

January 7, 2011

The Committee on the Elimination of Discrimination against Women

Re: Supplementary information on Bangladesh
Scheduled for review by the CEDAW Committee in its 48th Session

Dear Committee Members:

This letter is submitted to supplement the periodic report submitted by Bangladesh, which is scheduled for review by this Committee during its 48th Session in Geneva. The Center for Reproductive Rights (the Center), an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) as they are expressed in Bangladesh.

We wish to bring the Committee's attention to several areas of concern, including (1) the extremely high maternal mortality rate in Bangladesh, and the lack of updated indicators providing information on the leading causes of death; (2) the lack of data on maternal morbidity, including obstetric fistula, and the progress of programs implemented to attempt to address this problem; (3) the extremely high incidence of early pregnancy in Bangladesh; and (4) the disparities in access to reproductive health services experienced by rural women.

I. The Right to Reproductive Health Services and Information (Articles 10, 12, 14(2)(b), and 16(1)(e))

Reproductive rights are fundamental to women's health and social equality and are an explicit part of the Committee's mandate under CEDAW. Accordingly, a State's commitment to respect, protect, and fulfill these rights should receive serious attention.¹ Specifically, the Convention commits States that have ratified it to "ensure...[a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning;"² to "take all appropriate

measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those relating to family planning;”³ to “ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary;”⁴ and to “ensure, on a basis of equality between men and women...[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”⁵

A. Lack of Access to Quality Maternal Healthcare & Insufficient Data on Maternal Health

States parties to the CEDAW have a duty to ensure maternal health by providing women with the “appropriate services in connection with pregnancy” and by “promoting a proper understanding of maternity as a social function.”⁶ The CEDAW Committee has emphasized that high rates of maternal mortality and morbidity indicate potential violations of this duty.⁷ Similarly, the United Nations Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health has noted that “[a]voidable maternal mortality violates women’s rights to life, health, equality and non-discrimination.”⁸

Bangladesh ranks eighth in the world for number of maternal deaths worldwide,⁹ which is estimated by the World Health Organization (WHO) to currently be 12,000 deaths a year.¹⁰ The WHO has found that Bangladesh has a maternal mortality ratio (MMR) of 340 maternal deaths per 100,000 live births.¹¹ The WHO has also classified Bangladesh as a country “lacking good complete registration data” on maternal deaths,¹² qualifying that estimates of **the country’s MMR could be as high as 660.**¹³ The country itself estimates its MMR to be 348 as of 2007, according to its 2009 Progress Report on the Millennium Development Goals (2009 MDG Progress Report).¹⁴ Even under the government’s current projections, Bangladesh is only set to reach an MMR of 222 by 2015; by any estimate, Bangladesh is **falling far short of its MMR target** of 143 per 100,000 live births as defined by MDG 5.¹⁵ Furthermore, Bangladesh’s MMR, even by the government’s own measure, is **well above the South Asia regional average of 280 deaths.**¹⁶

As noted above, the WHO has characterized Bangladesh as lacking a comprehensive registration data of maternal deaths.¹⁷ The United Nations Population Fund (UNFPA) has similarly noted that Bangladesh must strengthen its maternal death reporting system, and has recommended that the country institute

perinatal death reviews, which would include verbal autopsies for deaths that occur at home and clinical audits for those that occur in health facilities.¹⁸ The dearth of comprehensive data on maternal health in Bangladesh includes a lack of updated information about the causes of both maternal death and maternal morbidity. The most recent data on the major causes of pregnancy-related deaths was compiled in 2001; this continues to be the data cited by the government.¹⁹ According to this study, the major causes of pregnancy related deaths are post-partum hemorrhage, eclampsia, obstructed labor, and unsafe abortion.²⁰ This study, however, has not been updated, and hard data on the causes of maternal mortality was therefore not included in the 2007 Bangladesh Demographic Health Survey (BDHS) conducted by the government. As a result, **there is a complete lack of data on current causes of maternal death, as well as a lack of detailed information on the leading causes of such death.**²¹ For example, despite the fact that unsafe abortion is listed as a major cause of maternal death and it is illegal in most circumstances,²² the government of Bangladesh has not published any recent numbers on the specific mortality due to unsafe abortion. Similarly, the United Nations Children's Fund (UNICEF) and UNFPA have recently each noted in their maternal health profiles of Bangladesh **that 14% of maternal deaths are due to violence against women.**²³ Discussing the role of gender-based violence in maternal mortality in Bangladesh in its 2009 MDG Progress Report, the government noted that "[t]here is increasing recognition of the importance of improved gender equity in health sector plans and programmes, but implementation of policies and plans has thus far, been limited."²⁴ However, while the State party has indicated the need to gather general data on violence against women,²⁵ it has failed to provide any information on why this is such a significant cause of maternal mortality or what steps it has taken to address this situation.²⁶ Additionally, in its 2005 progress report on the MDGs, the government of Bangladesh stated **that reliable estimates are not available for maternal morbidity;**²⁷ the 2009 MDG Progress Report does not even broach this issue.

Bangladesh is also failing significantly in providing quality maternal health services that meet internationally-recognized medical standards. The WHO recommends that women receive four antenatal visits during a pregnancy, beginning in their first trimester of pregnancy.²⁸ Under the MDGs, Bangladesh has committed to providing 100% of the pregnant women population with four antenatal visits during pregnancy.²⁹ Yet, in Bangladesh, only 21% of all women are able to access four antenatal checkups.³⁰ **Almost 40% of women do not receive even a single antenatal checkup** during their entire pregnancy³¹ and only 24% of all women receive their first antenatal care visit during the first trimester.³²

Overwhelmingly, Bangladeshi women deliver at home without access to trained medical providers.

Over 60% of women in Bangladesh deliver their children with just an untrained birth attendant or a *dai*, while 6% are attended by relatives, friends, and neighbors, and 2% are unattended completely.³³

Only 18% of all births in Bangladesh are attended by a medically trained provider,³⁴ and only 22% of births occur in health facilities.³⁵ Unsurprisingly, Bangladesh reported in its 2009 MDG Progress Report that the proportion of childbirths attended by skilled birth attendants is “still very low,”³⁶ and meeting the target under the MDGs for 50% skilled delivery attendance by 2015 “will be extremely challenging.”³⁷

Government public facilities for emergency obstetric care are insufficient and too poorly equipped to meet human rights standards. Of the few women who do give birth in health facilities, most seek care in the private sector rather than the public sector,³⁸ indicating that women face significant difficulties in accessing government-provided care. In the 2009 MDG Progress Report, the government of Bangladesh stated that even in the health facilities, there are concerns about the availability and quality of skilled attendants,³⁹ which leads to a low utilization of emergency obstetric care.⁴⁰ In order to ensure access to emergency obstetric care, the government needs to create 24-hour health facilities.⁴¹ However, **public spending on health has remained relatively small**, in part due to official procedures that allocate public resources based on renewing past allocations rather than adjusting the amount of funding based on accurate indicators of need.⁴²

Postnatal care, which is crucial in the prevention of maternal mortality and the prevention, detection, and treatment of maternal morbidity, is also severely lacking in Bangladesh. A significant percentage of maternal deaths occur during the 24 hours following delivery,⁴³ and the first two days following delivery are a crucial period for monitoring complications related to delivery.⁴⁴ Further, besides assessing and treating delivery complications, postnatal checkups are when medical providers can counsel women on how to care for themselves and their children post-delivery.⁴⁵ According to the 2007 BDHS, only 21% of women received postnatal care by a doctor, nurse, or midwife, while 9% of women received postnatal care from a non-medically trained provider. Strikingly, **70% received no postnatal checkup at all.**⁴⁶ Of women with complications, less than half (42%) received treatment for these complications from a medically trained provider.⁴⁷

There are serious underlying sociocultural factors which expose women to greater risks to their maternal health. **Many women face extreme difficulty in seeking reproductive healthcare, as a result of social marginalization, lack of autonomy in personal decisions, and low socio-economic status.**⁴⁸ Practices

such as early marriage and early childbearing, discussed below, as well as poor male and community participation in issues related to maternal health compound the barriers faced by women.⁴⁹ UNICEF has specifically noted that there is “little understanding about the need for rest and additional nutritious foods during pregnancy,”⁵⁰ and that “the low status of women within the family means one in every two women will have her health care decided by her husband.”⁵¹ In a context where violence against women constitutes such a significant cause of maternal death, it is essential to note that, due to the country’s patriarchal social structure, few women who have experienced violence go to the hospital seeking care.⁵² Addressing these sociocultural barriers is a necessary step to reduce maternal mortality and morbidity.

High Incidence of Fistula

The lack of access to quality maternal health services puts Bangladeshi women at risk of serious maternal morbidity, as well as mortality. Obstetric fistula is a form of maternal morbidity particularly pervasive in Bangladesh. **The most recent public estimates of obstetric fistula, from 2002, found that nationwide, over 400,000 women were living with vesicovaginal fistula while 16,000 women had rectovaginal fistula.**⁵³ Obstetric fistula occurs when women experience prolonged labor without timely medical intervention, resulting in harm to the tissue either separating the vagina and the bladder (vesicovaginal fistula) or the vagina and the rectum (rectovaginal fistula).⁵⁴ Vesicovaginal fistula leads to a woman’s inability to control her bladder and ultimately experiencing uncontrollable urine leakage, while rectovaginal fistula leaves a woman unable to control her bowel movements and to leak feces.⁵⁵ Due to both the constant leakage and the resulting smell, women with obstetric fistula are often ostracized by their communities, abandoned by their spouses, and unable to find employment. Their health and lives may be further seriously compromised, as obstetric fistula can cause stillbirths and result in a range of incontinence-related infections if left untreated.⁵⁶

A high incidence of obstetric fistula is indicative of a wide range of human rights violations both in neglecting to prevent the injury, as well as in failing to adequately provide for detection and treatment once it has occurred.⁵⁷ While obstetric fistula has been eliminated in almost all industrialized countries through quality maternal healthcare,⁵⁸ it persists in some developed countries due to insufficient availability of healthcare, and because of discriminatory social practices. Many of the same sociocultural issues that give rise to vulnerability to maternal mortality also lead to an increased risk of obstetric fistula, including a reliance on harmful traditional practices in childbirth.⁵⁹ Obstetric fistula reflects the State’s failure to provide accessible and quality maternal healthcare, as well as to prevent early pregnancy as

required under CEDAW. Early pregnancy and inadequate nutrition also lead to a greater risk of obstetric fistula due to the pregnant woman's smaller pelvic size.⁶⁰ Moreover, a lack of antenatal and postnatal care due to poverty and residence in rural areas have both been shown to predispose women to obstetric fistula,⁶¹ and to lead to barriers in seeking medical care.⁶² As stated above, the failure to treat obstetric fistula also further violates women's rights. The State has an obligation to ensure access to healthcare necessary to protect women's reproductive health, as well as to address the socially isolating effects of fistula and the devastating impact on women's health and quality of life.⁶³

The high incidence of fistula in Bangladesh is well-recognized by the international community, and Bangladesh is a target country for UNFPA's Campaign to End Fistula.⁶⁴ However, while international efforts to address this issue have begun, **there exists a lack of data on the current incidence of obstetric fistula**, as well as on the underlying social and economic inequities that specifically need to be addressed to reduce this morbidity in Bangladesh. The last comprehensive study of obstetric fistula in Bangladesh was published in 2003, and relies on data from that same year.⁶⁵ Current data is essential to developing effective policies and monitoring progress,⁶⁶ including determining whether the incidence of fistula has in fact been reduced as a result of the existing interventions.

B. Lack of Access to a Full Range of Contraceptive Methods

Access to contraceptives and family planning is central to protecting women's rights to life and health. The CEDAW Committee has reiterated that lack of access to contraceptives impedes women's right to "decide freely and responsibly on the number and spacing of their children."⁶⁷ In order to protect these rights, "women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services."⁶⁸

In Bangladesh, contraceptive prevalence rate for married women is 56%,⁶⁹ meaning **almost half of all married women do not use contraceptives**. 57% of contraceptive users in Bangladesh stop using their chosen method within 12 months of starting.⁷⁰ The 2007 BDHS establishes that the unmet need for family planning is 16.8 percent,⁷¹ which represents **an increase in the percentage of women with unmet need** from the previous BDHS figures measured in 2004.⁷² Contraceptive use has particularly declined between 2004 and 2007 among several specific populations, including markedly decreasing for women above 30, among women with little or no education, and in all but two administrative regions.⁷³ These numbers indicate that **Bangladesh is falling short of meeting another of its MDG targets, under**

which Bangladesh has committed to *reducing* the unmet need for family planning to 7.6% by 2015.⁷⁴

Looking beyond the national level statistics, it is important to note that significant disparities exist both in contraceptive methods used among women, as well as in availability of modern methods throughout regions. For example, only 25% of married women in Sylhet, the region with the highest fertility rate, use modern methods compared to more than 50% in Khulna and Rajshahi.⁷⁵ Even among those that have access to modern methods, there exists a disproportionate reliance on short-term methods, rather than long-term methods. Experts have repeatedly noted that the preponderance of one method is indicative of provider bias/service provision bias,⁷⁶ meaning that women are not given access to a full range of methods and choices. The pill is by far the most popular method followed by injectables. Overall, less than 8% of women rely on long-term and highly effective methods like the intrauterine device and sterilization.⁷⁷ BDHS data reflects that use of long-term methods decreased sharply for over a decade, but appears to have stabilized somewhat in 2007; long-term method use is only at 7% amongst married women, whereas in 1993-1994 this number was at 11%.⁷⁸ The 2007 BDHS states that a “significant shortage” of injectables in Bangladesh, which negatively impacted provision of this particular method, could be the cause of this decrease.⁷⁹

II. The Right to Non-Discrimination (Articles 1, 2, 12, and 14)

The CEDAW Committee has recognized that the right to healthcare should be upheld without discrimination to either biological, societal,⁸⁰ or geographic factors. The CEDAW Convention is violated, therefore, when adolescent women or rural women face disproportionate risks of maternal mortality and morbidity.

A. Discrimination in Fulfillment of the Right to Maternal Health for Rural Women

Under CEDAW, States parties “shall take into account the particular problems faced by rural women”⁸¹ and “shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.”⁸² CEDAW Article 14(2)(b) establishes that States parties must “take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure...access to adequate health care facilities, including information, counselling, and services in family planning.”⁸³

While access to maternal healthcare is limited for all women in Bangladesh, urban and rural women experience serious disparities in accessing antenatal and postnatal care. The disparities are most evident in the MMRs—the MMR in rural areas is 393, nearly 40% higher than the MMR in urban areas (242).⁸⁴

Additionally, the government estimates that **urban women are 2.5 times more likely than rural women to have made the four or more antenatal visits** that WHO has established as the global standard for maternal healthcare.⁸⁵ There are significant disparities regarding type and quality of medical attention during childbirth as well. Women in urban areas are 3 times more likely than women in rural areas to give birth in a health facility.⁸⁶ **Only 13% of rural women's births are attended by medically trained providers**, compared to 36.5% of urban women. Rural women are also less likely to receive iron supplements to protect against anemia and hemorrhage, or key antenatal services, including receiving routine blood and/or urine tests, being weighed, and receiving an ultrasound.⁸⁷ While postnatal care is extremely low for women nationwide, rural women are much less likely to receive it: **74% of rural women receive no postnatal care**, compared to the 55.5% of urban women.⁸⁸

B. Discrimination in Fulfillment of the Right to Reproductive Health for Adolescents

Under General Recommendation 24, the CEDAW Committee guarantees adolescent women the right to healthcare without distinction from adult women,⁸⁹ stating that “special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as...the girl child.”⁹⁰ The Committee has specifically expressed concern about the challenges young women face in seeking reproductive healthcare⁹¹ and repeatedly expressed concern about high rates of early pregnancy in its Concluding Observations to States parties.⁹²

Early childbearing is a common practice in Bangladesh and constitutes an extreme violation of women's rights to survive pregnancy and childbirth.⁹³ Bangladesh has the highest percentage of females married by age 18 in all of South Asia and ranks fourth in the world for percentage of girls married by age 18.⁹⁴ Two out of three women marry before the legal age of 18.⁹⁵ Further, in Bangladesh, **the number of deaths due to pregnancy is double among adolescents.**⁹⁶ Childbearing among adolescent females has not declined despite the fact that all other age groups have experienced a substantial decrease.⁹⁷ Nationally, **33% of adolescents have begun childbearing**, a number that has not changed since at least

2004.⁹⁸ The government has estimated the adolescent birth rate to be 60 pregnancies per 1,000 women, while agencies like UNICEF have placed that number as high as 127 births per 1,000 women.⁹⁹ Even with the government's lower estimate, **Bangladesh's adolescent birth rate is one of the world's highest.**¹⁰⁰ In Bangladesh, early pregnancy tends to **further marginalize already marginalized groups** and occurs more frequently in rural areas, among the poor and the less educated.¹⁰¹ Almost half of all women with no education have already begun childbearing¹⁰² and in the lowest wealth quintile, 42% of adolescents have begun childbearing, as compared to 20% in the highest wealth quintile.¹⁰³

Both antenatal and postnatal care are extremely lacking for adolescent women. Only 55.8% of pregnant women under 20 receive antenatal care from a medically trained provider. This means **almost half do not receive medical attention from a trained provider during pregnancy.**¹⁰⁴ Further compounding the risk to adolescents' health, **68% of women under the age of 20 receive no postnatal checkup** at all after childbirth.¹⁰⁵

The risks experienced by adolescent women are exacerbated by the inability to time and space their births. The median birth interval for adolescents is substantially shorter than the national average, and **almost half of births to mothers ages 15-19 follow an interval of less than 24 months.**¹⁰⁶ Short birth intervals, meaning intervals of less than 24 months, jeopardize women's health and increase the risk of maternal death.¹⁰⁷

III. Questions

In light of the submission above, the Center hopes that the Committee will consider addressing the following questions to the government of Bangladesh:

1. What measures is the government taking to remove barriers to access to maternal health services and to ensure that all women receive essential antenatal care, trained assistance in childbirth, and postnatal care? Is the government taking any steps to increase access to trained birth attendants and improve the quality of maternal healthcare? What steps does the government plan to take, including what policies or programs will it modify or develop, to meet the MDG targets to reduce the MMR to 143 and to increase both antenatal visits to 100% and skilled delivery attendance to 50% by 2015?

2. What steps is the government planning to take to implement a comprehensive maternal death reporting system, including documenting the causes of maternal death? Is the government taking any measures to collect information on unsafe abortion and violence against women as causes of maternal death in Bangladesh?
3. Can the government provide data on obstetric fistula to show the progress and impact of current interventions and strategies to prevent the occurrence of obstetric fistula and to provide appropriate medical services (corrective surgery) to those suffering from it? What is the government doing to address the sociocultural barriers that increase the likelihood of obstetric fistula, including inadequate nutrition and early childbearing?
4. What measures is the government taking to promote access to a full range of contraceptive methods and to promote women's informed decision-making. What means is the government taking to ensure that the MDG target of reducing unmet need for contraception to 7.6% is met? Is the government taking any steps to address the recent increase in unmet need for contraceptives?
5. Has the government introduced any special measures to address the disparities in access to maternal healthcare experienced by rural women? What is the government doing to increase access to antenatal and postnatal care and to increase the presence of skilled birth attendants during delivery for rural women specifically?
6. What is the government doing to address the high incidence of early pregnancy? What measures has the government taken with respect to adolescents already at risk of early pregnancy, including married adolescents? Has the government taken steps to promote access to reproductive information and services, such as family planning, and quality maternal healthcare to prevent early pregnancy and address the potential complications for early pregnancy?

Respectfully submitted by:



Payal Shah
Legal Adviser for Asia
International Legal Program

¹ Government of Bangladesh, *Combined Sixth and Seventh Periodic Report of States Parties*, CEDAW/C/BGD/6-7 (Mar. 24, 2010), <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/288/51/PDF/N1028851.pdf?OpenElement> [hereinafter *Bangladesh Country Report* (2010)].

² Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR (34th Sess.), Supp. No. 46, at 193, art. 10(h), U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

³ *Id.* art. 12(1).

⁴ *Id.* art. 12(2).

⁵ *Id.* art. 16(1)(e).

⁶ *Id.* arts. 12(2) and 5(b).

⁷ Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Women and Health* (20th Sess.), para. 17, U.N. Doc. A/54/38, at 5 (1999), *available at* <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm> [hereinafter CEDAW Committee, *General Recommendation No. 24*].

⁸ CEDAW, *supra* note 2; Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled "Human Rights Council,"* U.N. Doc. A/HRC/4/28 (Jan. 17, 2007), *available at* http://www.wunrn.com/news/2007/12_07/12_03_07/120307_special_files/120307_special.pdf.

⁹ WORLD HEALTH ORGANIZATION (WHO) ET AL., *TRENDS IN MATERNAL MORTALITY: 1990 TO 2008* 17 (2010), *available at* http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf [hereinafter WHO, *TRENDS IN MATERNAL MORTALITY*].

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.* at 36.

¹³ *Id.* at 23.

¹⁴ GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH, GENERAL ECONOMICS DIVISION, PLANNING COMMISSION, *THE MILLENNIUM DEVELOPMENT GOALS, BANGLADESHI PROGRESS, PROGRESS REPORT 2009* 16 (2009), *available at* <http://www.undp.org.bd/info/pub/Bangladesh%20MDGs%20Progress%20Report%202009.pdf> [hereinafter *Bangladesh, 2009 MDG PROGRESS REPORT*].

¹⁵ *Id.* at 91.

¹⁶ WHO, *TRENDS IN MATERNAL MORTALITY*, *supra* note 9, at 20.

¹⁷ *Id.* at 36.

¹⁸ United National Population Fund (UNFPA), *Bangladesh, Thematic Review of Safe Motherhood in Bangladesh*, http://www.unfpa-bangladesh.org/php/safe_motherhood_thematic_review.php.

¹⁹ NATIONAL INSTITUTE OF POPULATION RESEARCH AND TRAINING ET AL., *BANGLADESHI MATERNAL HEALTH SERVICES AND MATERNAL MORTALITY SURVEY 2001, FINAL REPORT* (2003), *available at* <http://www.measuredhs.com/pubs/pdf/FR142/FR142.pdf> [hereinafter *BANGLADESHI MATERNAL HEALTH SERVICES SURVEY 2001*].

²⁰ *Bangladesh, 2009 MDG PROGRESS REPORT*, *supra* note 14, at 90.

²¹ *BANGLADESHI MATERNAL HEALTH SERVICES SURVEY 2001*, *supra* note 19, at 27.

²² UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, *ABORTION POLICIES, A GLOBAL REVIEW: BANGLADESH* 47-48, <http://www.un.org/esa/population/publications/abortion/profiles.htm> (go to "Bangladesh").

²³ United Nations Children's Fund (UNICEF), *Maternal Health in Bangladesh, Key Statistics*, at 2, http://www.unicef.org/bangladesh/MATERNAL_HEALTH.pdf; UNFPA, *Bangladesh*, http://www.unfpa-bangladesh.org/php/about_bangladesh.php.

²⁴ *Bangladesh, 2009 MDG PROGRESS REPORT*, *supra* note 14, at 96.

²⁵ *Bangladesh Country Report* (2010), *supra* note 1, at 88.

²⁶ *Id.*

²⁷ GOVERNMENT OF BANGLADESH & UNITED NATIONS, *MILLENNIUM DEVELOPMENT GOALS, BANGLADESH PROGRESS REPORT 2005* 36 (2005), http://www.searo.who.int/LinkFiles/MDG_Reports_BangladeshMDG.pdf.

²⁸ Childinfo, *Monitoring the Situation of Children and Women, Statistics by Area, Maternal Health*, http://www.childinfo.org/antenatal_care.html; *BANGLADESH, DEMOGRAPHIC HEALTH SURVEY 2007* 112 (2009),

available at <http://www.measuredhs.com/pubs/pdf/FR207/FR207%5BApril-10-2009%5D.pdf> [hereinafter BDHS 2007].

²⁹ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 16.

³⁰ See BDHS 2007, *supra* note 28, at 112.

³¹ See *id.* at 109-110.

³² *Id.* at 113.

³³ *Id.* at 109, 118.

³⁴ *Id.* at 109.

³⁵ *Id.* at 117.

³⁶ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 21.

³⁷ *Id.* at 91.

³⁸ BDHS 2007, *supra* note 28, at 117.

³⁹ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 90; UNICEF, Maternal and Neonatal Health in Bangladesh, Key Statistics, at 3, http://www.unicef.org/bangladesh/Maternal_and_Neonatal_Health.pdf.

⁴⁰ UNICEF, Maternal and Neonatal Health in Bangladesh, Key Statistics, *supra* note 38, at 2.

⁴¹ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 97.

⁴² *Id.* at 96.

⁴³ BDHS 2007, *supra* note 28, at 120.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ BDHS 2007, *supra* note 28, at 120, 121.

⁴⁷ UNICEF, Maternal and Neonatal Health in Bangladesh, Key Statistics, *supra* note 39, at 1.

⁴⁸ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 96.

⁴⁹ *Id.*

⁵⁰ UNICEF, Maternal and Neonatal Health in Bangladesh, Key Statistics, *supra* note 39, at 2.

⁵¹ *Id.*

⁵² *Id.* at 3.

⁵³ ENGENDERHEALTH, SITUATION ANALYSIS OF FISTULA IN BANGLADESH: REPORT 10 (Sept. 2003), available at <http://www.engenderhealth.org/files/pubs/maternal-health/Bangladesh-Fistula-Report.pdf> [hereinafter SITUATION ANALYSIS OF FISTULA IN BANGLADESH].

⁵⁴ UNFPA, Campaign to End Fistula, <http://www.endfistula.org/>; *id.*

⁵⁵ *Id.*

⁵⁶ R.J. Cook et al., *Obstetric Fistula: The Challenge to Human Rights*, 87 INT'L J. OF GYNEC. & OBSTET. 74 (2004), available at <http://www.fistulacare.org/pages/pdf/Partners/Virtual-Resource-Center/JournalNews/Overview/cook.pdf>.

⁵⁷ *Id.* at 72.

⁵⁸ *Id.* at 73.

⁵⁹ *Id.*

⁶⁰ *Id.* at 72.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*; CEDAW, *supra* note 2.

⁶⁴ UNFPA, Campaign to End Fistula, <http://www.endfistula.org/>.

⁶⁵ SITUATION ANALYSIS OF FISTULA IN BANGLADESH, *supra* note 52, at 4.

⁶⁶ See, e.g., CEDAW Committee, *Concluding Observations: Burkina Faso*, paras. 31-32, U.N. Doc. A/60/38 (2005); *Ghana*, paras. 32-34, U.N. Doc. CEDAW/C/GEO/CO/3 (2006); *Namibia*, paras. 24-25, U.N. Doc. CEDAW/C/NAM/Co/3 (2007).

⁶⁷ CEDAW Committee, *General Recommendation No. 21: Equality in Marriage and Family Relations* (13th Sess.), art. 16 (1)(e), U.N. Doc. A/49/38, at 1 (1994), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 250 (2003), available at <http://www1.umn.edu/humanrts/gencomm/gener21.htm>.

⁶⁸ *Id.*

⁶⁹ BDHS 2007, *supra* note 28, at xxvi.

- ⁷⁰ *Id.* at 69.
- ⁷¹ Demographic Health Survey—Country Quickstats: Bangladesh, http://www.measuredhs.com/countries/country_main.cfm?ctry_id=1&cntrytab=quickstats&cn=Bangladesh.
- ⁷² Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 95.
- ⁷³ BDHS 2007, *supra* note 28, at 63.
- ⁷⁴ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 16.
- ⁷⁵ BDHS 2007, *supra* note 28, at 63.
- ⁷⁶ *See, e.g.*, Women are Watching their Governments, MDG 5 Watch, http://www.mdg5watch.org/index.php?option=com_content&view=article&id=115&Itemid=168.
- ⁷⁷ BDHS 2007, *supra* note 28, at xxvi.
- ⁷⁸ *Id.* at 62.
- ⁷⁹ *Id.* at 60.
- ⁸⁰ CEDAW Committee, *General Recommendation No. 24*, *supra* note 7, para. 6.
- ⁸¹ CEDAW, *supra* note 2, art. 14(1).
- ⁸² *Id.*
- ⁸³ *Id.* art. 14(2) and art. 14(2)(b).
- ⁸⁴ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 91.
- ⁸⁵ BDHS 2007, *supra* note 28, at 112.
- ⁸⁶ *Id.* at 18.
- ⁸⁷ *Id.* at 113, 115.
- ⁸⁸ *Id.* at 121.
- ⁸⁹ CEDAW Committee, *General Recommendation No. 24*, *supra* note 7, para. 8.
- ⁹⁰ *Id.* para. 6.
- ⁹¹ *See, e.g.*, CEDAW Committee, *Concluding Observations: Chile*, para. 227, U.N. Doc. A/54/38 (1999); *Greece*, paras. 207–08, U.N. Doc. A/54/38 (1999); *Mauritius*, para. 211, U.N. Doc. A/50/38 (1995); *Mexico*, para. 394, U.N. Doc. A/53/38 (1998); *Nigeria*, para. 171, U.N. Doc. A/53/38/rev.1 (1998); *Paraguay*, para. 123, U.N. Doc. A/51/38 (1996); *Peru*, para. 341, U.N. Doc. A/53/38/rev.1 (1998); *Venezuela*, para. 236, U.N. Doc. A/52/38/rev.1 (1997); *Zimbabwe*, para. 148, U.N. Doc. A/53/38 (1998).
- ⁹² *See, e.g.*, CEDAW Committee, *Concluding Observations: Barbados*, paras. 249- 250, U.N. Doc. A/57/38 (2002); *Ecuador*, paras. 317-318, U.N. Doc. A/58/38 (2003); *Estonia*, para. 100, U.N. Doc. A/57/38 (2002); *Mozambique*, para. 36, U.N. Doc. CEDAW/C/MOZ/CO/2 (2007); *Saint Kitts and Nevis*, paras. 101-102, U.N. Doc. A/57/38 (2002); *Uganda*, para. 147-148, U.N. Doc. A/57/38 (2002).
- ⁹³ UNICEF, Maternal and Neonatal Health in Bangladesh, Key Statistics, *supra* note 39, at 2.
- ⁹⁴ Measure DHS, Online Tools, <http://www.statcompiler.com/> (Using parameters to compile data into a graph showing age when women are married worldwide and regionally)(Bangladesh ranks fourth in the world among countries with Demographic Health Surveys).
- ⁹⁵ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 93.
- ⁹⁶ UNICEF, Maternal and Neonatal Health in Bangladesh, Key Statistics, *supra* note 39, at 2.
- ⁹⁷ BDHS 2007, *supra* note 28, at 52.
- ⁹⁸ BDHS 2007, *supra* note 28, at 56.
- ⁹⁹ UNICEF, Maternal and Neonatal Health in Bangladesh, Key Statistics, *supra* note 39, at 1.
- ¹⁰⁰ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 91; *id.* at 2.
- ¹⁰¹ Bangladesh, 2009 MDG PROGRESS REPORT, *supra* note 14, at 93.
- ¹⁰² BDHS 2007, *supra* note 28, at 56.
- ¹⁰³ *Id.*
- ¹⁰⁴ *Id.* at 110.
- ¹⁰⁵ *Id.* at 121.
- ¹⁰⁶ *Id.* at 54.
- ¹⁰⁷ *Id.* at 53.