

1. Bangladesh



Statistics

GENERAL

Population

- Total population: 146,700,000.¹
- Population by sex: 69,510,190 (female) and 73,854,260 (male).²
- Percentage of population aged 0–14: 37.0.³
- Percentage of population aged 15–24: 20.4.⁴
- Percentage of population in rural areas: 74.⁵

Economy

- Annual percentage growth of gross domestic product (GDP): 4.9.⁶
- Gross national income per capita: USD 360.⁷
- Government expenditure on health: 1.4% of GDP⁸
- Government expenditure on education: 1.3% of GDP⁹
- Population below the poverty line: 33.7% (below national poverty line); 36.0% (below USD 1 a day poverty line); 82.8% (below USD 2 a day poverty line).¹⁰

WOMEN'S STATUS

- Life expectancy: 61.8 (female) and 61.0 (male).¹¹
- Average age at marriage: 18.0 (female) and 25.5 (male).¹²
- Labor force participation: 57.2% (female) and 89.8% (male).¹³
- Percentage of employed women in agricultural labor force: 77.4.¹⁴
- Percentage of women among administrative and managerial workers: 5.¹⁵
- Literacy rate among population aged 15 and older: 30.2% (female) and 49.4% (male).¹⁶
- Percentage of female-headed households: 9.¹⁷
- Percentage of seats held by women in national government: 2.¹⁸

CONTRACEPTION

- Total fertility rate: 3.46 lifetime births per woman.¹⁹
- Contraceptive prevalence rate among married women aged 15–49: 54% (any method) and 43% (modern methods).²⁰
- Prevalence of sterilization among couples: 8.7% (total); 7.6% (female); 1.1% (male).²¹
- Sterilization as a percentage of overall contraceptive prevalence: 17.7.²²

MATERNAL HEALTH

- Lifetime risk of maternal death: 1 in 42 women.²³
- Maternal mortality ratio per 100,000 live births: 377.²⁴
- Percentage of pregnant women with anemia: 53.²⁵
- Percentage of births monitored by trained attendants: 13.²⁶

ABORTION

- Total number of abortions per year: 100,300.²⁷
- Annual number of hospitalizations for abortion-related complications: 71,800.²⁸
- Rate of abortion per 1,000 women aged 15–44: 3.8.²⁹
- Breakdown by age of women obtaining abortions: 14.6% (under 20); 25.6% (between 20–24); 24.2% (between 25–29); 20.6% (between 30–34); 11.1% (between 35–39); 3.9% (40 or older).³⁰
- Percentage of abortions that are obtained by married women: 96.7.³¹

SEXUALLY TRANSMISSIBLE INFECTIONS (STIs) AND HIV/AIDS

- Number of people living with sexually transmissible infections: Information unavailable
- Number of people living with HIV/AIDS: 13,000.³²
- Percentage of people aged 15–24 living with HIV/AIDS: 0.01 (female) and 0.01 (male).³³
- Estimated number of deaths due to AIDS: 650.³⁴

CHILDREN AND ADOLESCENTS

- Infant mortality rate per 1,000 live births: 64.³⁵
- Under five mortality rate per 1,000 live births: 97 (female) and 88 (male).³⁶
- Gross primary school enrollment ratio: 101% (female) and 100% (male).³⁷
- Primary school completion rate: 76% (female) and 68% (male).³⁸
- Number of births per 1,000 women aged 15–19: 117.³⁹
- Contraceptive prevalence rates among married female adolescents: 27.8% (modern methods); 4.9% (traditional methods); 32.9% (any method).⁴⁰
- Percentage of abortions that are obtained by women younger than age 20: 14.6.⁴¹
- Number of children under the age of 15 living with HIV/AIDS: 310.⁴²

ENDNOTES

1. See UNITED NATIONS POPULATION FUND (UNFPA), *THE STATE OF WORLD POPULATION 2003*, at 75 (2003) [hereinafter *THE STATE OF WORLD POPULATION 2003*]. Estimates for 2003.
2. See United Nations Population Fund (UNFPA), UNFPA Country Profiles, available at <http://www.unfpa.org/profile/default.cfm> (last visited Aug. 12, 2003) [hereinafter UNFPA Country Profiles]. Estimates for 2001.
3. See THE WORLD BANK, *WORLD DEVELOPMENT INDICATORS 2003*, at 38 (2003) [hereinafter *WORLD DEVELOPMENT INDICATORS 2003*]. Estimates for 2001.
4. See UNFPA Country Profiles, *supra* note 2.
5. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 75. Estimates for 2001.
6. See *WORLD DEVELOPMENT INDICATORS 2003*, *supra* note 3, at 186 (2003). Estimates for 1990–2001.
7. See THE WORLD BANK, *WORLD DEVELOPMENT INDICATORS 2003, DATA QUERY*, available at <http://devdata.worldbank.org/data-query/> (last visited Feb. 24, 2004). The statistical figure was obtained through the Atlas method. Estimates for 2002.
8. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 75.
9. See United Nations, Infonation, Government Education Expenditure, available at http://www.un.org/Pubs/CyberSchoolBus/infonation/e_infonation.htm (last visited Dec. 18, 2003). Estimates for 1990–99.
10. See *WORLD DEVELOPMENT INDICATORS 2003*, *supra* note 3, at 58. The statistical figures were based on 2000.
11. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 71.
12. See UNFPA Country Profiles, *supra* note 2.
13. See *id.*
14. See World Health Organization South-East Asia Region (WHOSEA), *Women's Health in South-East Asia, Women's health and development indicators– Bangladesh*, at http://w3.whosea.org/women/regtab_ban.htm (last visited Aug. 19, 2003). Estimates for 1995–96.
15. See UNITED NATIONS, *THE WORLD'S WOMEN 2000*, at 146 (2000) [hereinafter *WORLD'S WOMEN 2000*].
16. See UNFPA Country Profiles, *supra* note 2.
17. See *WORLD'S WOMEN 2000*, *supra* note 15, at 48. Estimates for 1991/1997.
18. See SAVE THE CHILDREN, *STATE OF WORLD'S MOTHERS 2003*, at 39 (2003) [hereinafter *STATE OF WORLD'S MOTHERS 2003*]. This indicator represents the percentage of seats in national legislatures or parliaments occupied by women.
19. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 75.
20. See *id.*
21. See ENGENDERHEALTH, *CONTRACEPTIVE STERILIZATION: GLOBAL ISSUES AND TRENDS*, tbl. 2.2, at 47 (2002). Estimates for 1996–97.
22. See *id.*, tbl. 2.5, at 55. Estimates for 1996–97.
23. See WHO ET AL., *MATERNAL MORTALITY IN 1995: ESTIMATES DEVELOPED BY WHO, UNITED NATIONS CHILDREN'S FUND (UNICEF), UNFPA 42* (2000). Estimates for 1995.
24. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 71.
25. See *STATE OF WORLD'S MOTHERS 2003*, *supra* note 18, at 39.
26. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 75.
27. See Stanley K. Henshaw et al., *The Incidence of Abortion Worldwide*, 25 INT'L FAM. PLANNING PERSP. S30–S38 (Supp. 1999), available at <http://www.agi-usa.org/pubs/journals/25s3099.html> (last visited Aug. 19, 2003). Estimates for 1995–96.
28. See *id.* Number includes 19,400 women hospitalized due to complications resulting from a menstrual regulation procedure. Estimate for 1995–96.
29. See UNITED NATIONS (UN), POPULATION DIVISION, DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, UNITED NATIONS WORLD ABORTION POLICIES 1999, U.N. Doc. ST/ESA/SER.A/178 (1999), available at <http://www.un.org/esa/population/publications/abt/abt.htm> (last visited Aug. 20, 2003). Estimates for 1995–96.
30. See Akinrinola Bankole et al., *Characteristics of Women Who Obtain Induced Abortion: A Worldwide Review*, 25 INT'L FAM. PLANNING PERSP. 68–77 (1999) [hereinafter Akinrinola Bankole et al.], available at <http://www.agi-usa.org/pubs/journals/2506899.html> (last visited Aug. 21, 2003). The statistical figure was obtained through ad hoc surveys and hospital records.
31. See *id.* The statistical figures were obtained through ad hoc surveys and hospital records. Estimates for 1991.
32. See UNAIDS & WORLD HEALTH ORGANIZATION (WHO), *EPIDEMIOLOGICAL FACT SHEETS ON HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS UPDATED 18 AUGUST 2003: BANGLADESH 2* (2003) [hereinafter UNAIDS], available at <http://www.who.int/GlobalAtlas/home.asp> (last visited Aug. 18, 2003). Estimates for 2001.
33. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 71.
34. See UNAIDS, *supra* note 32, at 2.
35. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 71.
36. See UNFPA Country Profiles, *supra* note 2.
37. See *THE STATE OF WORLD POPULATION 2003*, *supra* note 1, at 71. The ratios indicate the number of students enrolled per 100 individuals in the appropriate age-group. The ratio may be more than 100 because the figures remain uncorrected for individuals who are older than the level-appropriate age due to late starts, interrupted schooling or grade repetition.
38. See *id.*
39. See *id.*
40. See Saroj Pachauri & K.G. Santhya, *Reproductive Choices for Asian Adolescents: A Focus on Contraceptive Behavior*, 28 INT'L FAM. PLANNING PERSP. 186–195 (2002), available at <http://www.agi-usa.org/pubs/journals/2818602t.html> (last visited Aug. 21, 2003). Estimates for 1991.
41. See Akinrinola Bankole et al., *supra* note 30. The statistics were obtained through ad hoc surveys and hospital records.
42. See UNAIDS, *supra* note 32, at 2.

Bangladesh was part of the Mauryan Empire, the first great indigenous empire on the Indian subcontinent, until the third century. The region passed into the control of Muslim princes in the thirteenth century and the territory comprising present-day Bangladesh was absorbed into the Moghul Empire three centuries later.¹ By 1757, the British East India Company had gained total dominion over the Moghul Empire, and transferred sovereignty to the British Crown a century later.²

In 1947, the Indian subcontinent was partitioned along religious lines, resulting in the creation of largely Hindu India and Muslim East and West Pakistan.³ Frictions over ethnicity, language, economy, and class developed between East and West Pakistan, which were separated by 1,600 miles of Indian territory. The two regions grew further apart during the 1950s and 1960s.⁴ In 1963, Sheikh Mujibur Rahman (Mujib), who would later become Bangladesh's first prime minister, took control of East Pakistan's dominant political party, the Awami League (People's League).⁵ Mujib, a strong proponent of East Pakistani autonomy, spearheaded the movement for independence in the 1960s.⁶

In 1970, the Awami League won control of the national assembly in Pakistan's first direct elections, which promised the league control of the government with Mujib as prime minister.⁷ However, the convening of the assembly's inaugural session was indefinitely postponed as Mujib called for a general strike and demanded that his government be given sovereign control of East Pakistan.⁸ Negotiations ensued between Pakistan's West Pakistan-dominated national government and the Awami League; the negotiations eventually collapsed, leading to the government's decision to resolve the "problem" of East Pakistan by repression.⁹ A bloody crackdown by the Pakistani army in East Pakistan on March 25, 1971, led to the first proclamation of an "independent, sovereign republic of Bangladesh" the very next day and the formation of an independent government in December of that year.¹⁰ The Constitution of the People's Republic of Bangladesh was adopted on November 4, 1972.¹¹

Power changed hands among several leaders during the remainder of the century. Mujib was assassinated in 1975 and was succeeded by Major General Zia Rahman in 1978, who introduced a multiparty presidential system of government.¹² He was assassinated shortly thereafter.¹³ Lieutenant General Hossain Mohammad Ershad seized power in a 1982 coup and declared Bangladesh an Islamic Republic in 1988, but resigned in 1990 in the face of opposition.¹⁴ The Bangladesh Nationalist Party won parliamentary elections in 1990 and Begum Khaleda Zia, Rahman's widow, became the first female prime minister of Bangladesh. A 1991 constitutional

amendment returned Bangladesh to a parliamentary system of governance, with the prime minister serving as head of government and the president serving a largely ceremonial role.¹⁵ The Bangladesh Nationalist Party lost in the 1996 elections to the Awami League, but returned to power in 2001, with Khaleda Zia again leading the government as prime minister.¹⁶

There are an estimated 129 million people living in Bangladesh, the majority of whom are Bengali; a small percentage are non-Bengali Muslims or from tribal groups.¹⁷ Although the official language is Bangla, English is widely used as an unofficial second language.¹⁸ Islam is the predominant religion in Bangladesh (83% of the population), followed by Hinduism (16%) and Buddhism and Christianity (1% combined).¹⁹

Bangladesh has hosted large refugee populations over the past decade. Some 250,000 Muslim refugees fled to Bangladesh from Burma between 1991 and 1992 because of religious and other forms of persecution.²⁰ Most of these refugees have since repatriated, although some 21,900 of this original group remain in Bangladesh and are recognized as refugees by the government.²¹ The government does not, however, recognize an estimated 100,000 additional Burmese who fled to Bangladesh since 1993; it considers them to be illegal immigrants.²² There are also some 60,000 internally displaced ethnic groups, mostly Chakma, and an unknown number of internally displaced Hindus and other religious minorities.²³

Bangladesh has been a member of the United Nations (UN) since 1974.²⁴ It is also a member of the Commonwealth of Nations, Organization of Islamic Conference, and South Asian Association for Regional Cooperation (SAARC).²⁵

I. Setting the Stage: The Legal and Political Framework of Bangladesh

Fundamental rights are rooted in a nation's legal and political framework, as established by its constitution. The principles and goals enshrined in a constitution along with the processes it prescribes for advancing them, determine the extent to which these basic rights are enjoyed and protected. A constitution that upholds equality, liberty and social justice can provide a sound basis for the realization of women's human rights, including their reproductive rights. Likewise, a political system

committed to democracy and the rule of law is critical to establishing an environment for advancing these rights. The following section outlines Bangladesh's legal and political framework.

A. THE STRUCTURE OF NATIONAL GOVERNMENT

The preamble to the constitution establishes the "high ideals of absolute trust and faith in the Almighty Allah, nationalism, democracy and socialism meaning economic and social justice..." as fundamental principles of the constitution.²⁶ The constitution provides for a parliamentary system of government, and outlines the roles of the three branches of government: executive, legislative and judicial.

Executive branch

The president, who is largely a figurehead, serves as chief of state and is elected by the parliament.²⁷ He or she is also commander in chief of the armed forces.²⁸ The president makes the appointments of the prime minister and the Chief Justice of the Supreme Court independently; all other presidential powers are exercised with the advice of the prime minister.²⁹ Such powers include the authority to appoint ministers of state, deputy ministers and other ministers, as well as judges for the Supreme Court and other courts throughout the country; summon, prorogue and dissolve parliament; grant pardons, reprieves and respites; and remit, suspend or commute any sentence passed by any court, tribunal or other authority.³⁰ All international treaties must first be submitted to the president, who then presents them to parliament for ratification.³¹ The president may serve up to two five-year terms, which need not be consecutive.³²

The Thirteenth Amendment to the Constitution, known as the Caretaker Government Amendment, significantly enhances the president's role when, at presidential direction, parliament is dissolved and a caretaker government is installed to supervise new elections.³³ Under such an interim government, the president's powers are considerably increased: he or she has control over the Ministry of Defense; the authority to declare a state of emergency; and the power to appoint and dismiss a "chief advisor" and other members of the caretaker government.³⁴ The caretaker government is collectively responsible to the president, and carries out routine government functions until a new parliament is elected and the president's powers revert to their normal level.³⁵

The prime minister, who serves as the head of government, holds most of the executive power in government.³⁶ The president appoints as prime minister the parliamentarian who commands the support of the majority of members of parliament.³⁷ The prime minister heads the cabinet, known as the Council of Ministers, which serves primarily to advise

the president in the exercise of his or her duties.³⁸ The council is collectively accountable to parliament.³⁹

Legislative branch

The constitution provides for a unicameral legislature, known as the House of the Nation.⁴⁰ It consists of 300 members elected by popular vote every five years from single territorial constituencies.⁴¹ A constitutional amendment reserving an additional 30 seats for women expired in May 2001, however, the government recently approved a draft proposal to reserve 45 parliamentary seats for women.⁴² Parliament automatically dissolves five years from the date of its first meeting, unless the president dissolves it sooner.⁴³

Parliament's principal function is to create laws.⁴⁴ Every proposed bill must be presented to the president for approval.⁴⁵ The president then has 15 days to assent to the bill or remand it to parliament for reconsideration or amendment.⁴⁶ If the president fails to respond to a bill, it is automatically considered to be approved.⁴⁷ Bills concerning monetary issues may not be introduced in parliament without a recommendation by the president. Parliament may amend the constitution by a two-thirds majority vote.⁴⁸

In addition to its legislative powers, parliament has the power to levy taxes.⁴⁹

B. THE STRUCTURE OF LOCAL GOVERNMENTS

For administrative purposes, the country is divided into six divisions: Barisal, Chittagong, Dhaka (the capital), Khulna, Rajshahi, and Sylhet.⁵⁰ Each division is further divided into 64 *zilas* (districts).⁵¹ Below *zilas*, there are further urban and rural subdivisions.⁵² In rural areas, *zilas* are subdivided into 507 *thanas* (subdistricts), below which are about 4,479 unions.⁵³ Below unions are over 86,000 villages.⁵⁴ In urban areas, the main subdivisions are 6 city corporations and more than 200 municipalities.⁵⁵ These are further subdivided into a number of wards.⁵⁶

The central government exerts a great deal of control over local government bodies in all aspects: it determines their structure, composition and functions; formulates detailed rules that govern the authority of elected members, the assessment of taxes and other important areas; and exercises wide authority in local financial and administrative matters.⁵⁷ The central government must also approve all regulations made by local bodies.⁵⁸

Executive branch

Bangladesh's six divisions are each governed by a divisional commissioner.⁵⁹ The commissioner has only a supervisory role in relation to the division's departments and agencies, which are directly linked to a correlate office at the central level.⁶⁰ He or she also coordinates the administration of local

bodies at the *zila* level.⁶¹

Zilas are the focal point of Bangladesh's administrative system.⁶² Each *zila* within a division is headed by a deputy commissioner, who is assisted by a large number of officials and other personnel appointed by the central government.⁶³ The responsibilities of *zila* administrations include preparation of annual and mid-term plans, physical infrastructure projects and administration of rural development programs.⁶⁴

Legislative branch

Local government consists of locally elected bodies. These bodies are called union *parishads* (union councils) in rural areas, and city corporations and *pourashavas* (municipalities) in urban areas.⁶⁵ Seats are reserved for women in all local government bodies.⁶⁶

Union *parishads* consist of a chairman and 12 members. Their main responsibilities include maintaining law and order; adopting and implementing development plans in agriculture, education, health, cottage industries, and other areas; promoting family planning; implementing assigned schemes; protecting and maintaining public property; reviewing the development activities of all union-level agencies; and registering births and deaths.⁶⁷

Pourashavas and city corporations are headed by a chairperson and mayor, respectively, and are made up of other elected officials.⁶⁸ These bodies are authorized to perform various socioeconomic and civic functions.⁶⁹ Their responsibilities include constructing and maintaining physical infrastructure; overseeing refuse management; regulating the water supply; preventing infectious diseases and epidemics; and registering births, deaths and marriages.⁷⁰ Members of urban local governments serve a five-year term.⁷¹

C. THE JUDICIAL BRANCH

The Supreme Court is made up of the Appellate Division (upper division, based in the capital), and the High Court Division (lower division, with seven regional benches).⁷² The law declared by the Appellate Division is binding on all courts below it, including courts comprising the High Court Division.⁷³ The Appellate Division hears appeals from the High Court Division.⁷⁴ Appeals are a matter of right in cases involving substantial questions of constitutional law; a sentence of death or life imprisonment; punishment for contempt of the High Court Division; or other cases as provided by acts of parliament.⁷⁵ The Appellate Division also has discretion to grant appeals to cases that fall outside these categories.⁷⁶ In addition, the president may refer any question of law that is of public importance to the Appellate Division.⁷⁷ The High Court Division has original jurisdiction and may hear appeals from district courts.⁷⁸ It may also withdraw a

case from a lower court and hear the case itself if it involves a substantial question of constitutional law or is of general public importance.⁷⁹ The president appoints a chief justice and other judges for the Appellate Division and the High Court Division.⁸⁰ Judges may hold office until the age of 65.⁸¹ However, the president may remove a judge on grounds of "physical or mental incapacity" or "gross misconduct" upon the advice of the Supreme Judicial Council, a constitutionally mandated body that inquires into the conduct and capacity of tenured judges.⁸²

There is a complex system of civil and criminal courts under the High Court Division, as well as courts and tribunals of special jurisdiction at the village level.⁸³ Civil courts include the Court of the District and Additional District Judge, the Court of the Subordinate Judge, the Court of the Assistant Judge, and other lower courts.⁸⁴ The ordinary criminal court system is made up of different levels of sessions and magistrates' courts.⁸⁵

The 1985 Family Court Ordinance established a system of family courts at the *zila* and *thana* levels.⁸⁶ These courts have exclusive jurisdiction over all matters relating to the dissolution of marriage, restitution of conjugal rights, dower (a sum of money or property given to the bride by the groom in consideration of Muslim marriage), maintenance, guardianship, and custody of children.⁸⁷

Special statutory tribunals have also been established to hear cases specifically involving offenses against women. The 1974 Special Powers Act provides for the establishment of "special tribunals" for the "speedy trial [and] effective punishment of certain grave offenses."⁸⁸ Such tribunals consist of one or more sessions judges or a magistrate.⁸⁹ Offenses that are triable under the act include certain "prejudicial act[s]" and offenses related to violence against women, including rape.⁹⁰ The 2000 Prevention of Oppression Against Women and Children Act similarly provides for the establishment of one or more tribunals in each *zila* to try offenses under the act.⁹¹ Such tribunals consist of one government-appointed district or sessions judge and additional district or sessions judges.⁹²

In addition, administrative tribunals established by parliament exercise jurisdiction over certain issues, including the terms and conditions of public servants, and the acquisition, administration and disposal of personal property vested in or managed by the government.⁹³

Customary forms of alternative dispute resolution

Shalish are traditional, informal dispute-settling mechanisms at the village level.⁹⁴ These bodies play a central role in rural life and retain popular support.⁹⁵

Generally, any villager with a grievance may petition to

have a *shalish* hear his or her case.⁹⁶ A *shalish* is then formed, usually consisting of village elders or prominent leaders known as village *matbars*.⁹⁷ The *shalish* may engage in mediation or, as is more often the case, arbitration, and issue binding verdicts on both parties.⁹⁸ Typical cases involve family or land disputes, inheritances and petty theft.⁹⁹

In recent years, *shalish* arbitration has been used by self-appointed village religious leaders to declare *fatwas* (religious edicts issued by Muslim clergy) that impose extrajudicial punishments, such as whipping or stoning to death, mostly against women for perceived moral transgressions.¹⁰⁰ Islam dictates that *fatwas* may only be declared by *Mufti* (religious scholars) with expertise in Islamic law.¹⁰¹ In January 2001, a high court issued a landmark ruling declaring all *fatwas* illegal, intending to end the extrajudicial enforcement of *fatwas* such as those issued by *shalish*.¹⁰² However, in declaring all *fatwas* illegal, the court's ruling sparked violent public protests, with Muslim groups calling the ruling an attack on their religious freedom.¹⁰³

D. THE ROLE OF CIVIL SOCIETY AND NON-GOVERNMENTAL ORGANIZATIONS (NGOs)

The NGO Affairs Bureau is the governmental body responsible for regulating NGOs in Bangladesh.¹⁰⁴ The law requires that all NGOs register with the bureau and renew their registration every five years.¹⁰⁵ The bureau must approve all NGO projects and foreign funding for projects.¹⁰⁶

More than 950 NGOs operate in Bangladesh.¹⁰⁷ Of these, about 780 are involved in microcredit, education, sanitation, and nutrition programs, and about 175 work in family planning, providing about one-fourth of the country's overall family planning services.¹⁰⁸ A large number of NGOs also focus on women's issues.¹⁰⁹ Development NGOs work in about 78% of villages, benefiting about 24 million people.¹¹⁰

The Family Planning Association of Bangladesh is the country's oldest and largest NGO providing sexual and reproductive health services.¹¹¹ The organization has 20 branches and 11 special work units throughout the country, and is supported by a wide network of professionals and some 3,000 volunteers.¹¹²

E. SOURCES OF LAW AND POLICY

Domestic sources

The principal domestic sources of law in Bangladesh are the constitution and legislation. The constitution is the "supreme law" of the land and claims to represent the "solemn expression of the will of the people."¹¹³ It enumerates the enforceable fundamental rights of all citizens, including the rights to equality before the law, the protection of the law and the prohibition of discrimination based on religion, race, caste, sex, or

place of birth.¹¹⁴ Other enforceable rights include freedom of movement, assembly, association, thought and conscience, speech, and religion.¹¹⁵ The constitution also issues several broad directives to the state, called the Fundamental Principles of State Policy, that are not legally enforceable but provide guidance to the government in performing its functions.¹¹⁶

Legislation comprises laws made by or under the authority of parliament, orders, regulations made by a government ministry under the authority of a statute, and bylaws made by local government or other authorities exercising powers conferred upon them by the legislature.¹¹⁷ As a by-product of colonial rule, legislation modeled after English common law still governs many private and commercial spheres in Bangladesh.¹¹⁸

The main codifications of law include the 1860 Penal Code and the 1898 Code of Criminal Procedure. There is no comprehensive code of family law.¹¹⁹

Existing laws are reviewed periodically by the Law Commission, a statutory body constituted under the 1996 Law Commission Act.¹²⁰ The commission's primary functions include recommending amendments to discriminatory laws and enactments of new laws that protect women's and children's rights; identifying conflicts between existing laws and recommending the codification of laws on the same subject; and recommending the reform of laws that are inconsistent with fundamental rights.¹²¹

The religious personal laws of Bangladesh's various religious communities govern matters within the private sphere, including marriage, divorce, custody, inheritance, and maintenance. With respect to the Muslim community in Bangladesh, certain provisions of *Sharia* (Islamic injunctions as laid down in the *Quran* and *Sunnah*) have been codified into legislation, such as the 1961 Muslim Family Laws Ordinance.¹²² There is also a significant non-Muslim population to whom *Sharia* is not applicable, and whose own religious laws govern matters related to private and family life.¹²³

Government policies are formulated within the broad framework of the constitution and its Fundamental Principles of State Policy, and have traditionally been articulated and put into operation through successive five-year development plans. These plans are comprehensive policy documents that set forth the government's main objectives in various areas of national development, including health, poverty reduction, education, and population. They include specific objectives and programmatic measures targeted toward marginalized groups, including women and children. The Fifth Five Year Plan, covering 1997–2002, was the most recent operative five-year plan.¹²⁴ In 2003, the government announced the National

Strategy for Economic Growth, Poverty Reduction and Social Development, a three-year development plan prepared in consultation with various domestic stakeholders and development partners such as the World Bank and the International Monetary Fund.¹²⁵ The document provides broad national strategies for achieving Bangladesh's development goals in light of the country's national priorities and the UN Millennium Development Goals.¹²⁶ The strategy is to be finalized by December 2004.¹²⁷ Although the government has not officially resigned the five-year plans, it has indicated that such three-year plans will form the basis of Bangladesh's future development planning.¹²⁸

International sources

Bangladesh has ratified several UN treaties and conventions including: the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the Convention on the Rights of the Child (Children's Rights Convention); the International Convention on the Elimination of All Forms of Racial Discrimination (Racial Discrimination Convention); the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant); and the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant).¹²⁹ Bangladesh has also ratified the Optional Protocol to CEDAW.¹³⁰

Bangladesh ratified CEDAW with reservations to several articles on the grounds that they conflict with *Sharia* law.¹³¹ These articles address methods to eliminate discrimination against women; equal rights to family benefits; and the elimination of discrimination in marriage and the family.¹³² Bangladesh withdrew its reservations to the articles relating to equal rights to family benefits and the elimination of discrimination in the family in 1997.¹³³ In 1996, the Ministry of Women and Children's Affairs instituted a committee to review and make recommendations relating to the government's reservations to CEDAW.¹³⁴

The government of Bangladesh has also participated in several key international conferences and endorsed the development goals and human rights principles contained in the resulting consensus documents. International consensus documents the government has adopted include the 1993 Vienna Declaration and Programme of Action; the 1994 International Conference on Population and Development (ICPD) Programme of Action; the 1995 Beijing

Declaration and Platform for Action; and the 2000 United Nations Millennium Declaration.¹³⁵

Bangladesh is also a signatory to the SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution, and the SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia.¹³⁶

II. Examining Reproductive Health and Rights

In general, reproductive health issues are addressed through a variety of complementary, and sometimes contradictory, laws and policies. The manner in which these issues are addressed reflects a government's commitment to advancing reproductive health. The following section presents key legal and policy provisions that together determine women's reproductive rights and choices in Bangladesh.

A. GENERAL HEALTH LAWS AND POLICIES

The constitution's Fundamental Principles of State Policy promise government provision of the "basic necessities of life, including ... medical care" to citizens of Bangladesh.¹³⁷ The principles further proclaim that the "[s]tate shall regard the raising of the level of nutrition and the improvement of public health as moving its primary duties ..."¹³⁸ The principles include a separate provision for the improvement of public health in rural areas.¹³⁹

Since independence, the government has undertaken several initiatives to address the population's health needs, particularly those of the rural population.¹⁴⁰ Currently, the National Health Policy, approved by the cabinet in 2000, the Health, Nutrition and Population Sector Programme for 2003–2006 and the National Strategy for Economic Growth, Poverty Reduction and Social Development provide the health policy framework.¹⁴¹

Objectives

The government's commitments under the constitution and various international conventions and consensus documents, including the ICPD Programme of Action and the Beijing Declaration and Platform for Action, inform the goals, policy principles and strategies of the National Health Policy.¹⁴² The policy's goals are the following:

- develop the health and nutritional status of the

RELEVANT LAWS AND POLICIES

- National Health Policy, 2000
- Health, Nutrition and Population Sector Programme, 2003–2006
- National Strategy for Economic Growth, Poverty Reduction and Social Development
- Private Medical Service Act, 2003

population and make necessary basic medical services available to all people;

- develop a system to ensure easy and sustained availability of health services in both urban and rural areas;
- ensure optimum quality, acceptability and availability of government primary health-care services at the *thana* and union levels;
- reduce malnutrition, especially among mothers and children, and implement effective and integrated programs to improve the nutritional status of all segments of the population;
- undertake programs to reduce the rates of maternal and child mortality over the next five years to an “acceptable level”;
- adopt measures to ensure improved maternal and child health at the union level and institute facilities in each village for safe childbirth;
- improve overall reproductive health resources and services;
- ensure the presence of full-time doctors, nurses and other medical staff, and provide and maintain necessary medical equipment and supplies, at government health-care facilities at the *thana* and union levels;
- devise ways for people to make optimum use of available government health-care facilities and services, and ensure quality of management and service delivery at government hospitals;
- formulate specific laws and policies to regulate medical colleges and private health clinics;
- strengthen and expedite the family planning program to achieve replacement level fertility;
- explore ways improve the acceptability, accessibility and effectiveness of the family planning program among low-income communities;
- arrange special health services for people with physical and mental disabilities and the elderly;
- determine ways to make the family planning program and health management more accountable and cost-effective by using more skilled personnel; and
- introduce systems for the treatment of all types of “complicated diseases” and reduce the need for foreign travel to obtain necessary medical treatment.¹⁴³

Underlying the policy and its goals are several principles, which include the following:

- to enable every citizen, especially women and children, to obtain health, nutrition and reproductive health services on the basis of social justice and equality and constitutional rights;

- to make essential primary health-care services available in all regions of the country;
- to promote local participation in health planning, management, fundraising, and monitoring of service delivery with the aim of decentralizing health management and establishing people’s rights and responsibilities in the health system;
- to encourage collaboration between the government and the NGO sector to ensure effective health-care delivery;
- to ensure the availability of family planning methods through integrating, expanding and strengthening family planning activities;
- to encourage adoption and application of effective and efficient technology, operational development and research activities to strengthen and increase the use of health, nutrition and reproductive health services; and
- to provide legal support with respect to the rights and responsibilities of health-care providers and clients.¹⁴⁴

The policy also enumerates an exhaustive list of strategies to implement its goals. Some highlights of the strategies are the following:

- emphasize services for disease prevention and health promotion;
- use cost-effective methods to maximize the availability of high-quality health services;
- ensure the availability, efficacy and affordability of essential medicines in light of current needs;
- integrate an epidemiological surveillance system with disease control programs and assign responsibility for the system to a specific institution;
- implement a management information system and a computerized communication system nationwide to facilitate planning, implementation and monitoring of health services;
- establish a National Training Institute to provide training and continuing medical education to public and private health personnel;
- establish health and nutrition education units in each *thana*;
- charge minimum user fees in public hospitals and clinics to maintain a safety net for low-income and disabled clients;
- encourage NGOs to play a complementary role to the government in providing health services;
- design and implement an effective referral system to link the various tiers of health services;

- provide client-centered general health and reproductive health services; and
- adopt a strategy of providing a package of essential health services at a “one-stop center” and introduce it nationwide.¹⁴⁵

The government developed the Health, Nutrition and Population Sector Programme to improve upon the Health and Population Sector Programme, which expired in 2003.¹⁴⁶ The new program’s stated goals are in line with the country’s overall development policies and aim to achieve “sustainable improvement of the health, nutrition and family welfare” of the population, especially of low-income and vulnerable groups such as women, children and the elderly.¹⁴⁷ Building upon the prior program’s goal of providing a package of core health-care services, called the Essential Services Package, the Health, Nutrition and Population Sector Programme aims to increase the availability and utilization of the package and include additional select services.¹⁴⁸ It also strives to ensure that services are “user-centered, effective, efficient, equitable, affordable, and accessible.”¹⁴⁹ The components of the Essential Services Package include the following:

- reproductive health care, including maternal and adolescent nutrition;
- child health care and nutrition;
- communicable disease control;
- limited curative care; and
- behavior change communication.¹⁵⁰

The program also proposes to upgrade physical health-care facilities and improve staff deployment in the delivery of essential services.¹⁵¹

The program has the following priority objectives:

- reduce the maternal mortality rate;
- reduce the total fertility rate; and
- reduce malnutrition;
- reduce the mortality rates of infant and children under age five; and
- reduce the burden of tuberculosis and other diseases.¹⁵²

The program sets forth a series of detailed strategies and targets to help achieve each of the above objectives. (See “Reproductive Health Laws and Policies” for specific strategies related to reproductive health.) It additionally provides strategies in the following areas:

- provision of essential health services through newly designated local facilities;
- accessibility and quality of care of secondary and tertiary hospital services;
- control and prevention of public health issues; and
- prevention of injuries due to violence and accidents.¹⁵³

The goals and priorities of the Health, Nutrition and Population Sector Programme fit within the framework of the National Strategy for Economic Growth, Poverty Reduction and Social Development.¹⁵⁴ In light of the “constitutional obligation of developing and sustaining a society in which the basic needs of all people are met,” the strategy aims to substantially reduce poverty in Bangladesh in the next generation.¹⁵⁵ It hopes to achieve ten goals by 2015, several of which relate to improving the health status of the population. Vis-à-vis health, its goals are the following:

- reduce mortality rates among infants and children under age five by 65% and eliminate gender disparity in child mortality;
- reduce the proportion of malnourished children under age five by 50% and eliminate gender disparity in child malnutrition;
- reduce the maternal mortality rate by 75%; and
- ensure access to reproductive health services to all people.¹⁵⁶

The strategy highlights several policy priorities in the health sector, which include the following:

- address “pro-poor concerns” in the health sector;
- control communicable diseases;
- improve maternal and child health to reduce high child and maternal mortality rates;
- ensure implementation and accessibility of a package of essential health services, with a focus on the health needs of low-income and vulnerable groups in both urban and rural areas;
- include services for noncommunicable diseases in the package of essential health services;
- provide subsidized family planning methods, especially to low-income women;
- address emerging health problems such as arsenic and dengue;
- enhance the health sector’s capacity to address HIV/AIDS and take measures to assess the prevalence of the problem;
- enhance the public health sector’s ability to manage new threats to the health of the population;
- mobilize resources from external sources in financing health services;
- substantially improve the present level of health sector governance;
- decentralize the delivery of health services;
- increase local participation in the health sector, particularly of women and low-income groups;
- improve accessibility to modern health services; and
- strengthen nutrition programs at the institutional

level and provide a “nutrition-support package” to the lowest-income segment of the population and vulnerable groups through existing food programs.¹⁵⁷

Infrastructure of health-care services

Government facilities

The Ministry of Health and Family Welfare is the main governmental body responsible for the formulation and implementation of national health policies, and the administration, coordination and management of the health-care and family planning service delivery system.¹⁵⁸ The ministry is made up of two separate directorates for health and family welfare, each of which is headed by a director general, who is responsible to the minister.¹⁵⁹ The Directorate of Health Services, which employs more than 75,000 health personnel, is responsible for curative care and some aspects of public health, such as immunization.¹⁶⁰ The Directorate of Family Planning is responsible for family planning services and some maternal and child health services, such as prenatal care.¹⁶¹

Public health-care services are delivered through a hierarchy of government hospitals and other facilities, which are categorized into four primary groups:

- thana health complexes;
- district and general hospitals;
- medical college hospitals; and
- specialized hospitals.¹⁶²

Thana health complexes, which exist at the *thana* level, are considered primary-level facilities and provide only very basic medical services and operations (complicated cases are referred to district hospitals).¹⁶³ The typical facility has 31 beds and is staffed by about 5 doctors, 6 nurses and 31 other staff.¹⁶⁴ On average, one facility provides 50,000 outpatient visits, 2,300 inpatient admissions and 200 operations per year.¹⁶⁵ There are about 402 of these facilities in the country.¹⁶⁶ A large proportion include units that provide maternal and child health services.¹⁶⁷

District and general hospitals are secondary-level facilities at the *zila* level.¹⁶⁸ Like thana health complexes, they provide basic medical services, but they have more inpatient facilities and staff, and are equipped with more sophisticated basic equipment (such as X-ray machines) and also perform major surgery.¹⁶⁹ District and general hospitals typically have a bed size of 50 or 100.¹⁷⁰ A 100-bed district hospital is typically

staffed by 10 doctors, 26 nurses and 33 other staff, and provides an average of 68,000 outpatient visits, 7,000 inpatient admissions and 1,200 operations per year.¹⁷¹ There are about 59 district hospitals in the country.¹⁷²

Medical college hospitals are larger inpatient medical facilities that offer more sophisticated and differentiated services than lower-level facilities.¹⁷³ Their bed size ranges from 540 to 1,100, and each is staffed by 40–90 doctors and 140–370 nurses.¹⁷⁴ No data is available on the number of medical college hospitals and the specific services and number of specialized hospitals.

The government health-care infrastructure also includes facilities that focus on the provision of maternal and child health and family planning services. At the *zila* and *thana* levels, maternal and child welfare centers provide birth spacing methods, perinatal health care to mothers, menstrual regulation services, and primary health care to children under age five.¹⁷⁵ There are about 96 of these facilities.¹⁷⁶ Below the *thana* level, union health and family welfare centers are the

focal point for family planning and health services.¹⁷⁷ There are some 3,000 of these facilities.¹⁷⁸ (See “Family planning services” for more information on government delivery of family planning services.)

While the government has concentrated on expanding health services, the ratio of providers to patients is still high. According to 1997 data, the doctor to population ratio was 1 to 5,506, and the hospital bed to population ratio was 1 to 3,231.¹⁷⁹

Privately run facilities

Due to recent trends toward greater privatization and trade liberalization, privately owned and managed hospitals, clinics and diagnostic laboratories have become actively involved in the provision of health-care services.¹⁸⁰ There were 2,003 private health service establishments operating in the country in 1996–97, 87% of which were located in

urban areas, and about 46% in Dhaka alone.¹⁸¹ Slightly more than half of all private health-care facilities are pathology laboratories.¹⁸² About 25% of all facilities are unregistered and unapproved by the government.¹⁸³ According to 1996–97 data, there were 21,785 doctors in the private health sector, compared with only 1,717 doctors in the public health sector.¹⁸⁴ In contrast, there was much less disparity between the

RELEVANT LAWS AND POLICIES

- National Reproductive Health Strategy, 1997
- Health, Nutrition and Population Sector Programme, 2003–2006
- National Health Policy, 2000
- Drugs Act, 1940; and Drugs (Control) Ordinance, 1982
- Technical Information on Various Contraceptive Methods, Ministry of Health and Family Welfare, 1997
- National Food and Nutrition Policy, 1997
- Penal Code, 1860
- Safe blood legislation, 2002
- National Policy on HIV/AIDS and STD Related Issues, 1997
- National Strategic Framework, 2002–2006
- Population policy

two sectors in the total number of nurses and other health-related providers in the country.¹⁸⁵

In an effort to improve the quality of care in the private health sector, the cabinet approved the Private Medical Service Act in 2003.¹⁸⁶ The act, which aims to ensure standard service provision in private clinics, laboratories and diagnostic centers, is scheduled for parliamentary review.¹⁸⁷ One of its main objectives is to remedy the ineffective regulation of private medical facilities under existing law.¹⁸⁸

NGOs also fill a critical role in the provision of health-care services. Some 400 NGOs are involved in such activities.¹⁸⁹

Financing and cost of health-care services

Government financing

Government expenditure on health constituted 36.4% of total expenditure on health and 7.1% of total general government expenditure, or Tk 293.75 (USD 5) per capita, in 2000.¹⁹⁰

More than half of the Ministry of Health and Family Welfare's budget in 2002–2003 went to the Directorate of Health Services, which spent almost one-fifth of its budget on drug license fees.¹⁹¹ Almost one-fourth of the ministry's budget went to the Directorate of Family Planning, which spent most of its budget on health and family planning services.¹⁹²

Reproductive health and child health represent, respectively, about 26% and 21% of total government spending on health.¹⁹³ About three-fourths of the government's health budget is allocated for health-care facilities at or below the *zila* level.¹⁹⁴

Private and international financing

Given the limited amount of government resources allocated to health, the private sector plays an important role in the financing of health services. According to 2000 estimates, private expenditure on health constituted 63.6% of total health expenditure.¹⁹⁵ Most private expenditure is out-of-pocket spending by patients, with households spending about Tk 411.25 (USD 7) annually per capita for health care.¹⁹⁶

Since 1975, an international consortium of development agencies has provided financial and technical assistance to the government of Bangladesh for the implementation of successive health projects, each lasting five to six years.¹⁹⁷ While early investments from the consortium were largely focused on expenditures for infrastructure, including buildings, supplies, equipment, and staff salaries, there was a growing recognition leading up to the mid-1990s of the need for substantive reform of the public health system.¹⁹⁸ The Health, Nutrition and Population Sector Programme is one such reform effort in which external donors are projected to invest approximately Tk 419,130.69 lakh (about USD 749 million).¹⁹⁹

External aid to the health sector has focused largely on rural areas.²⁰⁰ However, there has been a growing awareness

among donors of the need to improve urban health services.²⁰¹ Aid-supported efforts in the urban primary health-care sector have included projects by the World Bank, the United States Agency for International Development and the United Nations Children's Fund (UNICEF).²⁰²

Other major donors to the health sector include the governments of Canada, Germany, Great Britain, the Netherlands, and Sweden, and the European Commission.²⁰³

Cost

Government health services are officially free of charge.²⁰⁴ However, patients are often subject to hidden and incidental costs.²⁰⁵ Patients seeking health care in government hospitals must pay the cost of most drugs and medical supplies used in their treatment.²⁰⁶

In the private sector, fees for doctors and specialists are Tk 200–300 (USD 3.40–5.11) and fees for medical practitioners are Tk 50 (USD 0.85).²⁰⁷ Fees for Ayurvedic and homeopathic practitioners are Tk 25–30 (USD 0.43–0.51), and fees for midwives and nurses, Tk 20–30 (USD 0.34–0.51).²⁰⁸

Regulation of health-care providers

The Bangladesh Medical and Dental Council, a statutory body constituted under the 1973 Medical Council Act, regulates medical practice in Bangladesh, including the standards of medical education and the registration of physicians. The council also has statutory authority to discipline members of the medical profession for professional misconduct.²⁰⁹ Punishment may include suspension or cancellation of a physician's registration with the council.

Similar regulatory bodies for other health-care providers include the Bangladesh Nursing Council and the Pharmacy Council.²¹⁰

The National Health Policy aims to restructure and strengthen such bodies to ensure strict compliance with registration requirements and monitor the quality of care and ethical conduct of health-care providers.²¹¹

Regulation of reproductive health technologies

No data is available on how reproductive health technologies are regulated in Bangladesh.

Patients' rights

There is no specific legislation on patients' rights and remedies for medical malpractice.²¹² The Bangladesh Medical and Dental Council has statutory authority to hear malpractice claims of patients, but a court order suspended the council's complaint mechanism several years ago.²¹³ According to the council, only two doctors have had their licenses temporarily suspended for medical malpractice over the last 30 years.²¹⁴

Under a proposed law to address the absence of patients' rights in medical malpractice cases, health-care practitioners could face up to ten years' imprisonment and a fine of

Tk 1,000,000 for malpractice.²¹⁵ The bill is pending parliamentary review.²¹⁶

One of the proposed activities of the Health, Nutrition and Population Sector Programme is to develop and implement a Charter of Rights for health-care users and providers.²¹⁷

B. REPRODUCTIVE HEALTH LAWS AND POLICIES

The National Reproductive Health Strategy and the Health, Nutrition and Population Sector Programme are the primary government policies and programs on reproductive health.

The National Reproductive Health Strategy, adopted in 1997 and based upon the principles set forth in the ICPD Programme of Action, emphasizes a client-centered and life-cycle approach to reproductive health services. The strategy prioritizes the following reproductive health issues:

- safe motherhood, including infant care;
- family planning;
- menstrual regulation and care of postabortion complications; and
- management of reproductive tract infections and sexually transmissible infections (STIs);
- infertility services; and
- adolescent health care.²¹⁸

The strategy is divided into nine points of action, which include the following:

- improving the delivery of reproductive health services by reorganizing service delivery, linking the different tiers of service delivery and providing specialized services at peripheral levels of service delivery;
- conducting further research on women's reproductive health needs;
- implementing appropriate activities to develop human resources in health-care services, including staff training and orientation;
- implementing information, education and communication programs or behavior change communication programs to ensure the full implementation and maximization of reproductive health services;
- strengthening health-care management through the restructuring, coordination, monitoring, and re-prioritizing of the industry;
- establishing a mechanism to review implementation of the policy from the national to community level;
- empowering women to seek reproductive health services through financial incentives, legal and policy initiatives, and advocacy and community mobilization efforts;

- improving and reorganizing other sectors; and
- promoting infant and child survival, growth and development.²¹⁹

The strategy also gives particular emphasis to instituting gender sensitization training and posting female medical officers at all levels of reproductive health services.²²⁰

- Reproductive health care is one of the primary components of the Health, Nutrition and Population Sector Programme's Essential Services Package. The priority areas identified within reproductive health care are the following:
 - safe motherhood, including prenatal and postnatal care, safe delivery, emergency obstetric care, and maternal nutrition;
 - prevention of unsafe abortion through safe menstrual regulation services;
 - family planning, including infertility care;
 - adolescent health care; and
 - prevention of reproductive tract infections and HIV/AIDS.²²¹

The program includes several goals and strategies that aim to improve the reproductive health status of the population and the delivery of related services. (See "Family Planning," "Maternal Health" and "Sexually Transmissible Infections (STIs) and HIV/AIDS" for information on specific strategies.)

The National Health Policy and Bangladesh's population policy also have specific objectives and strategies related to reproductive health. (See "General Health Laws and Policies" and "Family Planning" for National Health Policy provisions related to reproductive health.) Relevant strategies of the Bangladesh population policy are the following:

- ensure the provision of comprehensive, client-centered and high-quality reproductive health services, including family planning, at the *thana* and union levels;
- ensure "one-stop" service provision of essential reproductive health care and ensure home visits;
- ensure supplies of necessary equipment and medicines (including contraceptives) in all health-care facilities;
- ensure access among high-risk groups to reproductive health information and services to raise awareness about and prevent reproductive tract infections, STIs and HIV/AIDS; and
- ensure the opportunity and freedom to choose contraceptive methods according to individual needs and preferences.²²²

Family Planning

Although family planning was introduced through the voluntary efforts of social and medical workers as early as the 1950s, the establishment of the Directorate of Family Planning under the Ministry of Health and Family Welfare in 1965 marked the adoption of family planning as an official government-sector program.²²³

The Health, Nutrition and Population Sector Programme and the National Health Policy establish the government's current family planning goals and provide the main framework for the delivery of family planning services.

The primary objectives of the Health, Nutrition and Population Sector Programme with regard to family planning are to increase the contraceptive prevalence rate and lower the total fertility rate in Bangladesh.²²⁴ Specifically, the program aims to increase contraceptive use to 65% by the middle of 2006.²²⁵ To achieve this goal, the program proposes the following strategies:

- promote a more effective contraceptive “method mix”;
- increase male participation in family planning; and
- reduce discontinuation of contraceptive use by providing proper counseling, follow-up services and services for the management of contraceptive side effects and complications.²²⁶

Other related strategies geared toward reducing the total fertility rate include the following:

- improve the quality of family planning services through the revival of “doorstep services”;
- increase social awareness of family planning services;
- improve access to clinical family planning methods by offering high-quality services in hospitals and health-care facilities at the *thana* and union levels;
- intensify efforts to provide client-centered family planning information and services.²²⁷

Several of the objectives and strategies of the National Health Policy relate to improving family planning services. (See “General Health Laws and Policies” for information on specific objectives related to family planning.) A specific policy strategy is to improve management of domestic sources of family planning methods and encourage domestic entrepreneurs to produce family planning supplies.²²⁸

Contraception

Among currently married women aged 10–49, approximately 53.8% use a method of contraception, though 99.9% have knowledge of a method, according to national-level data from 1999–2000.²²⁹ The pill is the most commonly used method (23.0% of married women), followed by the injectable (7.2%) and female sterilization (6.7%).²³⁰ Use of any method increases with age; young women aged 10–14

and 15–19 have the lowest rates of contraceptive use (25.7% and 38.1%, respectively), whereas 35–39-year-olds have the highest rate (67.7%).²³¹ Current contraceptive use does not vary widely by area of residence; the prevalence of use of any method is approximately 52.3% in rural areas and 60.0% in urban areas.²³²

Contraception: legal status

The 1940 Drugs Act, the 1982 Drugs (Control) Ordinance and the National Drug Policy are relevant laws and policies in the regulation of contraceptives.²³³ The Directorate of Family Planning is the lead agency responsible for implementing and monitoring laws and policies related to contraceptives, and it has the authority to approve, with clearance from the Ministry of Health and Family Welfare, the availability and distribution of contraceptives in Bangladesh.²³⁴ The Directorate of Drugs Administration within the Ministry of Health and Family Welfare also plays a regulatory role.²³⁵ Both agencies are a part of the National Technical Committee, a body formed by the ministry to deal with technical regulatory issues on contraceptives.²³⁶

In 1998, the National Technical Committee approved dedicated products for emergency contraception, specifically Postinor-2.²³⁷ Dedicated products are available in family planning clinics, from physicians and in the markets.²³⁸ The cost per packet is Tk 24 (USD 0.45).²³⁹ However, the government family planning program does not currently promote emergency contraception, and such products are relatively unknown by providers and potential users.²⁴⁰ The Directorate of Family Planning, in collaboration with several international NGOs, is conducting a feasibility study to develop, test and document operational details for introducing emergency contraception as a backup for existing family planning methods.²⁴¹

Government policy prohibits the use of quinacrine as a method of contraception, including its use in clinical trials.²⁴²

Regulation of information on contraception

The Health, Nutrition and Population Programme promotes the dissemination of information on family planning services.²⁴³ Government policy explicitly allows individuals to receive information on condoms.²⁴⁴

Information on family planning is disseminated through several media, including television, radio, billboards, and newspapers.²⁴⁵ According to national-level data from 1999–2000, television was the most commonly reported source of information on family planning among women.²⁴⁶

Sterilization

Female sterilization is relied on by 6.7% of married women.²⁴⁷ Women deciding on sterilization generally undergo the procedure relatively early in their reproductive

years.²⁴⁸ More than two-thirds of sterilized women had the operation before age 30, while nearly one-third were sterilized before age 25.²⁴⁹ The median age at sterilization is 27.²⁵⁰

Sterilization: legal status

The technical guidelines on contraceptives issued by the Directorate of Family Planning specify the eligibility criteria for female and male sterilization.²⁵¹ Applicants must be currently married with at least two living children.²⁵² If the couple has only two children, the youngest child must be above the age of two.²⁵³ A couple may seek sterilization only “if the wife cannot use hormonal methods and the IUD.”²⁵⁴ The applicant seeking sterilization must voluntarily agree to the procedure.²⁵⁵ Sterilization is not available to individuals who are divorced, have no living spouse or have a mental illness.²⁵⁶

Sterilization policies

The Health, Nutrition and Population Sector Programme aims to facilitate access to permanent methods of contraception by expanding selected union health and family welfare centers for the provision of voluntary contraceptive services.²⁵⁷

As of 2003, government policy provided for reimbursement for lost wages and transportation costs to individuals who obtained sterilization.²⁵⁸ Payments were also offered to providers as well as to some referrers.²⁵⁹ The recently expired Health and Population Sector Programme had proposed additional incentives to boost the acceptance of sterilization, including providing sterilized individuals with insurance coverage for five years against the death of up to two children.²⁶⁰ The program had also suggested giving individuals who choose sterilization a “Family Planning Acceptor Card” that would qualify them for “preferential treatment” when presented at any government hospital or outpatient health facility. Due to the pending status of a final plan to implement the Health, Nutrition and Population Sector Programme, no data is available on whether these policies will continue under the new program.²⁶¹

Government delivery of family planning services

The government delivers family planning services through numerous public health-care facilities, including maternal and child welfare centers and thana health complexes at the *zila* and *thana* levels, and union health and family welfare centers and temporary satellite clinics at lower administrative levels.²⁶² Thousands of government fieldworkers and other health personnel such as family welfare visitors, family welfare assistants and health assistants also help implement the government’s family planning services.²⁶³ Family welfare visitors and assistants are specifically women.²⁶⁴

Fieldworkers and satellite clinics play especially crucial roles in the delivery of family planning services at the com-

munity level.²⁶⁵ Fieldworkers supply basic family planning information and referrals and distribute condoms and pills.²⁶⁶ Government satellite clinics, which are staffed by visiting personnel from health and family welfare centers, give contraceptive injections and insert IUDs in selected villages.²⁶⁷

Overall, about 64% of current users of modern contraceptives obtain their method from the public sector—36% from public facilities, mostly from thana health complexes and union health and family welfare centers, and 28% from government fieldworkers.²⁶⁸ Fieldworkers are by far the most popular source for pills in either the public or private sector, supplying about 45% of current pill users.²⁶⁹ Fieldworkers are also the most common public-sector source for condoms.²⁷⁰ Union health and family welfare centers are the primary overall source for IUDs and injectables, while thana health complexes are the main providers of female and male sterilization.²⁷¹

All public family planning services are delivered free of charge, though there is a nominal fee for pills and condoms.²⁷² Despite the free provision of family planning services, ways to recover program costs and move clients who can afford to pay into private services are increasingly being emphasized to maximize the sustainability of the family planning program.²⁷³

Family planning services provided by NGOs and the private sector

Family welfare services and contraceptives reach the population through private medical sources, non-governmental fieldworkers and clinics run by NGOs. The private medical sector, including clinics, doctors and pharmacies, serves approximately 22.3% of current users of modern contraceptive methods.²⁷⁴ Most users who rely on the private sector obtain their method from pharmacies.²⁷⁵ Pharmacies are the supply source for 30% of all contraceptive pill users and 52% of those who use condoms.²⁷⁶ NGO sector facilities, particularly static clinics, are the source for about 5.2% of users.²⁷⁷

Bangladesh has an active contraceptive social marketing program that distributes pills, condoms and oral rehydration salts through a system of thousands of retail outlets throughout the country, including pharmacies, small shops and kiosks.²⁷⁸ The proportion of pill users relying on social marketing brands increased from 14% in 1993–94 to 29% in 1999–2000.²⁷⁹

Maternal Health

Estimates of the maternal mortality ratio in Bangladesh range from 320 to 400 maternal deaths per 100,000 live births.²⁸⁰ Most mothers do not receive prenatal care.²⁸¹ The percentage of women who do receive such care is more than twice as high in urban areas (59%) than in rural areas (28%).²⁸²

Prenatal care is also much more common for births to younger women and women who are experiencing their first pregnancy.²⁸³ Over 90% of deliveries take place in the home.²⁸⁴ Sixty-four percent are attended by traditional birth attendants.²⁸⁵ Only 12% are assisted by trained personnel.²⁸⁶

Policies

One of the key objectives of the Health, Nutrition and Population Sector Programme is to reduce the maternal mortality rate in Bangladesh. In support of this goal, the government has formulated a Maternal Health Strategy. The strategy emphasizes several elements of maternal health care, including prenatal care, skilled birth attendants and emergency obstetric care.²⁸⁷ Specifically, it calls for the following:

- provide prenatal care to all women;
- expand emergency obstetric care in all *thanas* in phases;
- improve accessibility of maternal health services;
- raise awareness of maternal health care through information campaigns targeted to family members and communities;
- conduct verbal autopsies and death reviews in large hospitals to improve the accountability of health-care providers; and
- intensify behavior change communication activities.²⁸⁸

Specific target goals for 2006 are to increase the percentage of pregnant women who receive three prenatal care visits to 60% and deliveries assisted by skilled attendants to 35%.²⁸⁹

The National Health Policy also aims to reduce the maternal mortality rate and improve maternal health services. (See “General Health Laws and Policies” for specific objectives related to maternal health.)

The government recently entered into an agreement with several UN agencies to implement a pilot project on safe motherhood in the Tangail district in central Bangladesh by September 2006. The project will aim to elevate the status of low-income women and adolescent girls; raise community awareness about and preparedness for safe motherhood; improve access to and utilization of skilled birth attendants, emergency obstetric care and family planning services; and increase collaboration and coordination among the government, NGOs and UN agencies.²⁹⁰

Nutrition

About 45% of Bangladeshi mothers are considered acutely malnourished and 70% of pregnant women are anemic.²⁹¹ More than a quarter of Bangladeshis consume fewer than 1,800 calories per day.²⁹² Chronic malnutrition is especially severe among low-income segments of the population—virtually all low-income mothers in rural areas weigh fewer than 50 kilograms. Seventy percent of rural mothers in what are considered high-income households fall below this standard

as well.²⁹³ Throughout all stages of their lives, women consume fewer calories than men.²⁹⁴

In an effort to improve the nutritional health of the population, the government formulated the National Food and Nutrition Policy in 1997.²⁹⁵ The policy stresses the needs of pregnant and nursing mothers in particular. Its objectives include the following:

- increase production and availability of both staple and non-staple nutritious food;
- improve the health and nutritional status of the population, especially children, women and the elderly;
- arrange for proper disposal of waste and improve sanitation and environmental hygiene at the personal and community level to ensure safe drinking water; and
- provide formal and nonformal education on nutrition to the population, especially women and children.²⁹⁶

Reducing malnutrition in Bangladesh is a priority objective of the Health, Nutrition and Population Sector Program. The program aims to provide maternal nutrition services such as weight gain monitoring during pregnancy, vitamin supplements to underweight pregnant women and lactating mothers, and nutrition education.²⁹⁷ It also calls for institutional support to the National Nutrition Program, which provides food supplements and counseling on nutrition and health to pregnant and lactating mothers and children under age two.²⁹⁸ The Health, Nutrition and Population Sector also aims to make links with other existing food programs such as the Vulnerable Group Development Program, through which the government delivers a monthly ration of 31.25 kilograms of wheat per person to disadvantaged women in rural areas, including women of female-headed households who are lactating or have children.²⁹⁹ According to recent government data, the program has almost 400,000 beneficiaries.³⁰⁰

The National Health Policy also makes the reduction of malnutrition a primary objective. (See “General Health Laws and Policies” for information on specific objectives and strategies related to nutrition.)

Abortion and menstrual regulation

About 1.5% of pregnancies are reportedly terminated by abortion every year.³⁰¹ Approximately 2.8% of women who suspect they may be pregnant obtain menstrual regulation, a legal procedure provided at government health facilities that is widely used by women to end possible first-trimester pregnancies, though there is no determination of pregnancy prior to the procedure.³⁰² National-level data from 1999–2000 indicates that only about 5% of currently married women report that they have ever undergone menstrual regulation, though NGO studies consider this to be a substantial underestimate.³⁰³

Abortion and menstrual regulation: legal status

Abortion, except to save the life of the mother, is illegal under the penal code.³⁰⁴ Legal abortions must be performed by a qualified physician in a hospital.³⁰⁵

No data is available on the legal status of medical abortion in Bangladesh.

The severity of punishment for illegal abortion under the penal code depends upon whether the woman consented to the abortion and the stage of pregnancy at which the procedure was performed. A sentence of up to three years' imprisonment, fines or both may be imposed for causing an abortion with the woman's consent; the sentence increases to up to seven years if the woman is "quick with child," or past the fourth or fifth month (approximately) of pregnancy.³⁰⁶ This provision is equally applicable to a woman who induces her own abortion.³⁰⁷ Causing an abortion without the woman's consent, regardless of the stage of pregnancy, is punishable with ten years' imprisonment or a life sentence, fines or both.³⁰⁸

Despite the illegality of abortion, official government policy allows menstrual regulation as "a means of ensuring that a woman at risk of pregnancy is not actually pregnant."³⁰⁹ Because the procedure is considered a method of establishing non-pregnancy, as opposed to terminating a pregnancy, it is unaffected by laws restricting abortion and is thereby removed from the purview of the penal code.³¹⁰ The procedure has been available in government health facilities since 1979.³¹¹ According to official policy, menstrual regulation is allowed up to eight weeks from the last menstrual period by a trained family welfare visitor under the supervision of a physician, and up to the tenth week by a licensed medical practitioner trained in the procedure.³¹² The procedure is also often performed by paramedics in government clinics.³¹³ Menstrual regulation providers cannot provide services to unmarried women requesting the procedure.³¹⁴

Regulation of information on abortion and menstrual regulation

No data is available on laws or policies relating to the regulation of information on abortion and menstrual regulation in Bangladesh.

Abortion and menstrual regulation policies

The National Reproductive Health Strategy identifies menstrual regulation and care of postabortion complications as priority service areas in reproductive health.³¹⁵ A key reproductive health intervention in the Health, Nutrition and Population Sector Programme is the prevention of unsafe abortion through safe menstrual regulation services.³¹⁶

Government delivery of abortion and menstrual regulation services

Menstrual regulation is available in public health facilities at the *zila* level and below; these include maternal and child

welfare centers, thana health complexes, and union health and family welfare centers.³¹⁷ The procedure is not available in most district hospitals or in community clinics at the village level, though such clinics do provide information and referrals to higher-level facilities.³¹⁸ Menstrual regulation is available in all *thanas* and about two-thirds of all unions.³¹⁹ In addition, there are 18 menstrual regulation training programs throughout the country and, to date, some 6,200 doctors and 4,900 family welfare visitors have received formal training in the procedure.³²⁰

Treatment for complications from abortion is available at district hospitals.³²¹ Thana health complexes have the capacity to perform some lifesaving interventions for abortion complications.³²² Postabortion counseling on contraception has not yet been systematically incorporated into health services.³²³ However, post-menstrual regulation counseling on contraception has been emphasized in most health facilities that offer the procedure.³²⁴

Abortion and menstrual regulation services provided by NGOs and the private sector

The NGO sector plays a prominent role in providing menstrual regulation services and training.³²⁵ There are several non-governmental programs that provide training to government health personnel in the procedure.³²⁶

Sexually Transmissible Infections (STIs) and HIV/AIDS

Official data on the prevalence and nature of STIs in Bangladesh is very limited, due in large part to the lack of information systems to record the incidence of such infections and the inability of health-care workers at the grassroots level to diagnose STIs.³²⁷ Some studies indicate that there are 2.3 million individuals infected with STIs.³²⁸

Surveillance systems for HIV/AIDS are similarly weak. However, the government recognizes AIDS as an important health threat.³²⁹ As of 2001, 44 HIV-positive cases had been officially identified through surveys conducted among selected groups.³³⁰ The predominant mode of transmission of both HIV and STIs is sexual transmission.³³¹

Relevant laws

There are no specific national laws on STIs or HIV/AIDS. However, the penal code makes negligent or malicious acts likely to spread infection of life threatening disease punishable with imprisonment, fines or both. The prison terms range from up to six months for negligent acts to two years for malicious ones.³³² In other legislation related to HIV/AIDS, the government enacted a law on safe handling of blood products in 2002.³³³

Under certain matrimonial laws, a woman can seek divorce on the basis of her husband's infection with a venereal disease.³³⁴

There are no laws *per se* that prohibit discrimination against persons living with STIs or HIV/AIDS.

Policies for the prevention and treatment of STIs and HIV/AIDS

All national policies and programs on HIV/AIDS and STIs are formulated in consultation with the National AIDS Committee, an advisory body to the Ministry of Health and Family Welfare that was established in 1985.³³⁵ The committee is charged with responsibility for major policy issues and strategies; coordination of various sectors, including the NGO sector; supervision of the implementation of programs; and mobilization of resources.³³⁶ The committee is made up of representatives from nine ministries and various NGOs and community organizations.³³⁷ In recognition of the unique impact of HIV/AIDS and STIs on women, a “women’s wing” of the committee was established to raise awareness on HIV/AIDS issues related to women.³³⁸ In addition, the committee has a technical sub-body made up of experts from various fields that supervises the technical aspects of the government’s HIV/AIDS and STI prevention and control activities.³³⁹

The National Policy on HIV/AIDS and STD Related Issues, approved by the cabinet in 1997, and the National AIDS/STD Programme provide the main policy framework for the government’s response to the threat of AIDS in Bangladesh. The government has also prepared a National Strategic Framework for 2002–2006 for the implementation of HIV/AIDS prevention and control activities.³⁴⁰

The National Policy on HIV/AIDS and STD Related Issues proclaims several “fundamental principles” as the framework for all national responses to STIs and HIV/AIDS. These principles protect several key human rights and freedoms of persons living with STIs and HIV/AIDS, including the rights to marriage and a family; employment; the highest possible standard of physical and mental health; information (including information about STI related issues and condoms); confidentiality; and nondiscrimination in health care.³⁴¹ Specifically, the policy prohibits restrictions on the rights and freedoms of individuals based solely on their HIV-positive status.³⁴²

The policy has several broad aims, which include the following:

- to prevent the transmission of STIs and HIV;
- to provide services for the management of STIs; and
- to reduce the impact of HIV/AIDS on individuals and the community.³⁴³

It also provides guidelines on several key areas, including:

- HIV/AIDS epidemiological surveillance;
- HIV testing;
- management of HIV infection;

- counseling of HIV/AIDS patients and confidentiality issues;
- national blood transfusion services;
- information, education and communication on HIV/AIDS;
- condom promotion and distribution;
- HIV/AIDS issues as they relate to women, men, adolescents, children, and minority communities;
- HIV/AIDS issues as they relate to the workplace, prisons and the media;
- HIV/AIDS issues related to commercial sex and drug users;
- policies on STIs;
- social science and behavioral research on HIV/AIDS;
- clinical vaccine trials for STIs and HIV/AIDS;
- ethical aspects of HIV/AIDS research; and
- legal aspects of HIV/AIDS.³⁴⁴

The policy’s specific goals for the prevention and treatment of STIs include the following:

- promote accessible, effective and acceptable services for persons with STIs in the public and private health systems;
- include STI services in maternal and child health, prenatal and family planning services to the extent possible with available human and financial resources;
- target acceptable and effective STI services to high-risk populations; and
- implement first-level preventive measures, such as promoting safe sex practices and providing condoms, in the National AIDS/STD Programme.³⁴⁵

The policy specifically calls for providing STI services in health-care facilities up to the *thana* level, and for more research on STIs.³⁴⁶

The National AIDS/STD Programme, which evolved from the government’s first national AIDS control and prevention program in 1996, calls for a number of specific interventions to deal with the reality of HIV/AIDS in Bangladesh, which include the following:

- behavior change programs for commercial sex workers, intravenous drug users and truck drivers, including peer education and distribution of condoms;
- training for medical personnel on STIs and HIV/AIDS counseling and care;
- creation of a surveillance system for STIs and HIV/AIDS; and
- procurement of condoms, HIV test kits, drugs for treating STIs, and disposable equipment for the safe handling of blood and other medical equipment to strengthen laboratory STI- and HIV-diagnostic capacity.³⁴⁷

In 2000, the government agreed to a plan for the expansion of the program's activities for 2001–2005 with the support of the World Bank and the United Kingdom Department for International Development.³⁴⁸ The majority of these funds were intended for NGOs.³⁴⁹ As of May 2003, however, most of the funds had yet to be disbursed due to implementation difficulties.³⁵⁰

The priority action areas of the National Strategic Framework are the following:

- target activities to vulnerable populations;
- undertake advocacy and communication activities;
- promote safe blood practices;
- provide care and support to persons living with HIV/AIDS; and
- strengthen management of programs and institutional support, including for research.³⁵¹

In addition to specific national policies on STIs and HIV/AIDS, the Health, Nutrition and Population Sector Programme addresses HIV/AIDS in its goals and strategies. One of the program's primary objectives is to control communicable diseases, including HIV/AIDS.³⁵² In order to understand and address the true prevalence of such diseases, the strategy calls for improved data collection systems.³⁵³

In an attempt to combat the spread of HIV/AIDS and other STIs, the government has also adopted a national policy on safe blood transfusion.³⁵⁴ Among other things, the policy calls for a national committee to train medical personnel on blood screening and detection of STIs and HIV.³⁵⁵ Since 2000, 97 public and private blood transfusion facilities at the *zila* level and below have been provided with blood screening capabilities.³⁵⁶ The government has also endorsed a Code of Ethics for Blood Donations and Transfusions.³⁵⁷

NGOs have been instrumental in HIV/AIDS prevention and control activities at both the policy and service delivery levels. In 1993, NGOs working on AIDS-related issues in Bangladesh joined forces to form an STD/AIDS network, a coalition of 72 NGOs and more than 100 individuals.³⁵⁸

Regulation of information on STIs and HIV/AIDS

In conjunction with the government's HIV/AIDS prevention efforts, the mass media play an important role in raising awareness about HIV/AIDS.³⁵⁹ Information on HIV/AIDS is disseminated through television, radio, newspapers, and magazines, with television serving as the most important source of information on the disease.³⁶⁰

C. POPULATION

The government identified population growth as the country's biggest problem in 1976, and adopted a broad-based family planning program and official population policy to

address the problem.³⁶¹ Since the 1970s, this concern about population growth has been reflected in all successive five-year development plans and programs.³⁶² Also around the mid-1970s, the government deployed full-time family welfare assistants to provide family planning information, education and services to communities and instituted a social marketing program to promote the sale of pills and condoms.³⁶³ Between the early 1970s and early 1990s, government efforts to curb population growth led to a drastic decline in the total fertility rate, from 6.3 lifetime births per woman to 3.4.³⁶⁴ The total fertility rate in Bangladesh is currently 3.3 and the annual growth rate in 2001 was 1.48%.³⁶⁵

Since 1980, the government's population program has promoted integrated health and family planning programs.³⁶⁶ The current approach is to provide high-quality, client-centered family planning services as a means to curb population growth.

Population policy

Objectives

Bangladesh's population policy recognizes population stabilization as an "urgent national priority."³⁶⁷ The government promises to uphold its commitments under international consensus documents such as the ICPD Programme of Action and the Beijing Declaration and Platform for Action throughout its efforts to achieve this goal.³⁶⁸

The policy broadly aims to elevate the overall living standards of the people of Bangladesh by improving their reproductive health status and reducing the population growth rate.³⁶⁹ It calls for special attention to underserved areas and vulnerable groups.³⁷⁰ The policy's major objectives are the following:

- achieve a net reproductive rate of one by 2010 to stabilize the population by 2060 by providing accessible, affordable and quality reproductive health and family welfare services to people at all levels of society;
- address the causes of maternal mortality (including unsafe abortion) and reduce the infant mortality rate by providing adequate and quality pre- and post-natal care, emergency obstetric care and safe delivery services;
- reduce child mortality, disability and blindness by providing immunization, vitamin A supplements and other micronutrients;
- ensure the participation of different ministries in implementing population activities;
- encourage adolescent girls to participate in population activities and delay pregnancy until at least age 20;
- develop human resources by training officials

involved in health and population activities;

- take urgent steps to ensure that skilled health and family welfare workers assist up to 50% of deliveries by 2005 and all deliveries by 2010;
- ensure the right to access information on reproductive health and services, and create a demand for services through awareness-raising campaigns;
- ensure gender equality and women's empowerment by creating and enhancing opportunities in education and employment;
- provide information on nutrition to prevent malnutrition and ensure food to "destitute" women;
- reduce the influx in urban areas of people migrating from rural areas and encourage urban development planning; and
- ensure public health facilities and better living conditions (including water free of arsenic) in communities.³⁷¹

Policy strategies in support of these objectives are the following:

- ensure the provision of client-centered and quality reproductive health and family planning services;
- strengthen links between population and development;
- reduce gender discrimination in the provision of services
- give priority to the needs of low-income groups, especially women and children, in providing services;
- incorporate population issues in public policies on health, education, employment, the environment, migration and urbanization, food and nutrition, and other areas to raise awareness of population-related problems and their implications for society and individuals;
- use all available means of communication to promote the small family norm; and
- introduce population and reproductive health education in the formal school system and training institutions.³⁷²

(See "Reproductive Health Laws and Policies" for specific strategies relating to reproductive health.)

Implementing agencies

The National Population Council is the highest advisory body in the government on population policy issues.³⁷³ The council is chaired by the prime minister.³⁷⁴

Services related to population activities are delivered through the existing health infrastructure.³⁷⁵ (See "Infrastructure of health-care services" and "Family planning services".)

III. Legal Status of Women

Women's health and reproductive rights cannot be fully understood without taking into account the legal and social status of women. Laws relating to women's legal status not only reflect societal attitudes that shape the landscape of reproductive rights, they directly impact women's ability to exercise these rights. Issues such as the respect and dignity a woman commands within marriage, her ability to own property and earn an independent income, her level of education, and her vulnerability to violence affect a woman's ability to make decisions about her reproductive health-care needs and to access the appropriate services. The following section details the nature of women's legal status in Bangladesh.

A. RIGHTS TO GENDER EQUALITY AND NONDISCRIMINATION

The constitution guarantees the equality of all citizens before the law and equal protection of the law, and prohibits discrimination against any citizen based on religion, race, caste, sex, or place of birth.³⁷⁶ The prohibition of discrimination does not prevent the government from making special provisions for disadvantaged groups, particularly women.³⁷⁷ While the constitution guarantees women equal rights with men in "all spheres of the State and of public life," it does not extend this protection to the private sphere where various religious laws govern personal matters.³⁷⁸

Formal institutions and policies

The government created the Ministry of Women and Children's Affairs in 1978 to focus on the development needs and concerns of women and children.³⁷⁹ The ministry is the lead governmental agency for addressing women's issues and realizing the country's development goals for women.³⁸⁰ The ministry's responsibilities include formulation of national policies on women; implementation of special programs for women's development; coordination of the women's development-related aspects of different sectors; addressing with matters relating to women's legal and social rights; overseeing the control and registration of women's voluntary organizations; and engaging with international organizations in the field of women's develop-

ment.

RELEVANT LAWS AND POLICIES

- National Policy on Women's Advancement, 1997; and National Policy on Women's Advancement Action Plan, 1998
- National Strategy for Economic Growth, Poverty Reduction and Social Development
- Citizenship Act, 1951

ment.³⁸¹ At present, the ministry has three implementing agencies: the Department of Women's Affairs, *Jatiya Mohila Sangstha* (National Women's Council) and *Shishu* (Children's) Academy.³⁸² A Parliamentary Standing Committee on the Ministry of Women and Children's Affairs has also been established to raise and discuss ministry-related issues.³⁸³ The ministry makes regular reports to the committee on the progress of government initiatives for women's advancement.³⁸⁴

The National Council for Women's Development, created in 1995, reviews and monitors the implementation of policies related to women's advancement.³⁸⁵ Its other responsibilities include formulating laws, policies and regulations for ministries and other governmental bodies to advance women's legal rights and participation in all spheres of life.³⁸⁶ The council is composed of ministers and secretaries from several line ministries, public representatives and individuals, and is headed by the prime minister.³⁸⁷

Women-in-Development Focal Points are additional institutional mechanisms that were designed to ensure that gender concerns are included in the policies, plans and programs of all ministries and agencies.³⁸⁸ Individual officers oversee the focal points in all the line ministries. This initiative has the following priorities:

- formulation of sectoral plans that incorporate gender concerns;
- preparation of lists of women's programs for inclusion in annual development plans;
- review and modification of existing programs with a view to incorporating gender concerns;
- ensuring of gender-sensitive reporting;
- collaboration with other sectors and central agencies in order to achieve women-in-development goals; and
- monitoring and reporting on the progress toward achieving women-in-development goals.³⁸⁹

Issues related to women's advancement and equality are addressed in specific national policies as well as integrated into broader national development policies. The National Policy on Women's Advancement and its implementing action plan were adopted in 1997 and 1998, respectively.³⁹⁰ The policy's goals include the following:

- establish equality between men and women in all spheres;
- eliminate all forms of discrimination against women and girls;
- establish women's human rights;
- develop women as human resources;
- recognize women's contribution in social and economic spheres;

- eliminate poverty among women;
- establish equality between men and women in administration, politics, education, games, sports, and all other socioeconomic spheres;
- eliminate all forms of oppression against women and girls;
- ensure empowerment of women in the fields of politics, administration and the economy;
- ensure adequate health and nutrition for women;
- provide housing and shelter for women;
- create positive images of women in the media; and
- take special measures for women in disadvantaged situations.³⁹¹

A Women's Development Implementation and Evaluation Committee has been formed to monitor implementation of the policy's action plan.³⁹² Members of the committee include the joint secretaries and joint chiefs of various ministries, heads of implementing agencies of the Ministry of Women and Children's Affairs, and representatives of civil society groups.³⁹³

Women's advancement and gender equality are also key development goals in the National Strategy on Economic Growth, Poverty Reduction and Social Development. The strategy identifies gender equality as a "core development issue" and an overarching strategic goal.³⁹⁴ Its specific objectives in the area of women's advancement and gender equality include the following:

- combating continuing negative sex ratios;
- eliminating violence against women;
- reducing high maternal mortality;
- removing restrictions on women's employment and economic opportunities;
- ensuring formal equality;
- supporting quotas and affirmative action at all levels and in all spheres;
- creating "women-friendly" institutional environments; and
- generating sex-disaggregated statistics.³⁹⁵

(See "Labor and employment," "Access to credit," "Education," and "Right to Physical Integrity" for specific strategies.)

B. CITIZENSHIP

The constitution provides that Bangladeshi citizenship shall be determined and regulated by law.³⁹⁶ According to the 1951 Citizenship Act, women have equal rights with men to acquire, change or retain their nationality, and may obtain passports without the signature of their husbands or fathers.³⁹⁷ However, only Bangladeshi men can confer citizenship upon their children and spouses.³⁹⁸

In exercising its authority to review and make recommendations to existing laws to protect the rights of women and ensure a law's conformity with fundamental rights, the Law Commission had planned to review the Citizenship Act in its 2002–2003 agenda.³⁹⁹ No data is available on the outcome of the review.

C. RIGHTS WITHIN MARRIAGE

Marriage laws

The personal laws of the country's religious communities govern most aspects of private life, including matters relating to marriage.⁴⁰⁰ There has been no reform of marriage and divorce laws governing religious minorities in Bangladesh.⁴⁰¹

In addition to religious personal laws, some marriage-related laws apply to all Bangladeshis, irrespective of religious affiliation.

The 1872 Special Marriage Act allows people of different faiths, except Muslims, or those who do not ascribe to a particular faith, to legally register their marriage. The requirements for a valid marriage under the act include the following:

- at the time of marriage, neither party can have a living husband or wife;
- the man must be at least 18 years of age and the woman at least 14 years of age;
- parties under the age of 21 must obtain the consent of their father or guardian;
- the parties must not be within prohibited degrees of relationship; and
- the marriage must be registered.⁴⁰²

The act prohibits polygamy.⁴⁰³ Persons married under this act can seek to dissolve their marriage under the 1869 Divorce Act.⁴⁰⁴

The 1903 Foreign Marriage Act allows the legal registration of marriage between a foreign citizen and a Bangladeshi citizen.⁴⁰⁵

The 1929 Child Marriage Restraint Act establishes the legal marriage age at 18 for women and 21 for men.⁴⁰⁶ Although the act provides penal sanctions for marriages between underage individuals, it does not affect the validity of such marriages if they are solemnized under the purview of personal law.⁴⁰⁷

The 1980 Dowry Prohibition Act makes the giving, demanding or abetting of dowry from the bride or her family to the groom and his family an offense punishable with one year of prison, a fine or both.⁴⁰⁸ The act does not exempt the *stridhan* of a Hindu woman from its purview; *stridhan* refers to all property and gifts given to or acquired by a Hindu married woman during her lifetime over which she has exclusive con-

trol.⁴⁰⁹ The act has led to a withholding of this settlement from women.⁴¹⁰ Under the Prevention of Oppression Against Women and Children Act, any person who, on behalf of a woman's husband, causes or attempts to cause death or hurt to any person in connection with a demand for dowry may be subject to life imprisonment or 5–14 years' imprisonment, as well as a fine.⁴¹¹

Laws governing Muslims

Muslim Bangladeshis, in general, follow the *Hanafi* school of Muslim jurisprudence.⁴¹² Under Muslim personal law, marriage is a contract between two individuals. The Muslim Family Laws Ordinance, the 1974 Muslim Marriages and Divorces (Registration) Act and their respective accompanying rules regulate marriage between Muslims in Bangladesh.⁴¹³ These laws are applicable to all Muslim citizens of the country, irrespective of their religious sect or country of residence.

Under the Muslim Family Laws Ordinance, the legal age of marriage is 18 for women and 21 for men.⁴¹⁴

The Muslim Marriages and Divorces (Registration) Act requires that all marriages be registered by a licensed individual called a *nikah* registrar.⁴¹⁵ Any marriage not registered must be reported to a *nikah* registrar by the individual who solemnized the marriage; failure to report is punishable with imprisonment of up to three months, a fine or both. The failure to register, though punishable, does not invalidate the marriage.⁴¹⁶

The law does not prohibit polygamy. The Muslim Family Laws Ordinance provides that a man may marry a second wife upon the written permission of an appointed arbitration council composed of the chairman of the union *parishad* (or other appointed official), and representatives for the man and his wife or wives.⁴¹⁷ The man seeking to contract another marriage must submit an application to the council stating the reasons for the proposed marriage and obtain the consent of his existing wife or wives.⁴¹⁸ The council may grant permission for the proposed marriage if it is satisfied that the marriage is "necessary and just" based on any of the following factors:

- sterility;
- physical infirmity;
- physical unfitness for the conjugal relation;
- willful avoidance of a decree for restitution of conjugal rights; or
- insanity of the existing wife.⁴¹⁹

A party to the decision has a right of appeal to the *munsif* (legal officer) concerned, whose decision is final and not subject to review in any court of law.⁴²⁰ A second marriage contracted without permission of the council is not void, though the existing wife or wives may pursue legal measures against

the man.⁴²¹ The man may be required to pay the entire amount of dower to the existing wife or wives, and may be punished with imprisonment of up to one year and a fine.⁴²²

The law generally recognizes the marriage of a Muslim man to a non-Muslim woman if she is Jewish or Christian, but the marriage of a Muslim woman to a non-Muslim man is not valid.⁴²³ A marriage between a Muslim man and a Hindu woman, and between a Muslim woman and a non-Muslim man must take place in a civil court with the spouses declaring that they do not practice any religion.⁴²⁴

Laws governing Hindus

Hindu personal law governs marriage among Bangladeshi Hindus.⁴²⁵ The law considers marriage to be a sacrament.⁴²⁶ It also recognizes polygamy.⁴²⁷

Several codified laws enacted during the British colonial era apply in the area of marriage among Hindus in Bangladesh. These include the 1856 Hindu Widow's Re-Marriage Act, which legalizes the remarriage of Hindu widows, and the 1946 Hindu Marriage Disabilities Removal Act, which provides that an otherwise valid marriage does not become invalid by virtue of the parties' membership in the same *gotra* (clan) or in different subdivisions of the same caste.⁴²⁸

Laws governing Christians

The 1872 Christian Marriage Act allows for the solemnization of marriage between persons in Bangladesh, one or both of whom are Christian.⁴²⁹ The law also prescribes procedures for the registration of marriage.⁴³⁰ Polygamy is prohibited.⁴³¹

Divorce laws

Laws governing Muslims

There are several variants of divorce that are technically recognized in the *Sharia*. These include *talaq* (unilateral action by the husband), *mubarat* (mutual consent) and *khula* (at the initiation of the wife, provided that she agrees to forgo her financial rights, such as her dower).⁴³²

The Muslim Family Laws Ordinance regulates the procedure for seeking a divorce. Under the ordinance, men may seek divorce by pronouncing *talaq* and giving written notice to the chairman of the union *parishad* or other appointed official and a copy to his wife.⁴³³ The chairman is then bound to

constitute an arbitration council charged with the task of attempting reconciliation between the parties.⁴³⁴ If such efforts fail, divorce is generally effective after *iddat*—a three-month period that must pass before the divorce becomes effective—or, if the wife is pregnant at the time of *talaq*, at the end of her pregnancy, whichever occurs later.⁴³⁵

The parties may also contract at the time of marriage to delegate the right of *talaq* to the wife.⁴³⁶ In the absence of a delegated right of *talaq*, the ordinance provides two grounds upon which women may seek dissolution of their marriage: nonpayment of dower or failure to provide maintenance for a period of two years after a demand is made.⁴³⁷

In addition to these forms of divorce, judicial divorce is available under the 1939 Dissolution of Muslim Marriages Act. Under the act, a woman married under Muslim law may seek to dissolve her marriage by judicial decree on any of the following grounds:

In addition to these forms of divorce, judicial divorce is available under the 1939 Dissolution of Muslim Marriages Act. Under the act, a woman married under Muslim law may seek to dissolve her marriage by judicial decree on any of the following grounds:

- husband's whereabouts are unknown for four years;
- neglect or failure of the husband to provide her with maintenance for two years;
- addition of a new wife in contravention of the Muslim Family Laws Ordinance, which includes obtaining the consent of an existing wife or wives;

- a prison sentence of seven or more years for the husband;
- failure of the husband to perform, without reasonable cause, his marital obligations for three years;
- continued impotence of the husband from the time of marriage;
- insanity of the husband for two years or the husband's affliction with leprosy or a virulent venereal disease;
- marriage of the woman before the age of 16, provided that the marriage has not been consummated and she has repudiated the marriage before the age of 18;
- cruel treatment by the husband; or
- any other ground recognized under Muslim law.⁴³⁸

The act defines cruel treatment by the husband as the following:

- habitual assault or cruelty of conduct not amounting

RELEVANT LAWS AND POLICIES

- Special Marriage Act, 1872
- Foreign Marriage Act, 1903
- Child Marriage Restraint Act, 1929
- Dowry Prohibition Act, 1980
- Muslim Family Laws Ordinance, 1961
- Muslim Marriages and Divorces (Registration) Act, 1974
- Hindu Widow's Re-Marriage Act, 1856
- Hindu Marriage Disabilities Removal Act, 1946
- Christian Marriage Act, 1872
- Dissolution of Muslim Marriages Act, 1939
- Hindu Married Women's Right to Separate Residence and Maintenance Act, 1946
- Divorce Act, 1869
- Guardians and Wards Act, 1890

to physical ill-treatment;

- association with women of evil repute or leading an infamous life;
- attempting to force the wife to lead an immoral life;
- disposal of the wife's property or preventing her from exercising her legal rights over her property;
- obstructing her observance of her religious faith; or
- in cases of polygamous marriage, failure to treat the wife or wives equitably according to the injunctions of the *Quran*.⁴³⁹

The Muslim Marriages and Divorces (Registration) Act provides for a mediation process over a period of three months before a divorce can become effective.⁴⁴⁰

Laws governing Hindus

The concept of divorce does not exist in Hindu personal law.⁴⁴¹ However, the 1946 Hindu Married Women's Right to Separate Residence and Maintenance Act entitles married Hindu women to a right to a separate residence and maintenance on any of the following grounds, notwithstanding any custom or law to the contrary:

- cruelty;
- desertion;
- husband's remarriage;
- conversion to another religion;
- husband's maintaining a concubine in the marital home or habitually residing with a concubine; or
- any other justifiable reason.⁴⁴²

A woman loses her right if she is unchaste, converts to another religion or fails to comply without sufficient cause with a decree for the restitution of conjugal rights.⁴⁴³

Laws governing Christians

The Divorce Act provides the grounds for divorce for Christians, which differ between men and women.⁴⁴⁴ Under the act, men may petition for divorce on the ground of adultery.⁴⁴⁵ Women may seek divorce on any of the following grounds:

- conversion of the husband to another religion and his subsequent marriage to another woman;
- "incestuous adultery";
- bigamy coupled with adultery;
- the husband's marriage to another woman coupled with adultery;
- rape, sodomy or bestiality;
- adultery coupled with cruelty of a degree that, without adultery, would justify divorce *a mensa et toro* (the separation of a woman from the bed and board of her husband); or
- adultery coupled with desertion, without reasonable excuse, for at least two years.⁴⁴⁶

Either party may also petition to annul the marriage on any of the following grounds:

- impotence at the time of marriage and through the institution of the suit;
- the parties are within prohibited degrees of relationship;
- either party was a "lunatic" or an "idiot" at the time of marriage; or
- either party had a living spouse at the time of marriage.⁴⁴⁷

Judicial separation

Laws governing Muslims

Judicial separation is not recognized as a matrimonial remedy under Muslim law.

Laws governing Hindus

See "Divorce laws" for information.

Laws governing Christians

Under the Divorce Act, either party may obtain a decree of judicial separation on the ground of adultery, cruelty or desertion without reasonable excuse for two or more years.⁴⁴⁸

Maintenance and support laws

Laws governing Muslims

The Muslim Family Laws Ordinance imposes a duty on husbands to provide adequate and equitable maintenance to their wives during marriage. The ordinance interprets "adequate" to mean "proper and reasonable."⁴⁴⁹ In the case of married minors, the duty to pay maintenance devolves to a minor husband's father.⁴⁵⁰

A woman whose husband fails to provide maintenance may seek a legal remedy in court, file a complaint with the chairman of the union *parishad* (who is charged with constituting an arbitration council to settle the matter), or both.⁴⁵¹ The woman must give notice of maintenance proceedings to her husband.⁴⁵² The council is authorized to specify the amount of a maintenance award, including past maintenance if appropriate, and enforce payment by the husband.⁴⁵³

A woman is entitled to receive a living allowance after her husband's death from the proceeds of his property; his property may be divided among his heirs only after this requirement is met.⁴⁵⁴

A divorced woman is entitled to receive maintenance through the period of *iddat* but normally has no rights to maintenance or property beyond this period.⁴⁵⁵ However, a judgment of the Supreme Court awarded maintenance to a divorced woman beyond the *iddat* period, through the date of her remarriage.⁴⁵⁶

Laws governing Hindus

Hindu personal law governs matters involving maintenance among Hindus in Bangladesh.⁴⁵⁷

Laws governing Christians

Christian personal law governs matters involving maintenance among Christians in Bangladesh.⁴⁵⁸

Custody and adoption laws

All Bangladeshi citizens have recourse to the 1890 Guardians and Wards Act in matters relating to custody, which takes into consideration any applicable personal law by looking at the parties' religious faiths.⁴⁵⁹

Under the act, fathers are considered the primary guardians of minor children, and courts will not appoint another guardian unless the father is found to be unfit.⁴⁶⁰ In cases involving a married minor girl, the girl's husband is considered her natural guardian and courts will similarly not appoint another guardian unless he is found to be unfit.⁴⁶¹ Where a court must appoint a guardian, it is guided by several factors, including the circumstances that appear to be in the welfare of the minor, so long as they are consistent with the law to which the minor is subject.⁴⁶² In determining what would be in the welfare of the minor, the court considers the age, sex and religion of the minor; the "character and capacity" of the proposed guardian and his or her kinship to the minor; any wishes of a deceased parent; any existing or previous relationship between the proposed guardian and the minor or his property; and the preference of the minor, if such minor is old enough to form an intelligent preference.⁴⁶³

Laws governing Muslims

Under Muslim personal law, mothers may retain custody of their daughters until they reach puberty, and of their sons until they reach seven years of age.⁴⁶⁴

The father-in-law of a widow assumes custody of her children, and a widow must seek permission from a court to dispose of her minor children's property.⁴⁶⁵

Muslim personal law does not recognize the concept of adoption as widely understood in most societies.⁴⁶⁶

Laws governing Hindus

Hindu personal law considers the father to be the natural and legal guardian of the person and property of a minor child.⁴⁶⁷

Under the Hindu Widow's Re-Marriage Act, a widow who has not been expressly appointed in her deceased husband's will as guardian of their children may lose her right to custody upon remarriage.⁴⁶⁸ In such cases, the father, mother, paternal grandfather or grandmother, or any male relative of the deceased husband may petition a court to appoint a guardian for the care and custody of the children.⁴⁶⁹ However, in cases involving minor children who have no means to

support themselves, the mother's consent is always required for the appointment of a guardian, unless the proposed guardian has made provisions for the support and education of the children.⁴⁷⁰

Under Hindu law, male children may be adopted.⁴⁷¹

Laws governing Christians

Upon the death of her husband, a Christian woman automatically obtains guardianship of the couple's minor children and the children's property.⁴⁷² In cases of divorce, the Divorce Act provides that a court may use discretion in determining custody of the couple's minor children.⁴⁷³

D. ECONOMIC AND SOCIAL RIGHTS

Property laws

The constitution guarantees the right of every citizen "to acquire, hold, transfer or otherwise dispose of property" and prohibits the unlawful deprivation of property.⁴⁷⁴

Laws governing Muslims

Muslim personal law is the primary source of women's property rights. In general, Muslim personal law dictates that a male inherits double the share of a female. A widow is entitled to one-fourth of her husband's property when the couple has no children, and to one-eighth when there are children.⁴⁷⁵ In cases of polygamous marriage, the share is divided equally among the husband's wives.⁴⁷⁶ Where the wife predeceases her husband, he receives exactly double what his wife would have received in the reverse situation: one-half or one-fourth, depending on whether there are children.⁴⁷⁷

A daughter inherits one-half of her father's property, but where there is more than one daughter, the daughters inherit two-thirds collectively.⁴⁷⁸ When there is a son in the family, a daughter inherits one-half of what the son gets as residuary.⁴⁷⁹ An exception in *Shiah* Muslim jurisprudence provides that *Shiah* Muslim girls may inherit all of their father's property if there are no sons.⁴⁸⁰

Laws governing Hindus

Under Hindu personal law, the order of priority in inheritance is the following: son, grandson, great-grandson, daughter, daughter's son, father, mother, and so on.⁴⁸¹ According to the 1937 Hindu Women's Right to Property Act, a widow, or in the case of polygamous marriage, all widows, inherit the same share as a son.⁴⁸²

Laws governing Christians

Under the 1925 Indian Succession Act, Christians may make wills to bequeath any part of their property to any person of their choosing.⁴⁸³ In cases where a Christian dies with-

RELEVANT LAWS AND POLICIES

- Hindu Women's Right to Property Act, 1937
- Indian Succession Act, 1925
- Married Women's Property Act, 1874

out a legal will, the widow or widower and all lineal descendants inherit.⁴⁸⁴ Sons and daughters inherit equal shares.⁴⁸⁵

Rights to agricultural land

No data is available on laws relating to Bangladeshi women's rights to agricultural land.

Women's exclusive property

Laws governing Muslims

All property given as dower or bridal gifts is vested in the bride, who may deal autonomously with such property.

Laws governing Hindus

Hindu women have exclusive rights to their *stridhan*.⁴⁸⁶ Women are the sole owners of such *stridhan* and may dispose of it as they wish.⁴⁸⁷ Such property devolves to a woman's heirs upon her death.⁴⁸⁸

Laws governing Christians

Under the 1874 Married Women's Property Act, married Christian women's exclusive property includes the following:

- all wages and earnings from any employment, occupation or trade acquired or gained solely by the married woman;
- any money or other property acquired by the married woman through the exercise of any literary, artistic or scientific skill; and
- savings and investments from such wages, earnings and property.⁴⁸⁹

Under the act, a married woman may effect an insurance policy on her own behalf.⁴⁹⁰ She may additionally file a suit in her own name to recover her separate property.⁴⁹¹

Labor and employment

National-level data from 1995–96 indicates that 50.6% of women participate in the workforce.⁴⁹² Of working women, about 34% are unpaid family helpers; about 22% are self-employed; and 18% are day laborers.⁴⁹³ The agricultural and manufacturing sectors are a major source of women's employment. Women account for nearly 24% of all manufacturing workers, and 90% of all garment factory workers.⁴⁹⁴ In contrast, there are few women in formal public-sector employment, and even fewer in management or policy-making positions.⁴⁹⁵ Although women currently have lower overall rates of employment in comparison with men, it has been observed that women's workforce participation is increasing at a faster rate than that of men.⁴⁹⁶

The constitution guarantees all citizens the rights to equality and nondiscrimination in pursuit of public employment. The state may, however, designate certain positions to be suitable for only one sex.⁴⁹⁷

Under the constitution's Fundamental Principles of State Policy, the state is charged with responsibility for strengthening the country's productive capabilities and elevating citizens' standard of living by securing "the right to work, that is the right to guaranteed employment at a reasonable wage having regard to the quantity and quality of work."⁴⁹⁸ The principles further proclaim that work is a "right, duty and matter of honour for every citizen who is capable of working, and everyone shall be paid for his work on the basis of the principle, 'from each according to his abilities to each according to his work.'"⁴⁹⁹

The National Strategy for Economic Growth, Poverty Reduction and Social Development calls for several measures to remove restrictions on women's employment and economic opportunities, including the following:

- introduce equal opportunity laws and ensure equal wage for similar work;
- undertake affirmative measures to sustain and support women's employment such as providing child care and safe transport;
- increase women's participation in all activities in the agricultural sector;
- increase women's ability to earn income by providing training in starting small and medium scale business activities;
- introduce training facilities in vocational skills for women in high-tech industries through effective budgetary allocation; and
- formulate economic policies to reduce discrimination against women.⁵⁰⁰

In an effort to increase women's employment in government service positions, the government has instituted a quota system under which 10% of officially posted positions and 15% of non-posted positions are reserved for women.⁵⁰¹ The

government has also recently undertaken special measures for the appointment of women to senior administrative and management positions of deputy secretary and joint secretary.⁵⁰² In the realm of education, the government has undertaken measures to recruit women to fill 60%

of teaching positions at the primary-school level, 40% at the secondary-school level and at least 10% at the college and university levels.⁵⁰³

Some labor laws provide benefits to pregnant women and mothers, such as providing maternity leave and child-care facilities when more than 50 women are employed by an employer.⁵⁰⁴ In the formal sector, two three-month

RELEVANT LAWS AND POLICIES

- National Strategy for Economic Growth, Poverty Reduction and Social Development

periods of maternity leave are allowed during a woman's employment.⁵⁰⁵ This benefit is not yet ensured in the private and informal sector.⁵⁰⁶

NGOs play a significant role in encouraging women's labor force participation. In the garment manufacturing industry, some NGOs have instituted pilot programs in collaboration with employers to establish day care centers for female garment workers in factories.⁵⁰⁷ Garment manufacturers, the Bangladesh Garment Manufacturers and Exporters Association, the International Labor Organization, UNICEF, NGOs, and the government have initiated another collaborative effort to establish schools for child workers who have been removed from garment factories.⁵⁰⁸

Access to credit

The National Strategy for Economic Growth, Poverty Reduction and Social Development proposes several measures to improve women's access to credit, including the following:

- increase the availability of funds to give medium-size credits to women and encourage female entrepreneurs in both small and medium scale business activities;
- increase soft loans (with easy loan terms) for female-supported households;
- facilitate collateral provisions for women who do not own land;
- provide banking facilities for garment workers at their workplace; and
- provide home banking facilities to support women's savings habits.⁵⁰⁹

Microcredit programs have been a major effort of the government, international donors and NGOs to improve women's and other marginalized groups' access to financial services.

Three of the country's largest and best-known microcredit programs are the Grameen Bank, a project-turned-bank that spearheaded the microcredit movement in Bangladesh in the early 1980s; the Bangladesh Rural Advancement Committee, one of the largest NGO providers of microcredit to low-income individuals; and the Rural Development Project-12, a government program formed in 1988 under the Bangladesh Rural Development Board.⁵¹⁰ Between 1994 and 1999, the Grameen Bank alone disbursed about USD 2.4 billion to nearly 2.3 million borrowers.⁵¹¹

These programs, like most microcredit programs in Bangladesh, specifically target women and, as a result, women

make up the majority of borrowers. In the mid-1990s, about 94% of Grameen Bank's members, 88% of Bangladesh Rural Advancement Committee members and 70% of Rural Development Project-12 members were women.⁵¹² Overall, an estimated 10 million Bangladeshi women are beneficiaries of such programs.⁵¹³

Microcredit programs have been a key contribution of the NGO sector.⁵¹⁴ As of 1998, more than 750 NGOs in Bangladesh were involved in microcredit lending activities.⁵¹⁵ Roughly 160 NGOs receive financial support for their microcredit lending activities through the *Palli Karma Sahayak* Foundation, a quasi-governmental body that channels international and government aid to NGOs within Bangladesh; these NGOs lend to about 1.2 million borrowers.⁵¹⁶

Education

In 2000, the female literacy rate in Bangladesh was an estimated 49.5%, an increase from 34.2% in 1995.⁵¹⁷

The constitution's fundamental rights prohibit discrimination in admission to any educational institution on the grounds of religion, race, caste, sex, or place of birth.⁵¹⁸ The Fundamental Principles of State Policy charge the government with responsibility for establishing a "uniform, mass-oriented and universal system of education" and ensuring free and compulsory education for all children up to a level as determined by law.⁵¹⁹ They further enjoin the government to adopt effective measures to "relat[e] education to the needs of society" and eliminate illiteracy within such time as the government may determine.⁵²⁰

In an effort to translate these mandates into concrete laws and policies, the government enacted the Primary Education (Compulsory) Act in 1990 and National Education Policy in 2000. The Primary Education (Compulsory) Act, which was implemented in 1993, authorizes the government to make primary education mandatory for children aged 6–10 in any area of the country.⁵²¹

The National Education Policy reaffirms the government's commitment to making primary education uniform, free and compulsory. One of its specific objectives is to gradually extend the duration of universal and compulsory primary education to eight years by 2010.⁵²² The policy also calls for special efforts to improve women and girls' access to education. Specific strategies in furthering this goal include the following:

- creating a special fund to enable more women and girls to attend school;
- incorporating the issue of women's equal rights, as

RELEVANT LAWS AND POLICIES

- Primary Education (Compulsory) Act, 1990
- National Education Policy, 2000
- National Strategy for Economic Growth, Poverty Reduction and Social Development

well as positive and progressive images of women, in school curricula;

- providing equal opportunities for boys and girls at the secondary level in course selection;
- establishing vocational training and polytechnic institutes for girls;
- providing transportation and hostel facilities for girls who do not live near a secondary school;
- encouraging girls to pursue professional studies, including the sciences, medicine, law, and business
- providing scholarships and other need- and merit-based aid to women and girls for higher education and research; and
- involving women in all levels of educational policy-making.⁵²³

The policy also promotes adult education and nonformal education programs as complementary strategies in combatting illiteracy. Adult education programs target those aged 15–45 and include job skills training as part of the curriculum.⁵²⁴ Nonformal education programs are geared toward children aged 8–14 who are not enrolled in or have dropped out of the formal educational system.⁵²⁵ Nonformal education programs in Bangladesh have been a major contribution of the NGO sector in particular. As of 1999, there were more than 325 NGOs involved in literacy programs.⁵²⁶

The National Strategy for Economic Growth, Poverty Reduction and Social Development recognizes education as an important development issue. One of the strategy's primary goals is to eliminate gender disparity in primary and secondary education by 2015.⁵²⁷ The strategy also emphasizes efforts to improve technical and vocational educational opportunities for women.⁵²⁸

E. RIGHT TO PHYSICAL INTEGRITY

Efforts to combat violence against women are incorporated into Bangladesh's general development policies as well as specific national laws. The National Strategy for Economic Growth, Poverty Reduction and Social Development aims to substantially reduce or eliminate violence against women and children by 2015.⁵²⁹ The Prevention of Oppression Against Women and Children provides the legal framework for prosecuting a range of crimes of violence against women.

In addition to legal and policy efforts, the government has created institutional mechanisms to focus on the problem of violence against women. The Department of Women's Affairs has established a Cell Against Violence Against Women to provide legal counseling and assistance to female victims of violence in civil and criminal cases.⁵³⁰ Committees on violence against women have been formed by the government

at the *zila* and *thana* levels.⁵³¹ Women's investigation cells have also been established in several police stations to facilitate women's access to the police.⁵³² These cells, which are staffed by female police officers, investigate cases of violence against women. In addition, a special squad of the Criminal Investigation Department of the police force has been specifically mandated to investigate acid attacks against women.⁵³³

Rape

The penal code and the Prevention of Oppression Against Women and Children Act provide the legal framework for prosecuting crimes of rape.

The penal code defines rape as sexual intercourse with a woman under any of the following circumstances:

- against the woman's will;
- without the woman's consent;
- with the woman's consent, where consent has been obtained by putting the woman in fear of death or injury; or
- with the woman's consent, where the man knows he is not the woman's husband and the woman consents, believing that he is her husband.⁵³⁴

The code defines statutory rape as sexual intercourse with a girl under the age of 14.⁵³⁵ The code does not recognize marital rape as a crime, unless the wife is under the age of 13.⁵³⁶ The general rule is rationalized by the view, as stated in the code, that "one cannot be held guilty of raping his wife because her consent to marriage constitutes a consent to sexual intercourse with him which in law cannot be revoked during continuance of the marriage."⁵³⁷

In order to meet the burden of proof for the crime of rape, an alleged victim must provide:

- corroboration of her testimony by witnesses and medical evidence; and
- physical evidence of struggle or resistance (nonresistance by the woman may raise the inference of implied consent).⁵³⁸

The Prevention of Oppression Against Women and Children Act, which was passed to address the need for more effective prosecution of perpetrators of violence against women, prescribes severe punishments for crimes of rape. The act defines rape in accordance with the penal code.⁵³⁹ Under the act, persons convicted of rape are subject to life imprisonment and a fine.⁵⁴⁰ If an adult female or child victim of rape dies later as a result of the act, the convicted perpetrator may be subject to capital punishment.⁵⁴¹ Attempted rape is punishable with imprisonment of 5–10 years and a fine, and attempting to cause death or hurt after rape is punishable with life imprisonment and a fine.⁵⁴² The act also prescribes death or life imprisonment and a fine for each

individual who participates in a gang rape that results in the victim's injury or death.⁵⁴³ In cases of women raped while in police custody, the act provides that every individual directly responsible for the woman's safety while in custody is subject to 5–10 years' imprisonment and a fine.⁵⁴⁴ The act additionally charges an individual convicted of rape with financial responsibility for any child born as a result of the rape.⁵⁴⁵

Those arrested for crimes under the act are not eligible for bail during an initial investigation period of up to 90 days.⁵⁴⁶ The act provides for compensation to victims.⁵⁴⁷ It also provides a cause of action against investigating officers for negligence or willful failure in their duties.⁵⁴⁸

Incest

Sexual relationships between parent and child and between brother and sister are illegal under all the various personal laws. Christian and Hindu law also prohibit marriage between first cousins, with Hindu law additionally prohibiting marriage between other close relatives. The Special Marriage Act also forbids marriage between persons who are related within prohibited degrees.⁵⁴⁹

Domestic violence

There is no specific national legislation on domestic violence. Various acts of domestic violence may, however, be prosecuted under the penal code, the Prevention of Oppression Against Women and Children Act and the Dowry Prohibition Act.

Acts of violence such as causing hurt or grievous hurt may be prosecuted under the penal code.⁵⁵⁰ A husband who commits an act of violence causing his pregnant wife to miscarry may also be liable for the crime of causing miscarriage.⁵⁵¹

The Prevention of Oppression Against Women and Children Act prescribes severe punishments for causing or attempting to cause death or hurt by means of burns or corrosive poisonous substances.⁵⁵² (See "Customary forms of violence" for more information.)

One of the most common forms of domestic violence is that in connection with a demand for dowry. The Dowry Prohibition Act prohibits giving, taking or demanding dowry in consideration for marriage, making these acts punishable with imprisonment of 1–5 years, a fine or both.⁵⁵³ Under the Prevention of Oppression Against Women and Children Act, a husband or any relative or person acting on behalf of the husband who causes or attempts to cause his wife's death in connection with a demand for dowry is subject to life imprisonment and a fine.⁵⁵⁴ The punishment is lowered to 5–14

years of prison and a fine for attempting to cause hurt in connection with a demand for dowry.⁵⁵⁵

In addition to seeking criminal prosecution of an alleged perpetrator of domestic abuse, women may also seek civil redress under personal and marriage laws that grant divorce on the basis of cruelty.⁵⁵⁶

Sexual harassment

Under the penal code, a person who assaults or uses criminal force against a woman "intending to outrage or knowing it to be likely that he will thereby outrage her modesty" may be punished with up to two years' imprisonment, a fine or both.⁵⁵⁷ The code does not define the act or acts that constitute "an outrage to female modesty." Rather, explanatory comments in the code provide that a woman's

standard of modesty will vary "according to the country and the race" of the woman.⁵⁵⁸

The Prevention of Oppression Against Women and Children Act also prescribes punishments for the "sexual oppression" of women and children, defined as touching the sexual organs of a woman or child without consent, sexually assaulting a woman or making any "indecent gesture."⁵⁵⁹ Such acts may be punished with a minimum of two years' imprisonment and a fine, and a maximum of ten years' imprisonment.⁵⁶⁰

Commercial sex work

The constitution's Fundamental Principles of State Policy enjoin the government to "adopt effective measures to prevent prostitution and gambling."⁵⁶¹ Despite this mandate, there are no laws prohibiting a person over the age of 18 from engaging in sexual activity in exchange for money.⁵⁶²

In a 2000 case brought by more than 100 sex workers after law enforcement authorities closed down two brothels outside Dhaka, a high court ruled that prostitution as a livelihood is not illegal.⁵⁶³ Prostitutes must obtain a license to practice their trade after proving that they have no other means of earning an income.⁵⁶⁴

Sex-trafficking

The penal code and the Prevention of Oppression Against Women and Children Act provide the main legal framework for prosecuting commercial sex-related activities.

The penal code criminalizes a broad range of acts related to trafficking, including: kidnapping or abducting a woman for prostitution or other "immoral purposes"; selling, leasing, buying, hiring, or otherwise procuring a minor for prostitu-

RELEVANT LAWS AND POLICIES

- Penal Code, 1860
- Prevention of Oppression Against Women and Children Act, 2000
- Dowry Prohibition Act, 1980
- National Strategy for Economic Growth, Poverty Reduction and Social Development

tion or other “immoral purposes”; and importing a girl under 21 years of age from a foreign country for illicit intercourse.⁵⁶⁵

The Prevention of Oppression Against Women and Children Act prescribes severe penal sanctions for sex-related trafficking activities. Under the act, those convicted of trafficking women for prostitution or other “illicit immoral act[s]” are subject to a minimum of ten years’ imprisonment and a fine, and may receive life imprisonment or capital punishment.⁵⁶⁶ The act prescribes equivalent punishments for those who aid the principal crime, as well as for brothel caretakers and managers.⁵⁶⁷

NGOs play a significant role in meeting the social welfare and other needs of trafficking victims. NGO efforts encompass offering awareness-raising programs; providing legal aid for victims, including initiating legal action against traffickers; operating safe shelters for victims; providing counseling and health care for victims; and setting up reintegration and rehabilitation programs for victims.⁵⁶⁸

Customary forms of violence

Acid throwing is a prevalent form of violence against women in Bangladesh. In 2000, some 186 incidents of acid throwing were recorded, the majority of which were provoked by family disputes or sparked by a rejection of sexual advances or a proposal of marriage.⁵⁶⁹

The crime of acid throwing is specifically addressed in the Prevention of Oppression Against Women and Children Act, which prescribes capital punishment or life imprisonment and a fine for causing or attempting to cause death to a woman or child by means of a corrosive or similar substance.⁵⁷⁰ Similar punishments apply for causing permanent damage to a woman’s or child’s sight or hearing, or disfiguring the face, breast or sexual organ by the same means.⁵⁷¹ Less severe injuries are punished with 7–14 years’ imprisonment and a fine.⁵⁷² Acid throwing may also be prosecuted under provisions of the penal code relating to the crimes of hurt and grievous hurt.⁵⁷³

IV. Focusing on the Rights of a Special Group: Adolescents

The reproductive rights of adolescents, particularly the girl child, are often neglected. Adolescents face many age-specific disadvantages that are not addressed through formal laws and policies. The ability of adolescents to access the health system, their rights within the family, their level of education, and their vulnerability to sexual violence together determine

the state of their reproductive health and their overall well-being. The following section presents some of the factors that shape adolescents’ reproductive lives in Bangladesh.

A. REPRODUCTIVE HEALTH

Bangladeshi women begin childbearing early in life. By age 19, 58% of women are either pregnant or have already given birth.⁵⁷⁴

Maternal mortality and morbidity rates, which are exacerbated by acute and widespread malnutrition in Bangladesh, are high among adolescent girls.⁵⁷⁵ While the overall maternal mortality ratio is estimated to be 480–600 maternal deaths per 100,000 live births, the ratio exceeds 1,800 per 100,000 live births for those under the age of 19.⁵⁷⁶ Twenty-five percent of all maternal deaths occur to women under the age of 19.⁵⁷⁷ Among married adolescent girls, only 25.7% of 10–14-year-olds and 38.1% of 15–19-year-olds use some form of contraception.⁵⁷⁸

There are no separate national reproductive health policies specifically directed at adolescents.⁵⁷⁹ However, the Health, Nutrition and Population Sector Programme identifies adolescent health care as a key component of reproductive health care.⁵⁸⁰ The program aims to improve the nutritional status of adolescent girls by providing vitamin supplements and nutrition education.⁵⁸¹

Bangladesh’s population policy also has objectives relating to adolescent health, specifically with regard to family planning. (See “Population” for specific objectives relating to adolescents.)

In an attempt to increase adolescents’ awareness of reproductive health issues, the Department of Youth Development within the Ministry of Youth and Sports has developed programs to disseminate information on reproductive health and gender issues.⁵⁸² The project, which is supported by UNFPA, also works with approximately 500 youth clubs that service hard-to-reach groups in underserved areas.

NGO providers of reproductive health services and information include *Nari Maitree*, Concerned Women for Family Development and the Organization for Mothers and Infants.⁵⁸³ Both *Nari Maitree* and Concerned Women for Family Development have expanded reproductive health coverage for adolescents by setting up satellite clinics in various parts of the country.⁵⁸⁴

B. MARRIAGE

The median age at first marriage for women aged 20–49 is 15 years, with a difference of more than one year between urban and rural women.⁵⁸⁵

The Child Marriage Restraint Act, which applies to all citizens of Bangladesh, prescribes punishments for child mar-

riages. The act requires the bridegroom to be at least 21 years of age and the bride to be at least 18.⁵⁸⁶ While marriage to a minor may render the adult spouse criminally liable and subject to imprisonment of up to one month, a fine or both, it does not by itself render the marriage void.⁵⁸⁷ The act punishes any parent or guardian of a minor who promotes or permits a child marriage to be solemnized, or who fails to prevent it from being solemnized, with imprisonment of up to one month, a fine or both.⁵⁸⁸ Likewise, anyone who performs, conducts or permits a child marriage is subject to similar terms of punishment.⁵⁸⁹

The Special Marriage Act allows people of different faiths, except Muslims, or those who do not ascribe to a particular faith, to legally register their marriage. Under the act, the husband must be at least 18 and the wife at least 14.⁵⁹⁰ Additionally, parties under 21 must obtain the consent of the father or guardian to be married.⁵⁹¹ (See “Rights within Marriage” for more information.)

Laws governing Muslims

The Muslim Family Laws Ordinance specifies the legal marriage age as 18 for women and 21 for men.⁵⁹²

Under Muslim personal law, a minor may be given in marriage by his or her guardian until she or he reaches puberty.⁵⁹³ The Dissolution of Muslim Marriages Act allows a minor girl who was married before the age of 16 to repudiate the marriage before reaching 18 years of age, provided the marriage was not consummated.⁵⁹⁴ (See “Rights within Marriage” for more information.)

Laws governing Hindus

Hindu personal law governs marriage among Bangladeshi Hindus.⁵⁹⁵ The law permits child marriage and does not give the girl child the option to repudiate the marriage at any age.⁵⁹⁶

The Hindu Widow’s Re-Marriage Act provides that if the widow remarrying is a minor whose marriage has not been consummated, she may not remarry without the consent of her father or some other living male relative. (See “Rights within Marriage” for more information.)

Laws governing Christians

The Christian Marriage Act allows for the solemnization of marriage between parties, one or both of whom are Christian.⁵⁹⁷ (See “Rights within Marriage” for more information.)

C. EDUCATION

About 82% of primary-school age girls are enrolled in school, with a 60% completion rate.⁵⁹⁸ At the secondary level, about 41% of girls are enrolled in school.⁵⁹⁹ The dropout rate is generally higher in secondary than primary schools, particularly among girls in grades six to ten.⁶⁰⁰

The constitution’s Fundamental Principles of State Policy

enjoin the government to take measures to establish a free and compulsory education system.⁶⁰¹ The Primary Education (Compulsory) Act authorizes the government to provide compulsory education for children aged six to ten.⁶⁰²

One of the primary goals of the National Strategy for Economic Growth, Poverty Reduction and Social Development is to attain universal primary education for all children of primary-school age.⁶⁰³ With regard to secondary education, the strategy pledges to strengthen current initiatives to promote the education of children from low-income families and girls.⁶⁰⁴

Under the Food for Education program, which was launched as a pilot project in 460 unions in 1993, the government provides a free monthly ration of food grain to low-income households as an incentive to keep their primary-school age children in school.⁶⁰⁵ Female-headed households are included among households that qualify for the program.⁶⁰⁶ By 1999–2000, the program had been expanded to 17,403 schools in 1,247 unions, reaching 2.2 million households and 2.3 million students.⁶⁰⁷

Initiatives to increase the enrollment of girls in secondary school include an assistance program under which girls in grades six to ten who study at recognized schools and *madrasas* outside of urban areas receive free tuition and a stipend for books.⁶⁰⁸ The government has pledged to extend such assistance to grade 12.⁶⁰⁹

The Non-Formal Education System operates coeducational centers to meet the needs of students who have had to abandon formal schooling or who have been unable to attend formal schooling altogether.⁶¹⁰ Through nonformal education programs, children receive basic education and practical training and have the option of re-enrolling in formal schools for completion of their nonformal curriculum.⁶¹¹ The Directorate of Non-Formal Education has been responsible for developing both rural- and urban-based projects to provide learning opportunities for working children aged 8–14.⁶¹² Learning centers have been set up and managed by approximately 150 NGOs under the care of the directorate.⁶¹³ By December 2000, a total of 3,375 centers had been established with approximately 100,000 students, more than half of whom were girls.⁶¹⁴ The Bangladesh Rural Advancement Committee is one NGO that has been providing children with nonformal education since 1985 in remote villages of the country. The organization works in over 62,000 villages and operates some 34,000 schools with a current enrollment of 1.1 million children.⁶¹⁵

Knowledge of reproductive health, including reproduction, sexuality and menstruation, is extremely limited among Bangladeshi adolescents.⁶¹⁶ Moreover, their knowledge about symptoms of STIs and HIV/AIDS, as well as on how

STIs are transmitted and prevented, is less than adequate.⁶¹⁷

The National Policy on HIV/AIDS and STD Related Issues highlights the importance of providing adolescents with access to accurate and relevant information on sexual health.⁶¹⁸ It encourages educational institutions at all levels to include HIV/AIDS in their curricula.⁶¹⁹ (See “Education” for more information.)

An STD/AIDS Network, composed mainly of NGOs, was formed in 1993 to enable NGOs, in cooperation with the government, to coordinate a plan of action on STI/AIDS education and prevention. A number of NGO programs for adolescents include HIV/AIDS awareness in their health education activities.⁶²⁰

D. SEXUAL OFFENSES AGAINST MINORS

Reliable quantitative data on the prevalence of sexual abuse, sexual exploitation and child trafficking in Bangladesh is not available. However, small-scale studies indicate that these are rapidly growing problems that demand greater attention.⁶²¹ In one survey of child sexual abuse, more than half of all respondents had experienced some form of such abuse; children ages 10–14 experienced the most frequent abuse.⁶²²

The Prevention of Oppression Against Women Act criminalizes acts related to the sexual exploitation of minors. Under the act, trafficking in children, defined as persons under the age of 14, is punishable with death or life impris-

onment and a fine.⁶²³ The crimes of kidnapping, rape and “sexual oppression” under the act apply to children as well as adult women.⁶²⁴ (See “Right to Physical Integrity” for more information on these crimes.) The act trumps the punishments prescribed in the penal code for crimes relating to the sexual exploitation and trafficking of children, which are less severe than those under the act.⁶²⁵

In addition to legislation, Bangladesh has a specific national policy combating sexual abuse against minors. The National Plan of

Action against the Sexual Abuse and Exploitation of Children including Trafficking, adopted in 2002, identifies issues, objectives and strategies under the following seven broad “themes”:

- prevention;
- protection;
- recovery and reintegration;
- perpetrators;
- child participation;
- STIs, HIV/AIDS and substance abuse;
- coordination and monitoring.⁶²⁶

The plan’s objectives include the elimination of “child marriage,” the establishment of a system for identifying, reporting and providing referrals in cases of sexual offenses against minors, and the creation of safe havens for child victims of sexual abuse and exploitation, and children at risk.⁶²⁷

RELEVANT LAWS AND POLICIES

- National Plan of Action against the Sexual Abuse and Exploitation of Children including Trafficking, 2002

ENDNOTES

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390. BANGLADESH: A NATIONAL STRATEGY FOR ECONOMIC GROWTH, POVERTY REDUCTION AND SOCIAL DEVELOPMENT, *supra* note 125, annex 8, at 110.

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398. *Id.*
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403. *Id.* §§ 1(1), 16.
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405. *Id.*
406. Child Marriage Restraint Act, No. 19, 1929 § 2(a) (Bangl.). There is an anomaly in the law with respect to the minimum age of marriage laid down in the Special Marriages Act and the Child Marriage Restraint Act. Pursuant to the Child Marriage Restraint Act, it is probable that a parent can longer authorize an underage marriage as permitted in the Special Marriages Act, but the law is not clear. See Communication with Salma Sobhan, *supra* note 119.
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409. Communication with Salma Sobhan, *supra* note 119. The act does make an exception for Muslim dower. Dowry Prohibition Act, No. XXXV, 1980 § 2(b) (Bangl.).
410. Communication with Salma Sobhan, *supra* note 119. Such withholding has caused Hindu married women considerable financial hardship. *Id.*
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415. Muslim Marriages and Divorces (Registration) Act, No. LII, 1974, §§ 3–4 (Bangl.).
416. *Id.* § 5.
417. Muslim Family Laws Ordinance, No. VII, 1961 § 2(a)–(b) (Bangl.).
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419. *Id.* § 6(3). Muslim Family Law Rules, No. 658 Jd. IV/IA–2/611961, § 14 (Bangl.).
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422. Muslim Family Laws Ordinance, No. VII, 1961 § 6(5) (Bangl.).
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426. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.1.
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434. *Id.* § 7(4).
435. *Id.* §§ 7(3), 7(5).
436. See *id.* § 8.
437. *Id.* § 10 (comments).
438. Dissolution of Muslim Marriage Act, No. 8, 1939, §§ 2(i)–(iv), (vi)–(ix) (Bangl.).
439. *Id.* §§ 2(viii)(a)–(f).
440. See CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.3.
441. See *id.*
442. Communication with Naripokkho, *supra* note 401, at 6 (citing Hindu Married Women's Right to Separate Residence and Maintenance Act, 1946 (Bangl.)).
443. *Id.*
444. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.3.
445. Communication with Naripokkho, *supra* note 401, at 7 (citing Divorce Act, 1869 (Bangl.)). See CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.3.
446. Communication with Naripokkho, *supra* note 401, at 7 (citing Divorce Act, 1869 (Bangl.)).
447. *Id.* (citing Divorce Act, 1869, §§ 18–21 (Bangl.)).
448. *Id.* at 8 (citing Divorce Act, 1869, §§ 22–25 (Bangl.)).
449. Muslim Family Laws Ordinance, No. VII, 1961 § 9 (comments) (Bangl.).
450. *Id.*
451. *Id.* § 9(1)
452. *Id.* § 9 (comments).
453. *Id.* § 9(1), (3).
454. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.2.
455. *Id.* ¶ 2.15.3.
456. *Id.* ¶ 2.15.8.
457. Elimination of all forms of religious intolerance: Note by the Secretary-General, *supra* note 123.
458. *Id.*
459. LAW & RELIGION PROGRAM, EMORY LAW SCHOOL, LEGAL PROFILES: BANGLADESH, <http://www.law.emory.edu/IFL/index2.html> (last visited Mar. 2, 2004). See also Elimination of all forms of religious intolerance: Note by the Secretary-General, *supra* note 123.
460. See Communication with Naripokkho, *supra* note 401, at 10.
461. See *id.*
462. See *id.*
463. LAW & RELIGION PROGRAM, EMORY LAW SCHOOL, *supra* note 459.
464. RAMOS-JIMENEZ & CANDOR, *supra* note 206, at 15.
465. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.5.
466. See *id.* ¶ 2.15.5.
467. ADB COUNTRY BRIEFING PAPER: WOMEN IN BANGLADESH, *supra* note 380, at 6.
468. Hindu Widow's Re-Marriage Act, No. XV, 1856 § 3 (Bangl.).
469. *Id.*
470. *Id.*
471. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.5.
472. *Id.*
473. *Id.*
474. BANGL. CONST., art. 42.
475. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.6.
476. See HIDAYATULLAH & HIDAYATULLAH, *supra* note 432, § 63.
477. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.6.
478. *Id.*
479. *Id.*
480. *Id.*
481. *Id.*
482. *Id.*
483. RAMOS-JIMENEZ & CANDOR, *supra* note 206, at 15. See also CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.6.
484. RAMOS-JIMENEZ & CANDOR, *supra* note 206, at 15.
485. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.6.
486. RAMOS-JIMENEZ & CANDOR, *supra* note 206, at 15.
487. *Id.*
488. Communication with Salma Sobhan, *supra* note 119.
489. Married Women's Property Act, No. III, 1874, § 4 (Bangl.).
490. *Id.* § 5.
491. *Id.* § 7.
492. An extended definition of labor force was used. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, tbl. 9. 1995–1996 appears to be the most recent year for which this data is available. See DATA SHEET 1999, *supra* note 50, § 5.
493. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, tbl. 12.
494. *Id.* ¶¶ 1.2.5, 2.10.4.
495. See *id.* ¶ 1.2.5.
496. See *id.* ¶ 1.2.1.
497. BANGL. CONST., art. 29(c).
498. *Id.* art. 15(b).
499. *Id.* art. 20.
500. BANGLADESH: A NATIONAL STRATEGY FOR ECONOMIC GROWTH, POVERTY REDUCTION AND SOCIAL DEVELOPMENT, *supra* note 125, annex 8, at 109.
501. ICPD PROGRAMME OF ACTION: WHAT HAS BEEN DONE IN BANGLADESH, *supra* note 107, ¶ 3.6; CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.6.4.
502. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.3.7.
503. Tahera Ahmed & Abdul Wahab, *Population, Development and Education*, in POPULA-

- TION AND DEVELOPMENT ISSUES IN BANGLADESH: NATIONAL PLAN OF ACTION BASED ON ICPD '94 RECOMMENDATIONS, *supra* note 320, at 211.
504. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.3.6.
505. *Id.*
506. *Id.*
507. *Id.*
508. *Id.*
509. BANGLADESH: A NATIONAL STRATEGY FOR ECONOMIC GROWTH, POVERTY REDUCTION AND SOCIAL DEVELOPMENT, *supra* note 125, annex 8, at 109.
510. News Release No. 99/2063/SAS, The World Bank Group, New Study Confirms Benefits of Bangladesh's Microcredit Programs (Jan. 14, 1999) (on file with Center for Reproductive Rights); Development Economics Vice Presidency & Poverty Reduction and Education Management Network (PREM), The World Bank, PREM NOTES, no. 8, *Using microcredit to advance women 1* (1998).
511. New Study Confirms Benefits of Bangladesh's Microcredit Programs, *supra* note 510.
512. *Using microcredit to advance women*, *supra* note 510, at 2.
513. ICPD PROGRAMME OF ACTION: WHAT HAS BEEN DONE IN BANGLADESH, *supra* note 107, ¶ 3.6.
514. Communication with Salma Sobhan, *supra* note 119.
515. *Using microcredit to advance women*, *supra* note 510, at 2.
516. New Study Confirms Benefits of Bangladesh's Microcredit Programs, *supra* note 510.
517. Zinatun Nesa Talukdar, State Minister of Ministry of Women and Children Affairs, Statement at the Special Session of the U.N. General Assembly Women 2000: Gender Equality, Development and Peace for the Twenty-First Century (June 5, 2000), <http://www.un.org/womenwatch/daw/followup/beijing+5stat/statments/bangladesh5.htm> (last visited Feb. 16, 2004).
518. BANGL. CONST., art. 28.
519. *Id.* art. 17(a).
520. *Id.* art. 17(b)–(c).
521. (Obligation to) Primary Education Act, 27, 1990 § 3 (Bangl.); UNESCO BANGKOK, GOOD PRACTICES: GENDER EQUALITY IN BASIC EDUCATION AND LIFELONG LEARNING THROUGH CLCs: EXPERIENCES FROM 15 COUNTRIES, pt. 2, at 19 (2003). See also BUDGET SPEECH 2003–2004, *supra* note 126, ¶ 20.
522. MINISTRY OF EDUCATION, GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH, NATIONAL EDUCATION POLICY 2000: ENGLISH VERSION, ch. 2(B)(1).
523. *Id.* ch. 17.
524. See *id.* ch. 3.
525. See *id.*
526. ICPD PROGRAMME OF ACTION: WHAT HAS BEEN DONE IN BANGLADESH, *supra* note 107, ¶ 3.7.
527. BANGLADESH: A NATIONAL STRATEGY FOR ECONOMIC GROWTH, POVERTY REDUCTION AND SOCIAL DEVELOPMENT, *supra* note 125, ¶ 4.1, at 23.
528. *Id.* ¶ 5.65, at 46.
529. *Id.* ¶ 4.1, at 23. See annex 8 for specific measures to achieve this goal.
530. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.4.
531. *Id.*
532. *Id.*
533. Report of the Special Rapporteur on violence against women, its causes and consequences, Radhika Coomaraswamy, in accordance with Commission on Human Rights Resolution 2000/45, Addendum, ¶ 8.
534. BANGL. PEN. CODE § 375. The code defines sexual intercourse as an act of actual penetration. Partial penetration that does not result in injury to the hymen is also sufficient to constitute the crime of rape. *Id.* § 376.
535. *Id.* § 375 (comments).
536. *Id.* § 375 Exception.
537. *Id.* § 376 (comments).
538. *Id.* Cruelty to Women (Deterrent Punishment) Ordinance, No. LX, No. 1983, § 7 (comments) (Bangl.).
539. Prevention of Oppression Against Women and Children Act, No. VIII, 2000, § 2(c) (Bangl.) (unofficial trans., on file with the Center for Reproductive Rights).
540. *Id.* § 9(i).
541. *Id.* § 9(ii).
542. *Id.* § 9(iv)(a)–(b).
543. *Id.* § 9(iii).
544. *Id.* § 9(v).
545. *Id.* § 13. Financial responsibility continues until a male child reaches 21 years of age and a female child married; if the child is disabled, until he or she has the capacity to earn a living.
546. *Id.* § 18(i), 19(ii).
547. *Id.* § 15.
548. *Id.* § 18(v).
549. Special Marriage Act, No. 3, 1872, § 3 (Bangl.).
550. See BANGL. PEN. CODE §§ 319, 320.
551. See *id.* § 312.
552. Prevention of Oppression Against Women and Children Act, No. VIII, 2000, § 4 (Bangl.) (unofficial trans. on file with Center for Reproductive Rights).
553. Dowry Prohibition Act, No. XXXV, 1980, §§ 3, 4 (Bangl.).
554. Prevention of Oppression Against Woman [sic] and Children Act, No. VIII, 2000, § 11 (ii) (Bangl.).
555. *Id.*
556. Dissolution of Muslim Marriage Act, No. 8, 1939, § 2(viii) (Bangl.).
557. BANGL. PEN. CODE § 354.
558. *Id.*
559. Prevention of Oppression Against Women and Children Act, No. VIII, 2000, § 10 (Bangl.).
560. *Id.*
561. BANGL. CONST., art. 18(2).
562. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.5.2.
563. *Bangladesh says prostitution legal*, BBC NEWS, Mar. 14, 2000.
564. *Id.*
565. See BANGL. PEN. CODE, §§ 366, 366A, 372–373, 366B.
566. Prevention of Oppression Against Women and Children Act, No. VIII, 2000, § 5 (Bangl.) (unofficial trans., on file with the Center for Reproductive Rights).
567. *Id.* § 5(ii)–(iii).
568. See CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.5.1.
569. Report of the Special Rapporteur on violence against women, its causes and consequences, *supra* note 533, ¶ 6. Saira Rahman, HURIGHTS Osaka, *Reflections on Women and Violence in Bangladesh* (2001), http://www.hurights.or.jp/asia-pacific/no_24/05Saira.htm (last visited Feb. 19, 2004).
570. Prevention of Oppression Against Women and Children Act, No. VIII, 2000, § 4(i) (Bangl.) (unofficial trans., on file with the Center for Reproductive Rights).
571. *Id.* § 4(ii)(a).
572. *Id.* § 4(ii)(b), (iii).
573. See BANGL. PEN. CODE §§ 319–320.
574. CRC Committee, Second periodic reports of States parties due in 1997: Bangladesh, *supra* note 51, ¶ 208.
575. See CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 1.2.3.
576. RAMOS–JIMENEZ & CANDOR, *supra* note 206, at 8.
577. *Id.* at 8.
578. BANGLADESH DEMOGRAPHIC AND HEALTH SURVEY 1999–2000, *supra* note 223, tbl. 4.7.
579. See RAMOS–JIMENEZ & CANDOR, *supra* note 206, at 10; see also Communication with Naripokkho, *Focusing on the Rights of a Special Group: Adolescents*, at 10 (2002) (on file with Center for Reproductive Rights).
580. CONCEPTUAL FRAMEWORK FOR HEALTH, NUTRITION AND POPULATION SECTOR PROGRAMME, *supra* note 146, ¶ 4.02.
581. *Id.* ¶ 4.04.
582. CRC Committee, Second periodic reports of States parties due in 1997: Bangladesh, *supra* note 51, ¶ 211.
583. Umrun Nahar, et al., Centre for Health and Population Research, *Reproductive Health Needs of Adolescents in Bangladesh: A Study Report*, at 11, Working Paper No. 161 (1999).
584. *Id.*
585. See BANGLADESH DEMOGRAPHIC AND HEALTH SURVEY 1999–2000, *supra* note 223, § 5.3, tbls. 5.3–5.4.
586. Child Marriage Restraint Act, No. 19, 1929, § 2, amended by Ordinances No. XXVII and No. XXXVIII, 1984 (Bangl.).
587. Child Marriage Restraint Act, No. 19, 1929, § 4, amended by Ordinance No. XXXVII, 1984 (Bangl.).
588. Child Marriage Restraint Act, No. 19, 1929, § 6 (Bangl.).
589. *Id.* § 5.
590. Special Marriage Act, No. 3, 1872, § 2(2) (Bangl.).
591. *Id.* § 2(3).
592. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.15.1.
593. UNITED NATIONS CHILDREN'S FUND (UNICEF) BANGLADESH, SUMMARY OF REPORT: BACKGROUND PAPER ON GOOD PRACTICES AND PRIORITIES TO COMBAT SEXUAL ABUSE AND EXPLOITATION OF CHILDREN IN BANGLADESH 12 (2002).
594. Dissolution of Muslim Marriage Act, No. 8, 1939, § 2(vii) (Bangl.).
595. See Elimination of all forms of religious intolerance: Note by the Secretary-General, *supra* note 123.
596. SUMMARY OF REPORT: BACKGROUND PAPER ON GOOD PRACTICES AND PRIORITIES TO COMBAT SEXUAL ABUSE AND EXPLOITATION OF CHILDREN IN BANGLADESH, *supra* note 593.
597. Communication with Naripokkho, *supra* note 401, at 4 (citing Christian Marriage Act, 1872 (Bangl.)).
598. CEDAW Committee, Third and fourth periodic reports of states parties: Bangladesh, *supra* note 17, ¶ 2.9.1.
599. CRC Committee, Second periodic reports of States parties due in 1997: Bangladesh, *supra* note 51, ¶ 263.
600. *Id.*
601. BANGL. CONST., art. 17.
602. CRC Committee, Second periodic reports of States parties due in 1997:

- Bangladesh, *supra* note 51, ¶ 234.
603. BANGLADESH: A NATIONAL STRATEGY FOR ECONOMIC GROWTH, POVERTY REDUCTION AND SOCIAL DEVELOPMENT, *supra* note 125, ¶ 4.1, at 23.
604. *Id.* ¶ 5.65, at 46.
605. CENTRE FOR POLICY DIALOGUE (CPD), POLICY BRIEF ON “EDUCATION POLICY”: CPD TASK FORCE REPORT, at 10.
606. BANGLADESH DEVELOPMENT GATEWAY, EDUCATION: FOOD FOR EDUCATION (on file with Center for Reproductive Rights).
607. POLICY BRIEF ON “EDUCATION POLICY”: CPD TASK FORCE REPORT, *supra* note 605.
608. CRC Committee, Second periodic reports of States parties due in 1997: Bangladesh, *supra* note 51, ¶ 265.
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613. *Id.* ¶ 257.
614. *Id.*
615. BANGLADESH RURAL ADVANCEMENT COMMITTEE (BRAC), ABOUT BRAC, www.brac.net/aboutb.htm (last visited Mar. 2, 2004); BUREAU OF DEMOCRACY, HUMAN RIGHTS, AND LABOR, U.S. DEPARTMENT OF STATE, *Country Report on Human Rights Practices for 2000: Bangladesh*, in STATE DEPARTMENT HUMAN RIGHTS REPORT 29 (2001) <http://www.usaid.gov/bd/files/hrr2000.pdf> (last visited Feb. 20, 2004).
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619. *Id.*
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623. Prevention of Oppression Against Woman and Children Act, No.VIII, 2000 §§ 2(k), 6 (Bangl.).
624. *Id.* §§ 7, 9–10.
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626. See MINISTRY OF WOMEN AND CHILDREN AFFAIRS, GOVERNMENT OF THE PEOPLE’S REPUBLIC OF BANGLADESH, NATIONAL PLAN OF ACTION AGAINST THE SEXUAL ABUSE AND EXPLOITATION OF CHILDREN INCLUDING TRAFFICKING 10 (2002).
627. *Id.* at 16, 19–20.