National 7th Five Year Plan in line with the SDG targets. Have you noticed any impact of this inclusion in family planning and sexual and reproductive health care?
5. We know that the government has undertaken a comprehensive program against violence against women (Multi Sectorial Programme Of Violence against women) to address the issue of gender-based violence and has set up a National Center on GBV. But so far the program has not reflected the vital focus on gender-based violence in family planning and the provision of sexual and reproductive health services. What do you comment on the subject?
6. A young woman who has been the survivor of child marriage, but at this moment she is not willing to have children. In this case, when she arrived at the service provider to seek family planning services, she was informed that she would need her husband's permission. But the woman does not want to tell her husband. The service provider informed her that it would not be possible for her to offer services without her husband's signature on this permission form. In this situation, the woman wants to make her own decision, but due to her social background, she has to rely on her husband's permission.
  - Do you think that the rights of the service recipients are being violated in this situation? Why do you think? If not, why not? If the rights have been violated, how can he get his remedy?

**A Female survivor of Gender-Based Violence (GBV) who has come to receive family planning and sexual and reproductive health care**

<b>Name of the Service Providing Institutions</b>	
<b>Address of the Institution</b>	House no ____ Road no: ____ Block no ____ Thana ----- District-----
<b>Name and Designation of the interviewee</b>	
<b>How long engaged with the service</b>	
<b>Date of the interview</b>	
<b>Name of the Interviewer</b>	

1. Did you get the service properly that you have come to take? If not, can you tell us about your experience?
2. Who told you about receiving services at this organization? Did any other organization send you here? If so, what is the name of the organization?
3. Is this the first time to come here to receive service? Are you satisfied with the behavior of the person who provided you the service?
4. Did you face any difficulties, if yes, what are those?
5. Do you have any suggestions for the people who are involved with this service providing organization? Is there any advice on the type of service provided?

## Questionnaire for the Legal aid service providing organization

<b>Name of the Service Providing Institutions</b>	
<b>Address of the Institution</b>	House no ____ Road no: ____ Block no ____ Thana ----- District-----
<b>Name and Designation of the interviewee</b>	
<b>How long engaged with the service</b>	
<b>Date of the interview</b>	
<b>Name of the Interviewer</b>	

1. You provide support to the women who are survivors of violence. Who do the women (age, gender, education, economic status, city-village, own profession) usually come to you for help? What type of support do they usually get?
2. Do you give legal assistance to the victims of gender-based violence as well as physical or emotional assistance? If so, how?
3. The woman is not willing to have a baby now or want to have a baby, forcing and pushing for abortion-does anyone come to help with these issues? Can you share one or two incidents with us? What are the chances of taking legal action in such cases?
4. Have you seen or does anyone told you anything about family planning and sexual and reproductive health services in Bangladesh that she has not been able to receive or have difficulty in receiving - or a reflection of the patriarchal social system? If so, what are they?





## ANNEX V: LISTS OF NETWORKING ORGANIZATIONS

Gender Based Violence (GBV) related Organization	
<b>CIDV Coalition</b>	2, 16 BLOCK # B, Lalmatia, Dhaka 1207 <a href="tel:01714-025069">01714-025069</a> , <a href="mailto:cidv.bd@gmail.com">cidv.bd@gmail.com</a>
<b>BRAC</b>	BRAC Centre, 75 Mohakhali, Dhaka-1212, Bangladesh <a href="tel:+880222281265">+88 02 2222 81265</a> . Ext: 3161, 3182, 3191 Fax: <a href="tel:880222263542">88 02 2222 63542</a> <a href="mailto:info@brac.net">info@brac.net</a>
<b>Plan International</b>	House 14, Road 35, Gulshan 2, Dhaka, Bangladesh <a href="tel:+88029860167">+880-2-9860167</a> , <a href="tel:8826209">8826209</a> , <a href="tel:8817589">8817589</a> <a href="mailto:plan.bangladesh@plan-international.org">plan.bangladesh@plan-international.org</a>
<b>We Can Campaign</b>	Amrai Pari (WE CAN) Secretariat 6/4 A, Sir Sayed Road (2nd Floor), Mohammadpur, Dhaka-1207 Bangladesh <a href="tel:+88029130265">+88 02 9130265</a> <a href="mailto:info@wecan-bd.org">info@wecan-bd.org</a> ; <a href="mailto:wecan_secretariatbd@yahoo.com">wecan_secretariatbd@yahoo.com</a> <a href="http://www.wecan-bd.org">www.wecan-bd.org</a> <a href="https://fb.com/wecanbangladesh">fb.com/wecanbangladesh</a>
<b>Sajida Foundation</b>	OTOBI Center, 5th floor, plot 12, Block CWS(C), Gulshan South Avenue, Gulshan 1, Dhaka 1212 <a href="tel:+88029890513">+8802-9890513</a> , <a href="tel:+88029851511">+8802-9851511</a> Fax: <a href="tel:+88029863165">+8802-9863165</a> <a href="mailto:inquiry@sajidafoundation.org">inquiry@sajidafoundation.org</a> <a href="https://sajidafoundation.org/">https://sajidafoundation.org/</a>
<b>Bangladesh Legal Aid and Services Trust (BLAST)</b>	1/1 Pioneer road, Kakrail (1.12 km) 1000 Dhaka, Bangladesh <a href="tel:00880283919702">0088-02-8391970-2</a> <a href="mailto:mail@blast.org.bd">mail@blast.org.bd</a> <a href="http://www.blast.org.bd">www.blast.org.bd</a> <a href="https://www.facebook.com/BLASTBangladesh/">https://www.facebook.com/BLASTBangladesh/</a>
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“ A woman took family planning method independently but for some unknown reason she conceived. In such situation, the husband brought his wife to the service center and openly scolded the woman and even was about to beat her. He held her throat brutally!

one of the informants mentioned during the interview



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