2015

Political environment and CSO networks relevant to SRHR in South Asia

IPPF International Planned Parenthood Federation
South Asia Region

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Abbreviation list

ADA	Afghan Development Association
ADDA	Agency for Assistance and Development of Afghanistan
AFGA	Afghan Family Guidance Association
AFPPD	Asian Forum of Parliamentarians on Population and Development
AHDS	Afghan Health and Development Services
AHERO	Afghanistan's Health Education and Reconstruction Organization
AIDS	Acquired Immune Deficiency Syndrome
AIHRC	Afghanistan Independent Human Rights Commission
ANC	Antenatal Care
ANDS	Afghanistan National Development Strategy
ARSH	Adolescent Reproductive and Sexual Health
ART	Antiretroviral Therapy
AWC	Afghanistan Women Council
AWEC	Afghan Women's Education Centre
AWN	Afghan Women's Network
BAP	Bangladesh AIDS Programme
BCC	Behavioural Change Communication
BDF	Bakhtar Development Foundation
BFHI	Baby Friendly Hospital Initiative
BHUs	Basic Health Units
BMIS	Bhutan Multiple Indicator Survey
BPHS	Basic Package of Health Services
BS	Birth Spacing
CBDRM	Community Based Disaster Risk Management
CBOs	Community Based Organisations
CCs	Community Clinics
CCPA	Child Care and Protection Act
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CME	Community Midwife Education
CMRA	Child Marriage Restraint Act, 1929
CoEVAW	Commission on Elimination of Violence Against Women
CRIN	Child Rights International Network
CSE	Comprehensive Sexuality Education
CSHP	Comprehensive School Health Programme
CSO	Civil Society Organisations
DACAAR	Danish Committee for Aid to Afghan Refugees
DGFP	Directorate General of Family Planning
DHS	Demographic and Health Survey
EC	European Commission
EPHS	Essential Package of Hospital Services
ESP	Essential Services Package
EVAW	Elimination of Violence Against Women
FCPD	Family and Child Protection Department
FGM	Female Genital Mutilation
FP	Family Planning
FPAN	Family Planning Association of Nepal
FSWs	Female Sex Workers
FWLD	Forum for Women, Law and Development
GDP	Gross Domestic Product
GECU	Gender and Empowerment Coordination Unit
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Bangladesh
HACCA	HIV/AIDS Coordination Committee of Afghanistan
HAPP	HIV/AIDS Prevention Project
HATI	HIV/AIDS Targeted Intervention
HAWACA	Humanitarian Assistance for the Women and Children of Afghanistan

HIV	Human Immunodeficiency Virus
HPN	Health, Population and Nutrition
HPNSDP	Health Population and Nutrition Sector Development Program
HPSP	Health and Population Sector Programme
HTTCA	Human Trafficking and Transportation (Control) Act
IBBSS	Integrated Biological Behavioural Surveillance Survey
ICDDR-B	International Centre for Diarrheal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
IDU	Intravenous Drug Use
IEC	Information, education and communication
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
INYO	Iran National Youth Organization
IOM	International Organization for Migration
IPPF	International Planned Parenthood Foundation
IYCF	The Infant and Young Child Feeding
JTMR	Joint Mid-Term Review of the National Response
LGBT	Lesbian, gay, bisexual and transgender
MA	Member Associations
MARPs	Most-at-Risk Populations
MDHS	Maldives Demographic Health Survey
MGFDSS	Ministry of Gender, Family Development and Social Security
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNDF	Maldives National Defence Force
MOLSAMD	Ministry of Labour and Social Affairs, Martyrs, and the Disabled
MoHA	Ministry of Home Affairs
MoHFW	Ministry of Health and Family Welfare
MoHME	Ministry of Health and Medical Education
MoPH	Ministry of Public Health
MoWA	Ministry of Women's Affairs
MR	Menstrual Regulation
MSM	Men who have sex with men
MSPVAW	Multi-Sectoral Programme on Violence Against Women
MSW	Male Sex Workers
NAPWA	National Action Plan for the Women of Afghanistan
NASP	National AIDS/STD Program
NCCHT	National Committee for Controlling Human Trafficking
NGO	Non-Governmental Organisation
NHAC	National HIV and AIDS Commission
NHSP II	Nepal Health Sector Programme II
NHSS	National HIV Sentinel Surveillance
NIFH	National Institute of Family Health
NPP	National Population Policy
NSMNH-LTP	National Safe Motherhood and New-born Health Long Term Plan
OCMC	One-stop Crisis Management Centres
OIC	Organization of Islamic Cooperation
ORCD	Organization for Research and Community Development
PDVA	Prevention of Domestic Violence Act
PID	pelvic inflammatory disease
PLHIV	People living with HIV
PWIDS	People who inject drugs
RAWA	Revolutionary Association of the Women of Afghanistan
RH	Reproductive Health
RTI	Reproductive Tract Infections
SDO	Sanayee Development Organization

SLDHS	Sri Lanka Demographic and Health Survey
SO	Suhada organization
SOGI	Sexual Orientation and Gender Identity
SPRC	Society for Protecting the Rights of the Child
SRH	Sexual and Reproductive Health
SRHS	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SWAD	Society for Women against Discrimination
TAA	Therapeutic Abortion Act
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TIP	Trafficking in Persons
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAW	Violence Against Women
VCCT	Voluntary Confidential Counselling and Testing
VCT	Voluntary Counselling and Testing
VWO	Voice of Women Organization
WASSA	Women Activities & Social Services Association
WHO	World Health Organisation
YFHS	Youth Friendly Health Services
YHC	Youth Health Café

Executive Summary

This political mapping exercise seeks to conduct a situational analysis and understand the policy and programmatic environment pertaining to Sexual and Reproductive Health and Rights (SRHR) in nine countries of the International Planned Parenthood Federation's (IPPF) South Asia region, namely Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka. It also aims to identify and prioritize issues of advocacy for SRHR in each of these countries as well as at the regional level and suggest strategies for advocacy on these issues with the government, non-government organizations, civil society organizations (CSO) and other relevant stakeholders. Therefore, it further attempts identify the most relevant CSOs working on issues related to SRHR. As the South Asia region is quite diverse, understanding the socio-cultural, religious and political dynamics impacting the SRHR policy and programmatic environment is also important and this has been captured through this mapping exercise.

In order to deliver against the aforementioned objectives, the exercise has been carried out in a structured manner where a well-defined analysis framework has been developed in alignment with IPPF's 5 A's – Access, Abortion, Adolescents, AIDS and Advocacy. 16 critical areas of SRHR (parameters) have been identified under these categories. Further, for each parameter, key indicators have been mapped across which information has been sought. This political mapping exercise is primarily based on secondary literature review. Apart from this, primary respondents from the IPPF Member Associations in some countries have been interviewed who have been instrumental is providing country specific insights particularly on policy and programmatic barriers.

The political mapping exercise reveals that there is a need to increase access to affordable and quality reproductive health services including an integrated package of family planning services through outreach initiatives, particularly to the vulnerable population such as migrants, PLHIV, people with diverse SOGI, sex workers, IDUs, and the like. Further, formulation and enforcement of laws protecting the rights and preventing discrimination of these populations are required. Even in case of early and forced marriage, while most of the countries have laws prohibiting the same, stronger enforcement and sensitization of officials in this regard is required. Sensitization of law enforcement officials dealing with human trafficking and gender based violence is also needed as these are issues where the victims are usually vulnerable and in most cases lack the social and financial support.

As far abortion is concerned, even though most countries have favourable policies pertaining to protecting the health of the woman, more efforts are required in terms of formulating and enforcing stringent laws to curtail illegal and unsafe abortions which are responsible for significant number of maternal deaths in this region, especially since abortion is an issue associated which social stigma in most of the countries in this region.

Some of the strategies in this regard include involvement of religious leaders to overcome cultural sensitivities, personal beliefs/attitudes of teachers and parents regarding sexuality education. Since South Asia region has a significant population below the age of 25 years, effectively leveraging the youth demographic can help to highlight the health issues of adolescents particularly related to SRHR. Greater engagement with policy makers and greater emphasis on evidence based advocacy can provide inputs to the ongoing advocacy efforts – policy advocacy, people centred advocacy and media advocacy.

1. Chapter 1: Background

The International Planned Parenthood Federation (IPPF) is a global service provider of Sexual and Reproductive Health (SRH) services in 172 countries. IPPF was founded in 1952 with eight national family planning (FP) associations coming together at the third International Conference on Planned Parenthood. Today, more than 60 years after its establishment, IPPF is a Federation of 152 Member Associations (MAs) working in 172 countries with over 65,000 service delivery points worldwide.

IPPF strives for a world in which all women, men and young people have access to the sexual and reproductive health information and services without any stigma or discrimination. IPPF's mission is "to improve the quality of life of individuals by providing and campaigning for Sexual and Reproductive Health and Rights (SRHR) through advocacy and provision of services, especially for poor and vulnerable people. The Federation defends the right of all people to enjoy sexual lives free from ill health, unwanted pregnancy, violence and discrimination".

Since the year 2012, IPPF has been operationalising programmes with three main goals - Unite, Deliver and Perform. It is supported and receives grants from international agencies to implement programmes. The European Commission (EC) supported one such advocacy project implemented by IPPF South Asia Regional Office in partnership with Asian Forum of Parliamentarians on Population and Development (AFPPD) and Member Associations in Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka. The broad objective of this project is to highlight and provide impetus to efforts in favour of SRHR issues, including capacity building of CSOs in advocacy, national and regional advocacy through policy makers and other parliamentarian stakeholders.

As part of the project, a landscape mapping exercise, in terms of SRHR policy framework in all the nine countries, was undertaken in order to understand and successively mobilise the political environment in favour of SRHR. This document highlights sexual and reproductive health issues in the nine countries mentioned above by mapping the policies, programmes and barriers related to the following 16 areas. For ease of understanding, we have categorised the issues under two broad domains – Healthcare service delivery related issues and Socio cultural issues.

Health	Socio cultural
Family Planning	Early and Forced Marriage
Reproductive Health Services	Prevention and Surveillance of Violence against Women (Gender Based Violence)
Prevention and Appropriate Treatment of Infertility	Sexual Orientation and Gender Identity Rights
Reproductive Tract Infections (RTIs)	Human Trafficking
Abortion	Sex Work
AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS	Conjugal rights (Marital rape)
Adolescent Reproductive and Sexual Health – Youth Friendly Services	Comprehensive Sexuality Education
	Other harmful practices (Honour Killing)
	Migrants (Provision of Health Services)

An extensive literature review was undertaken and situational analysis was done that provides a fairly good understanding of the above issues and areas for advocacy with the government and civil society organisations. A review of organisations working in the area of sexual and reproductive health was done to identify few civil society organisations which can be potential partners for advocacy in the nine countries. This document is based on literature review and research undertaken till 15th December 2014.

2. Chapter 2: Country Political Maps

2.1 Afghanistan

2.1.1 Situational Analysis

After 23 years of war, in December 2001, Afghanistan found itself facing extreme poverty, insecurity, political instability, appalling infrastructure and large gender disparities. These challenges were enormous, especially in light of the lack of social and human capital, the absence of government income through taxation or natural resources, the transitional status of the political system and the receipt of relatively little international aid. All these challenges added to the complexity of health sector development. An extensive analysis of the Afghan health situation, together with proposed policies, priorities and strategies, was published in early 2002 as the Master Plan for Reconstruction and Rehabilitation of the Health Situation in Afghanistan 2002-2006.

In February 2002, within the context of the Transitional Islamic State of Afghanistan, the then Ministry of Health developed a comprehensive interim health policy. To help close the gap between health policy and implementation, an interim health strategy for 2002-2004 was produced in August 2002 and finalised in February 2003. This interim strategy focused on laying the foundations for equitable, accessible, quality health care through strategic planning, management and actions that made the best use of limited resources. It set priorities and also stated what should be achieved by the end of 2004. By mid- 2004, it was generally agreed that the Ministry needed to focus more on accelerating the implementation of health care services, especially in underserved rural areas. The process involved in developing both the new national policy and strategy started in July 2004 and was coordinated by the Ministry's Policy and Planning Directorate.

Sexual and Reproductive Health Indicators

Indicators	Value	Year	Source
Total Fertility Rate	5.1 children per woman	2012	UNICEF
Contraceptive prevalence rate (%)	21.2	2008-12	UNICEF
Delivery care (%), Skilled attendant at birth	38.6	2008-12	UNICEF
Delivery care (%), Institutional delivery	32.9	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	47.9	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	14.6	2008-12	UNICEF
Maternal Mortality Rate (MMR)	330 per 1,00,000 live births	2008-12	UNICEF
Infant Mortality Rate (IMR)	71 per 1,000 births	2012	UNICEF
Health Budget (as % of GDP)	8.1	2013	World bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

2.1.2 SRHR Situation in the country

Family Planning

In Afghanistan, FP is part of the Ministry of Public Health's Basic Package of Health Services (BPHS) 2005, and FP services are offered as an integral component of basic health services at all levels.

The National Reproductive Health Strategy 2003-2005 aimed to improve women's health and reduce maternal risk by fulfilling the unmet needs for FP and increasing access to quality FP services. The National Reproductive Health Strategy 2006-2009 draws from the National Family Planning/ Birth Spacing Strategy 2006-2009 and includes the following objectives that relate to supply, demand and access to FP services: strengthen the capacity of providers to counsel, provide services and manage side effects and complications, promote involvement of males, religious and community leaders and communities; strengthen behavioural change communication (BCC) to increase demand for and use of FP, and social mobilisation among different sectors and populations to support a rapid demographic transition; expand the variety of ways that couples can access FP services both within and outside of the health sector.

The National Health Policy 2005-2009[1] talks about increasing the accessibility of mothers and women of child bearing age to modern FP services. Moreover, the National Action Plan for the Women of Afghanistan (NAPWA), 2007-2017 talks about promoting access to FP. FP is one of the main priorities of the National Reproductive Health Policy and Strategy 2012-2016. This strategy aims to increase the Couple Years Protection to 40% and percentage of health facilities with at least three modern FP methods to 100%. Afghanistan National Development Strategy (ANDS) 2008-2013 talks about delivering the different components of reproductive health as an integrated package, and increasing accessibility to and utilisation of modern FP services. The National Standard Treatment Guidelines for the Primary Level 2013 includes a chapter on FP for birth spacing which talks about the various methods of contraception available in Afghanistan.

Following are some of the barriers to FP according to the National Reproductive Health Strategy 2012-2016

- In Afghanistan, where the literacy rate of women is low, it is hard to train women to be health workers;
- Low community awareness of FP services due to the dispersed population, geographical barriers, and a lack of transportation infrastructure. Additionally, religion and cultural boundaries make families feel that FP is wrong;
- Lack of information about contraceptives has led to misconceptions about their purpose and side effects. In addition, women who live in rural areas may not be able to access the programmes. They receive inconsistent dosages, if they receive any medication at all;
- Lack of mechanisms for effective regulation of for-profit, private-sector clinics and governmental health services that focus on RH and FP;
- Lack of a national system for tracking budget expenditures (public and external) on health, including resources specific to reproductive, maternal and new-born/child health.

Reproductive Health Services

The Afghan Ministry of Public Health, responsible for the reconstruction of the health sector, established a National Health Policy in early 2002, focusing on equitable access to health care, based on a Primary Health Care concept. This includes basic health facilities providing essential health services to the entire population and an appropriate and accessible referral system dealing with emergency and obstetrics care. In this policy, reproductive health is listed among the health sector priorities to save and improve lives[2].

Article 54 of the Afghan Constitution 2004 and the National Health Policy 2005-2009 prioritises the improvement of the quality of maternal, child and reproductive health care in the country. Antenatal and delivery care are included as part of the primary health care system in Afghanistan. A BPHS (2005) has been defined to translate the policies into practice, under which a Maternal and New-born Health Package with five components (antenatal care, delivery care, postpartum care, FP, and care of the new-born) has been introduced.

The National Reproductive Health Policy and Strategy 2012-2016 aim to improve the reproductive health status of families in Afghanistan through the provision of integrated reproductive health services in partnership with communities, development partners and the private sector. The ANDS (2008 – 2013) talks about delivering the different components of reproductive health as an integrated package, and increasing accessibility to, and utilisation of, quality reproductive health care services, including antenatal care, intrapartum care, routine and emergency obstetric care and post-partum care, counselling and modern FP services. The National Public Nutrition Policy and Strategy 2010 – 2013 aims to protect and

[1] The MoPH mentions this policy, however, unable to obtain this document.
[2] National Health Policy 2005-2009, Ministry of Public Health, Afghanistan

promote healthy child and maternal nutrition, prevent chronic under-nutrition and associated micronutrient deficiency disorders, and reduce mortality from acute under-nutrition. The Strategic Plan for the Ministry of Public Health 2011-2015 aims at increasing the proportion of women having access to emergency and routine RH and Maternal, Neonatal and Child Health (MNCH) Care Services as one of its strategic objectives.

Though the aforesaid interventions have contributed significantly to improve mother and child health, some challenges still remain:

- According to a 2013 study on ANC and obstetric care in Afghanistan, underuse of available antenatal and obstetric health care was attributable to a variety of factors, including a limited understanding of its importance to maternal and infant health, lack of family support, financial problems, and transportation difficulties, especially for poorly educated rural women. Patients frequently complained of being treated disrespectfully, and health care providers correspondingly complained about poor working conditions, leading to exhaustion and lack of compassion. Widespread corruption, including the importance of personal contacts, was also emphasised as an obstacle to equitable antenatal and obstetric health care in Afghanistan[3].
- Afghan women face double jeopardy in securing their rights to health because of poor health infrastructure on the one hand and gender norms that place barriers on their access to health care on the other. Additionally, health worker's harsh behaviour at public health facilities, non-availability of medicines at public health facilities, suboptimal trust of clients on health worker's skill and knowledge, non-availability of female staff, non-availability of 24 hours of services at the public health facilities, and lack of women's decision making power are major barriers to seek health care[4].
- Traditions in Afghanistan raise many barriers to women accessing health services: women's restricted mobility impedes their ability to seek care. They are further restricted in choice of health treatments when these are subject to male approval, and treatment of women by male doctors is largely unaccepted[5].

Reproductive Tract infections (RTIs)

The National Standards for Reproductive Health Services: Family Planning for Birth Spacing 2003 talk about RTI as part of effective FP counselling. The National FP/BS Strategy 2006-2009 focuses on RTIs that are not diagnosed or adequately treated and prevention of pelvic inflammatory disease (PID) as a consequence of improperly managed deliveries and postpartum care. It provides guidelines that help health workers in screening FP clients for RTI/STIs. Prevention and management of Reproductive Tract infections are covered under National Reproductive Health Policy 2012-2016. The National Standard Treatment Guidelines for the Primary Level 2013 talk about diagnosis, management and prevention of PID which is a general term for female upper genital tract infections.

Prevention and Appropriate Treatment of Infertility

The extent of infertility in Afghanistan is not known. The National Reproductive Health Policy 2012-2016 talks about undertaking a prevalence survey to understand the extent of the problem in Afghanistan as well as prevention and management of sub-fertility/infertility. This policy calls for the establishment of a national clinical guideline for the diagnosis and basic management of infertility to be developed and made available to service providers.

According to the National Reproductive Health Strategy 2012-2016, while basic counselling and treatment for infertility is possible, advanced and highly technical interventions are currently not feasible. As a first step in developing an infertility programme, simple interventions for management of primary infertility and identification of opportunities for the prevention of secondary infertility can be initiated.

Abortion

[3]Rahmani, Zuhal, and Mette Brekke. "Antenatal and obstetric care in Afghanistan – a qualitative study among health care receivers and health care providers." *BMC Health Services Research*, 2013.

[4]Ministry of Public Health. "Gender Related Barriers to Access and Utilization of Primary Health Care Services with Focus on Access to First level Reproductive Health, and Mental Care Services." 2010.

[5]NAPWA, 2007-2017

Abortion in the Islamic Republic of Afghanistan is legal only when the mother's life is in danger, as per various articles of the Afghan Penal Code. Going by South Asian estimates, 15% deaths in maternal mortality are attributed to unsafe abortions (WHO, 2004). Afghanistan, being a post conflict country, has no reliable data on this. Moreover, since abortion is forbidden by religion, socially and legally, there is very little data on women/girls opting for induced abortion.

The National Reproductive Health Strategy 2012-16 talks about providing potential service of "complicated abortion" but there are no specific formal programmes to facilitate abortions as they are deemed illegal by the country's law. National Post Abortion Care Guidelines[6], which is a landmark document in the country towards ensuring increased access to abortion related services in the country. National Standard Treatment Guidelines for the Primary Level 2013 includes a component on management and prevention of abortion.

Some issues to be addressed are as follows:

- Because of the illegal status of abortions, desperate women may seek dangerous surgical options from untrained practitioners, often using hazardous methods in unsafe and unhygienic conditions. These can cause harm to the pregnant women and lead to infections and other serious medical issues. This is further aggravated in case of victims of rape who want to get an abortion, as the law in Afghanistan does not allow abortion in the case of rape or incest. Additionally, women try to obtain medical abortion pills on the black market, which are expensive and may not be safe to use[7].
- The few legal abortions that can occur in hospitals face several major issues. Even if a woman can legally get the abortion, there may not be a health centre in her area. The health centre in her area may not have trained personnel. In addition the abortions may not be free. Lastly, government hospitals where the abortions are offered may offer a low quality of care and may not have safe and clean facilities. Private hospitals are likely to be expensive and may not have personnel trained for abortions.
- Due to the cultural unacceptability of abortion, there is a fear of stigma among those in need for abortion services, which is aggravated among women from low economic status.

AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS

Based on available data, the HIV epidemic in Afghanistan seems to be low, but concentrated predominantly among people who inject drugs (PWIDs). The Integrated Biological Behavioural Surveillance Survey (IBBSS) in 2012 showed an overall 4.4% of HIV prevalence among PWIDs. The latest UNAIDS data from 2013 indicates that the epidemic presently remains under 0.1% among the general population, yet, has the potential to grow quickly from a small base of PWIDs to their sexual partners and thus to heterosexual men and women unless effective, vigorous, and sustained action is taken early. According to official National AIDS Control Program (NACP) reports a cumulative number of 1529 PLHIV was reported at the end of 2012[8].

In 2003, the Ministry of Public Health (MoPH) established the NACP. In 2005, the NACP and Drug Demand Reduction Directorate of the Ministry of Counter Narcotics approved a National Harm Reduction Strategy for IDU and the Prevention of HIV and AIDS, and in 2006, the NACP produced the National HIV/AIDS Strategic Plan for 2006-10 and Program Operational Plan for the Afghanistan National HIV/AIDS Strategic Framework 2006-2010. The National HIV Code of Ethics 2007 serves as the foundation for ethical practice of all HIV prevention, treatment, care and support services provided through and in association with the MoPH under the laws of Afghanistan. It applies to all government, non-government and private practitioners, service providers, counsellors, officers and agents in the delivery of the aforementioned services. The HIV/AIDS Coordination Committee of Afghanistan (HACCA) was established in 2007 as an independent body to coordinate the multi-sectoral response to HIV/AIDS. The National Strategic Framework on HIV/AIDS-II (2011-2015) addresses three main priority areas - preventing further progression of the HIV epidemic among IDUs and their partners, prison interventions

[6] Not available online. Need support from MA

[7] Singh, Susheela, Deirdre Wulf, and Heidi Jones. "Health Professionals' Perceptions About Induced Abortion in South Central and Southeast Asia." *International Family Planning Perspectives* 23, no. 2 (1997).

[8] NACP, "Global AIDS Response Progress Report, Afghanistan" 2014.

and addressing risky behaviours in order to reduce mortality and morbidity associated with HIV/AIDS. The National HIV and AIDS Policy 2012 provides the framework for a coordinated, multi-sectoral and priority response to HIV and AIDS as a basic health and human rights issue within the broad legislative guidelines and socio-cultural values of the country as well as aligned to standard international practices and policies. This policy also calls for a supportive environment where PLHIV are treated normally and can live with the same dignity as those without the disease. The National Reproductive Health Strategy (2012-2016) talks about increasing public awareness of STIs by through IEC interventions, improving the quality of STI clinical services and building the health workers' capacity in STI management.

Following are some of the barriers according to the 2014 Global AIDS Response Progress Report by NACP:

- There is no legal protection for PLHIV and key populations due to lack of an anti-discriminatory law. Stigma and discrimination toward PLHIV and key populations are widely spread at the different levels.
- Easy availability, production and distribution of drugs, including Heroin. As illicit drug use is punishable by law, prison interventions that include harm reduction are difficult to implement.
- Social and cultural barriers in reaching key affected populations.
- Effective integration of HIV and AIDS services within the national health care system, and ensuring Government contribution to the programme for sustainability purposes is a major challenge.
- Finance and procurement procedures of the government are lengthy. Therefore, access to essential supplies is a time consuming process.
- Gender issues, including needs of female drug users are not fully understood and addressed by the government programmes.
- The coverage of HIV response in the country is still relatively poor, limited to only eight provinces.
- Low awareness of HIV and risk behaviours and limited access to healthcare facilities.

Following are some of the barriers according to the 2012 Country Progress Report by the MoPH:

- Although there is a referral system between HIV and TB, it needs to be strengthened and thus increase the possibility of detection of cases and appropriate treatment. Similarly, referral systems need to be strengthened between outreach, drop-in centres, drug treatment, VCT and ART centres.
- Since Afghanistan's national AIDS programme is largely donor driven in terms of financing, there are multiple reporting systems that increase the work load and possibly result in duplicate reporting.

Adolescent Sexual and Reproductive Health services – Youth Friendly Services

Afghanistan has one of the world's youngest and fastest growing population[9]. In 2011, 40% of Aghanistan's population was between the age group of 15 to 24 years[10]. The National Child and Adolescent Health Policy 2009–2013 talks about increasing awareness of risks of early marriage and healthy lifestyles for adolescents, as well as the need to reduce the number of adolescent pregnancies to ensure better child health. The Draft Afghanistan National Youth Policy 2013 talks about increasing accessibility of youth to counselling on reproductive health services, life skills based SRH education, awareness about consequences of early marriage and adolescent pregnancy, accessibility to prevention, care and treatment of STDs and effective birth registration to ensure the development of a healthy young generation. The National Child and Adolescent Strategy 2009-2013 includes provision of adolescent health services such as provision of condoms and information on emergency contraception, risk reduction counselling for prevention of STIs, contraceptive services for delaying pregnancy, antenatal care for pregnant adolescents, referrals for ectopic pregnancies, counselling on menstrual problems, birth spacing and contraception, myths and misconceptions on sex related issues and harm reduction, syndromic management of STIs and referral. It also highlights a need to educate mothers as well as community members who influence the reproductive health and behavior of adolescents about these issues.

[9] UNFPA, 2012a. Available from: Afghanistan National Youth Policy (Draft), July 2013.
[10] Central Statistics Organisation, 2011. Available from: Afghanistan National Youth Policy (Draft), July 2013.

Customary and religious practices act as barriers to SRH and HIV services as young people are often deterred from accessing such services for fear of punishment for conduct considered immoral or because parental or spousal consent is a strict precondition for access to services[11].

Comprehensive Sexuality Education

The need to educate young people of their sexuality and other issues related to the same has been acknowledged and efforts are being made towards this direction. The National Health Policy 2005-2009 expresses the need for information and education about sexual health for young people and adolescents. Of the key programmes aimed at ensuring CSE, the National Reproductive Health Strategy 2012-2016 talks about creation of Family Health Action Groups which provide information and education by leveraging the family network. The strategy also proposes advocating for reproductive health education in schools in collaboration with the Ministry of Education. However, given the socio-cultural environment, sex is considered a taboo topic in Afghan society and most do not like to talk about it in the open.

Early and Forced Marriage

The 2010-11 Afghanistan Multiple Indicator Cluster Survey (MICS) found that 1 in 5 young women aged 15-19 years was currently married and about 15% of women aged 15-49 years were married before the age of 15.
The Article 70 of the Afghanistan Civil Code 1977 has stipulated the minimum age of marriage as 16 years for girls and 18 years for boys. Article 71 of the Civil Code also allows the father of a girl or a competent court to "consent" to the marriage of a girl who is 15 years old. However, marriage of a minor girl whose age is less than 15 years is not permissible under any circumstances. The supreme law of the land is the Constitution of the Islamic Republic Afghanistan 2004, which provides for the recognition of Sharia law under which there is no minimum age for marriage; however it is generally recognised as the age of a child who has reached puberty. Marriage without the consent of both parties is not valid under Sharia law and the Afghan Penal Code 1976. According to Article 28 of the Elimination of Violence Against Women (EVAW) Act 2009 a person marrying a woman who has not attained the legal age of marriage without considering Article 71 of Civil code, shall be sentenced to imprisonment and the marriage may be revoked in accordance with the provision of law. The National Child and Adolescent Health Policy (2009-2013) talks about increasing awareness of risks of early marriage and healthy lifestyles among adolescents. The Afghan Draft National Youth Policy 2013 seeks to raise public awareness on the adverse effects of early marriage and adolescent pregnancy. The National Child and Adolescent Health Strategy (2009 -2013) talks communicating with girls, families and communities to draw attention to the risks of early marriage. It includes collaboration with the Ministry of Education to promote health education on sexuality and risks of early marriage. Bangladesh is a member of the Organization of Islamic Cooperation (OIC), which in 2008 adopted the Plan of Action for the Advancement of Women recognising that early and forced marriages are an impediment to improving the health, education, political participation, social justice and well-being of women.

Despite the improvement in the situation and government's efforts to eliminate early marriage, there have been some barriers that hamper the progress.

- Enforcing the rule of law in Afghanistan can be exceptionally challenging due to the ongoing security situation in the country, creating an environment for tribal traditions like child marriage to thrive[12].
- It is common practice to give or exhange unmarried girls to resolve disputes or as dowry, usually in the context of a past crime or local conflict. Because these girls are perceived as atoning for the wrong committed by their family members, they are often the victims of serious abuse by the receiving family[13].
- It is difficult to address the issue of child marriage as there is a lack of official marriage documents. Cultural norms, which allow for child marriage, often take precedence.Stronger enforcement of the registration of all nuptials is urgently needed as a critical first step to begin monitoring and reducing the prevalence of child marriage.[14]

[11] Godwin, J. "Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services". (2013).
[12] Child Marriage in Southern Asia: Policy Options for Action. 2013
[13] Child Marriage in Southern Asia: Policy Options for Action. 2013
[14] According to a 2013 report on Child Marriage in Southern Asia: Policy Options for Action by AusAID

- Many leaders oversee the unions evidenced by the high incidence of child marriage. It is essential that elders and community leaders – especially religious leaders – receive training on the adverse effects of child marriage.[15]

Prevention and Surveillance of Violence against Women (Gender Based Violence)

Gender based violence is prevalent throughout Afghanistan, and often stems from power inequalities and asymmetries in Afghan society. According to the First Report on the Implementation of the EVAW Law in Afghanistan 2014, on average, 35 VAW cases were reported per 100,000 females in the country from 2012 to 2013. A total of 4505 VAW cases were reported during the same period.

The Constitution also led to the establishment of the Afghanistan Independent Human Rights Commission (AIHRC) which in part protects women's rights. The EVAW Law 2009 was formed to safegaurd the religious and legal rights of women, protect victims of violence, protect the well-being of families, prevent violence against women and prosecute prepetrators of any such violence. Under EVAW law, all provinces are mandated to have a Commission on Elimination of Violence Against Women (CoEVAW) to coordinate, plan and measure the implementation of the law. The Attorney General's Office has established specialised EVAW units in eight provinces for speedy resolution of cases. The NAPWA (2007-2017) focuses on eliminating women-directed violence in public and private spaces, raising awareness on human rights, especially women's rights, and gender-based violence within the security sector and promoting a culture of peace and non-violence. Women who are victims of violence can seek refuge in shelters or safe houses run by MoWA.
Mentioned below are current challenges that hinder the efforts aimed at suppressing gender based violence.

- The EVAW law requires a victim or her relative to file a complaint in most cases before State institutions will take action. If no complaint is filed or the woman withdraws a complaint due to family pressure or fear of reprisal, the State is not required to investigate or prosecute. [16]
- Community-based concerns—including the protection of her personal or family honour, the guarantee of custodial rights, and the security of the social and economic safety net woven by family connections—may be judged more valuable to a woman than her individual rights[17].
- Different agencies involved in the implementation of EVAW law and registering and processing cases keep their records in different ways. Recording of cases electronically remains a major challenge in EVAW law institutions.[18]
- In some areas, when a crime is reported to the police, the police or the court will attempt mediation instead of prosecution. As a result, women run the risk of going back into the same dangerous relationship that caused the mediation in the first place.[19]

Sexual Orientation and Gender Identity (SOGI) Rights

The Afghanistan Law of Marriages (1971) stipulates that a legal marriage must be between two Muslim adults of the opposite sex, and that it must meet the rules of Islamic law. Under Islamic law, homosexuality is strictly prohibited.

The National Strategic Framework on HIV/AIDS 2011-2015 identifies men who have sex with men (MSM) as one of the Most-at-Risk-populations (MARPs). Two health centres catering to MSMs are functional in Kabul and Mazar-i-Sharif. Due to the stigma attached to MSMs, these centres are designed as 'male health clinics'. Services provided include syndromic case management, promotion of knowledge, and consistent condom use.
Following are some of the barriers which inhibit the LGBT community in Afghanistan:

- Even though the practice of Bacha Baazi[20] has been outlawed, there is very little enforcement of the same[21].

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[15] According to a 2013 report on Child Marriage in Southern Asia: Policy Options for Action by AusAID
[16] According to a 2011 report by the United Nations Assistance Mission in Afghanistan titled 'A Long Way to Go: Implementation of the EVAW Law in Afghanistan'
[17] Luccaro, Tim, and Erica Gaston. "Women's Access to Justice in Afghanistan; Individual versus Community Barriers to Justice." 2014.
[18] According to the 2014 First Report on the Implementation of the EVAW Law in Afghanistan
[19] According to the 2014 First Report on the Implementation of the EVAW Law in Afghanistan
[20] Where prepubescent boys aged between 14-18 are sold to wealthy patrons for purposes of entertainment and illicit sex. In the absence of female dancers, these boys are made to perform feminine acts and gestures.

- Since homosexuality is viewed as illegal, it is largely hidden. This, combined with the stigma attached to it, has resulted in a very limited understanding of the networks, sexual and risk behaviours of such populations as well as the extent of the HIV epidemic among them. Research indicates very low levels of knowledge and very high risks[22].

Human trafficking

Afghanistan's Law Countering Abduction and Human Trafficking/Smuggling (2008) also prescribes penalties of life imprisonment for sex trafficking. This life sentence, however, is superseded by the Law on EVAW 2009 which decreased the maximum sentence for forced prostitution of females to 15 years' imprisonment. The Ministry of Labour and Social Affairs, Martyrs, and the Disabled (MOLSAMD) owns four short-term trafficking shelters in Kabul, Herat, Kunduz, and Nangarhar, which are operated by International Organization for Migration (IOM) and partner NGOs. In collaboration with international organisations, the MOLSAMD launched a series of TV spots in January 2014 warning against human trafficking[23]. The ANDS 2008-2013 talks about curtailing organised and international crimes including human trafficking.

In spite of the several efforts to combat trafficking, numerous barriers have been identified in the enforcement of the same such as:

- Afghanistan is yet to ratify the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (Palermo Protocol, 2000)
- As per a 2014 Trafficking in Persons report by the US Department of State, the Government of Afghanistan does not fully comply with the minimum standards for the elimination of trafficking; however, it is making significant efforts to do so. The Afghan government's response to the extensive human trafficking in its country and of its citizens was deficient. Victims of trafficking were usually prosecuted whilst the offenders were left unpunished. The law of trafficking also does not cover the sex trafficking of a child if coercion was not involved
- Despite increased international support of the Government's anti -trafficking programming, the understanding of human trafficking amongst law enforcing officials in Afghanistan continues to be low. There is often confusion between human trafficking and human smuggling[24]

Sex work

As per a Mapping and Situation Assessment conducted by the University of Manitoba in 2007, there were an estimated 1160 Female Sex Workers (FSWs) in three major cities of Afghanistan (Kabul, Mazar-i-Sharif, and Jalalabad) in 2007, with 898 in Kabul alone. The highest numbers of FSWs per capita were in Mazar-i-Sharif with approximately 2.8 FSWs per 1,000 adult women (aged 15-49)[25].

Prostitution is viewed as illegal in Afghanistan and married prostitutes are considered adulterers under the Article 427 of the Afghan Penal Code 1976. The National HIV/AIDS Policy 2012 includes FSWs as one of the MARPs. Since prostitution is viewed as illegal there are no Government programmes designed to address the health needs of sex workers. However, under the National Strategic Framework on HIV/AIDS for Afghanistan – II (2011 – 2015) there are two programmes available for FSWs in Kabul and Mazar-i-Sharif which provide syndromic case management of STIs, promotion of knowledge and consistent condom use as well as VCCT.

Since sex work is illegal in Afghanistan most of the sex work is driven underground. FSWs choose to keep their identity a secret and do not have access to programmes that combat HIV/AIDS, which leads to a continued spread of the disease.

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[21] The Diplomat. *Bacha Bazi: The Tragedy of Afghanistan's Dancing Boys.* August 23, 2014. http://thediplomat.com/2014/08/bacha-bazi-the-tragedy-of-afghanistans-dancing-boys/.
[22] National Strategic Framework on HIV/AIDS for Afghanistan-II (2011-2015)
[23] United States Department of State, 2014 Trafficking in Persons Report - Afghanistan, 20 June 2014
[24] 2014 Trafficking in Persons report by the US Department of State
[25] NACP (NACP), Country Progress Report 2014: Afghanistan

Migrants (Provision of Health Services)

As per the United Nations Department of Economic and Social Affairs, Population Division's World Population Prospects: the 2012 Revision, the net migration rate in Afghanistan is –2.6 migrants per 1000 population. In 2013, Afghanistan was seen as the biggest source country of refugees, with one out of every four refugees in the world being an Afghan and 95% of them living in Pakistan and Iran. Most of the migrants have returned to the country after leaving in the war torn years of the 1980's and 90's.

Article 52 of the Constitution of Afghanistan seeks to provide free healthcare, medical treatment and proper health facilities to all citizens of Afghanistan in accordance to the law. The National Policy on Internally Displaced Persons (IDPs) 2013 lists out rights, programmes, and policy goals for displaced people within Afghanistan. The Ministry of Refugees and Repatriation works with the Ministry of Health to provide health services to refugees. One of their top priorities is to establish and construct basic infrastructure such as health clinics.

Conjugal rights (Marital Rape)

Article 132 of the Shiite Personal Status Law 2009 requires women to obey their husband's sexual demands and stipulates that a man can expect to have sex with his wife at least "once every four nights" when travelling, unless they are ill. Since the issue of marital rape is not recognised, no data has been identified to shed light upon this issue.

Other harmful practises (Honour Killing)

As per Article 398 of the Penal Code 1976, "A person, defending his honour, who sees his spouse, or another of his close relations, in the act of committing adultery or being in the same bed with another and immediately kills or injures one or both of them shall be exempted from punishment for laceration and murder but shall be imprisoned for a period not exceeding two years". As has been observed, Article 398 deals with honour killings in Afghanistan and takes into account when the killing is a crime of passion. However, what constitutes honour killing remains ambiguous since it is not well defined in the law.

The existing programmes that address VAW also deal with honour killing, however not much information was identified in this regard. Under the EVAW law, all provinces are mandated to have a CoEVAW, which will coordinate, plan and measure the implementation of the law. The Attorney General's Office has established specialised EVAW units in eight of thirty four provinces. A special EVAW Law Prosecution Unit created in 2010 in Kabul investigates and prosecutes violence against women countrywide, including honour killings.

2.1.3 Highlights of the issues relevant from Advocacy perspective

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	• Involvement and sensitization of parents and teachers in programmes addressing the health needs of the youth population	• Generating awareness and sensitization, especially among male family members about SRH issues faced by adolescents
HIV and AIDS	• Need for an anti-discriminatory law to deter stigma and discrimination toward PLHIV • Effective integration of HIV and AIDS services within the national health care system • Strengthening referral systems between outreach, drop-in centres, drug treatment, VCT and ART centres	• Need to address gender issues, including needs of female drug users • Awareness generation on HIV and risk behaviours and access to healthcare facilities • Further increase in coverage of the HIV response
Abortion	• Formulation of guidelines to reduce unsafe and illegal abortions • Improvement in number and quality of health centres providing abortion services	• Campaign for legalizing abortion in case of rape or incest
Access to services and information	• Develop national clinical guidelines for the diagnosis and management of infertility, and introduce these guidelines at the BPHS and Essential Package of Health Services (EPHS) levels • Efficient enforcement of the EVAW law	• Need for a prevalence study to understand the problem of infertility • Provision of health services to FSWs • Campaign against social stigma for people with diverse SOGI
Others	• Need for sensitizing government officials about trafficking laws • Ratify the 2000 UN Palermo Protocol on human trafficking • Stronger enforcement of the registration of all nuptials	• Campaign to recognize the problem of marital rape • Awareness generation among elders and community leaders – especially religious leaders –on the adverse effects of child marriage

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies for Advocacy

- Even though a number of progressive policies and programmes have been initiated, it is vital that they are implemented effectively. Advocacy efforts towards effective implementation of programmes and constructive suggestions for their improvement may help in this regard.
- Having one of the youngest and fastest going population, Afghanistan can leverage its huge youth demographic by building a strong network of young peer educators, participation in international and national youth conferences and representation at global forums. This can help to highlight issues specially related to SRHR of adolescents.
- Due to continuous political instability in the country, building the advocacy capacity of CSOs as representatives of a diverse range of groups from all parts of Afghan society can be effective to influence policy makers in order to bring about targeted change.

2.1.4 Civil Society Organisations

S.No.	Names	Focus Thematic Areas
1	Revolutionary Association of the Women of Afghanistan (RAWA)	• Malalai Hospital • RAWA Schools • Orphanages

S.No.	Names	Focus Thematic Areas
		► Literacy courses ► Handicraft workshops ► Political action for Afghan Women
2	Afghanistan Women Council	► Empowerment of women ► Livelihood opportunities for Women - knitting, tailoring, MohraDozi, sewing, soap making, poultry farming and honey bee keeping. ► Microfinance programme
3	Afghan Institute of Learning	► Education and health ► Human rights ► Women's rights ► Leadership ► Street children
4	Humanitarian Assistance for the Women and Children of Afghanistan (HAWCA)	► Women's empowerment ► Community development ► Skill training for women ► Legal aid for women.
5	Organization for Research and Community Development (ORCD), Afghanistan	► Health Projects: IDPs within Afghanistan. ► Female literacy ► The organisation has also worked to train farmers in several rural areas.
6	Afghanistan's Health Education and Reconstruction Organization	► Runs a health clinic in Jalalabad. Currently constructing a larger hospital with natal care as well as other medical services.
7	Afghan Health and Development Services	► Health: Reproductive care and malnutrition. ► Education: Girls' education and midwifery training program. ► Community development ► Organisational development
8	Agency for Assistance and Development of Afghanistan (AADA)	► AADA works on Midwifery training, HIV testing programmes, and Family Health Houses.
9	Suhada Organization	► Health-operates various hospitals with nurse training facilities. ► Education- 118 schools ► Human Rights ► Sustainable development ► Child protection
10	Afghan Family Guidance Association (AFGA)	► Reproductive Health ► FP
11	Afghan Development Association (ADA)	► Agriculture and Rural Development ► Capacity Building and Trainings ► Education (Child & Youth Protection & Development- Formal & Informal Education) ► Environment Protection ► Advocacy and Social Research ► Gender and Human Rights ► Good Governance, Counter Narcotics and Anti-Corruption ► Emergency and Community Based Disaster Risk Management (CBDRM)
12	Afghan Women's Education Centre (AWEC)	► Increasing legal services for women ► Gender peace building ► Empowerment and livelihood ► Psychological treatment services.
13	Bakhtar Development Foundation (BDF)	► Health-DN has been implementing health programmes through 150 clinics and 5 hospitals to bring the services closer to the community. ► Education- The education programme focuses on midwifery training and getting Afghan street children back to school. ► Women Rights
14	Sanayee Development Organization (SDO)	► Peace-Building - Health Projects - Nutrition projects, mobile medical assistance, HIV testing

S.No.	Names	Focus Thematic Areas
		► Education Projects
15	Voice of Women Organization (VWO)	► Women's rights' issues, gender equity and equality ► Legal & Social Protection ► Access to Justice ► Advocacy for Women's Rights Legislation ► Education ► Health ► Capacity Building for Social Empowerment ► Vocational Training for Economic Empowerment
16	Women Activities & Social Services Association (WASSA)	► Legal and social protection, ► Civil society empowerment ► Conflict resolution & peace building ► Advocacy
17	Action Aid, Afghanistan	► Women Rights ► Community Development
18	DACAAR	► Water sanitation and hygiene - Clean Water Projects ► Natural resource management- improvement of irrigation infrastructure, and animal husbandry. ► Small scale enterprise development-vocational skills ► Women empowerment
19	Alliance of Health Organizations-Health Net TPO	► Health
20	Global Rights-Partners for justice, Afghanistan	► Afghan women ► Young Lawyers program ► Family Law training programmes educate women on family law to give them a voice in marriage, domestic violence, and child custody cases.
21	Women for Afghan Women	► Women's rights and laws. ► Human rights advocacy in local community, ► Literacy, ► Vocational and life skills education
22	Marie Stopes International, Afghanistan	► FP and Maternal Health Services. ► Manage abortion complications and provide post-abortion care, ► Sexually transmitted diseases including HIV/AIDS. ► Youth-friendly sexual and reproductive health information and services

International Conventions

S.No.	Name of the convention	Year of Signing/Attending
1.	Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others	Acceded in 1985
2.	International Conference on Human Rights, Tehran	1968
3.	International Covenant on Economic, Social and Cultural Rights	Acceded in 1983
4.	Convention on the Elimination of All Forms of Discrimination against Women	Signed in 1980, ratified in 2003
5.	Convention on the Rights of the Child	Signed 1990, ratified in 1994

6.	International Conference on Population and Development (ICPD), Cairo	Attended in 1994
7.	UN Fourth World Conference on Women, Beijing	Attended in 1995
8.	ICPD+5	Attended in 1995
9.	Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (Supplementing the United nations convention against transnational organised crime)	Acceded in 2014
10.	World Summit	Attended in 2005
11.	Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery	Acceded in 1966
12.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Acceded in 2002
13.	SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution	Attended in 2002
14.	ILO Convention 1999 (No. 182), Elimination of Worst Forms of Child Labour	Ratified in 2010

2.2 Bangladesh

2.2.1 Situational Analysis

In Bangladesh, the Ministry of Health and Family Welfare (MoHFW) is responsible for health policy formulation, planning and decision making at the macro level. The primary health care service provision operates at three tiers, i.e., upazila, union and the community linking them with the districts as part of the public sector health service.

With a view to accelerating progress of the health, population and nutrition (HPN) sector and addressing the challenges, the MoHFW, Government of Bangladesh (GOB) has been implementing the Health Population and Nutrition Sector Development Program (HPNSDP) for a period of five years from July 2011 to June 2016. After HPSP (1998-2003) and HNPSP (2003-2011), the HPNSDP is the third sector-wide program for overall improvement of health, population and nutrition sub-sectors. The priority of the program is to stimulate demand and improve access to and utilisation of HPN services in order to reduce morbidity and mortality; reduce population growth rate and improve nutritional status, especially of women and children.[26]

Sexual and Reproductive Health Indicators

Indicators	Value	Year	Source
Total Fertility Rate	2.2 children born per woman	2012	UNICEF
Contraceptive prevalence rate (%)	61.2	2008-12	UNICEF
Delivery care (%), Skilled attendant at birth	31.7	2008-12	UNICEF
Delivery care (%), Institutional delivery	28.8	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	54.6	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	25.5	2008-12	UNICEF
Maternal Mortality Rate (MMR)	220 per 1,00,000 live births	2008-12	UNICEF
Infant Mortality Rate (IMR)	33 per 1,000 live births	2012	UNICEF
Health Budget (as % of GDP)	3.7	2013	World Bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

2.2.2 SRHR Situation in the country

Family Planning

Bangladesh is one of the most densely populated countries in the world. According to the 2011 Population and Housing Census (PHC) of Bangladesh, the population of the country stood at about 149.8 million, with a population density of 1,015

[26] MoHFW, Govt of Bangladesh website.

persons per square kilometre.[27] The Bangladesh Demographic and Health Survey (DHS) of 2011 revealed that 61 % of currently married Bangladeshi women between the ages of 15 and 49 years use contraceptive method. More than half (52 %) use a modern method, and 9 % use a traditional method. The pill is by far the most widely used method (27 %), followed by injectable (11 %), periodic abstinence (7 %), male condoms (6 %), and female sterilization (5 %). The survey further highlighted the fact that government sector remains the major provider of contraceptive methods, catering to more than half of all users (52 %); and government field workers supplying 23 %. The private sector provides contraceptives to 43 % of all users, with pharmacies supplying 33 %.

The International Conference on Population and Development (ICPD) had a strong impact on the development of population policies in Bangladesh and influenced the population section of Bangladesh's Fifth Five Year Plan (FYP), the Health and Population Sector Programme (HPSP) 1998, and the National Population Policy (NPP), 2004. There has been a move away from the delivery of family planning services directly to clients at their homes to providing the Essential Services' Package at one-stop clinics. National Population Policy, 2004 was launched to improve the status of family planning, maternal and child health including reproductive health services and improve the living standard of the people by striking a balance between population and development in the context of Millennium Development Goals (MDGs).

Since 1980 the family planning program has emphasised the importance of integrating health and family planning services to provide an essential integrated package of high quality, client-centred services at a one-stop service point. The Ministry of Health and Family Welfare operates through two divisions, one of which is the Directorate General of Family Planning (DGFP) which is responsible for implementing Family Planning (FP) programmes and providing FP related technical assistance to the ministry. Presently, the HPNSDP 2011-2016 is the Sector wide approach (SWAp)[28] for the overall improvement of health, population and nutrition sectors. One of the priority areas of intervention earmarked in the program is Population and Family Planning Services. The HPNSDP's Program Implementation Plan (PIP) document sets out the sector specific strategies to achieve its goal, one of which is to "revitalise various family planning interventions to attain replacement-level fertility."

The FP programme comprises of a nationwide community based FP service delivery system, relying primarily on non-clinical methods such as oral pills and condoms.

Some of the key problem areas are as follows:

- Although the Fifth FYP, HPSP, and draft NPP all indicated that adequate quantities of contraceptive methods will be provided by the government and NGOs, ensuring the procurement and distribution of different contraceptive methods is not addressed fully by the existing and proposed population policies and programmes.[29]
- According to the Bangladesh DHS 2004, "One of the major controversial aspects of HPSP was the proposed transition from outreach or domiciliary family planning services to static community clinics (CCs). In the confusion surrounding this issue, the public sector lost a substantial share of FP service provision, very little of which was picked up by the CCs. Household visits for family planning by fieldworkers have fallen dramatically since the mid-1990s".[30]

Reproductive Health Services

In Bangladesh about 12,000 women die each year from maternal causes. It has been estimated that the risk of death from pregnancy and child birth-related causes in Bangladesh is much higher than in developed countries.[31]

The first SWAp HPSP (1998-2003) had placed "Safe Motherhood" as a separate and significant component, whereas the second SWAp, HNPSP was committed to reduce fertility, maternal and under-5 mortality under the broader context of reproductive health. The rights-based comprehensive National Maternal Health Strategy was adopted in 2001, which focuses on essential maternal services. Under HNPSP (2005-2011)[32], the government has undertaken five sub-programmes

[27] Ministry of Health and Family Welfare. Bangladesh Demographic and Health Survey, 2011.
[28] The SWAp program aims to provide a package of essential, quality health care services that respond to population needs, especially those of children, women, the elderly, and the poor.
[29] CPD- UNFPA. Bangladesh's Population Policy: Emerging Issues and Agenda. (Paper series, no. 23.
[30] Khan, A.R. and Khan, M. (2010) Population Programs in Bangladesh: Problems, Prospects And Policy Issues
[31] BRAC. Maternal Neonatal and Child Health Programmes in Bangladesh. 2007. (Research Monograph series no.23)
[32] The HNPSP officially began in 2003, but various delays meant that it did not actually start until 2005.

including a) family planning services, b) clinical family planning services, c) Maternal and Child Health (MCH) care and services, d) adolescent healthcare, and e) support services and coordination, which are being implemented through a countrywide facility network. The HPNSDP is the third sector-wide programme that aims to reduce population growth rate and improve nutritional status, especially of women and children. Current Government service delivery includes comprehensive emergency obstetric services at most district hospitals and some upazila facilities, and obstetric first aid at the union level. The MoHFW is piloting a maternal health voucher scheme in 33 upazilas to increase poor women's utilisation of quality maternal health services. The Infant and Young Child Feeding (IYCF) practices and Baby Friendly Hospital Initiative (BFHI) of the government are also expected to contribute significantly in improving maternal and neonatal health.

The aforesaid interventions have contributed significantly to improve MCH, some challenges still remain:

- The utilisation of Public MCH-FP service provision in Bangladesh is unbalanced, with low utilisation of most facilities at the community level (upazila and below) and over utilisation of facilities at the district and at teaching hospitals. Where utilisation is low, the quality of service remains poor.[33]
- The quality of maternal health services provided by government institutions is below expectations, due to a large number of problems such as inadequate number of doctors/nurses/technicians, non-availability and pilferage of medicines and supplies, long waiting time, poor maintenance and shortage of equipment, unhygienic physical environment, scarcity of power and water, neglect of follow-up care, widespread absenteeism of medical personnel, and inadequate training and knowledge of service providers on issues, along with irregularities in the management system are some of the reasons. [34]
- Traditional Birth Attendants (TBAs) and traditional systems continue to dominate the rural scenario in Bangladesh, and there exists a wide socio-cultural gap between those practising traditional medicine and modern medicine.[35]
- According to UNICEF, different types of superstitions have been identified in Bangladesh which are harmful to achieving healthy and safe motherhood. Mostly these practices involved restriction of mobility, consumption of optimal food and growth of the foetus (such as the belief that eating more will lead to dangerously large babies). Along with supernatural explanations for complications, the social expectations of women to deliver in the home could also delay seeking professional medical care in the case of onset of complications, leading to increased risk of maternal mortality.[36]
- Lack of health education, risks and danger signs and awareness prevent many people from seeking modern health care, even when these are available free. As a common health practice, people first attempt a home remedy, and when disease persists, they prefer to visit traditional healers. If symptoms increase in severity and these initial options prove ineffective, they approach modern medical practitioners and tertiary facilities.[37]

Prevention and Appropriate Treatment of Infertility

The issue of infertility remains neglected in Bangladesh's reproductive health policy, with the emphasis on the problem of overpopulation. As a result of this, the dominant state ideology in Bangladesh is related to controlling fertility, and the implementation of the FP programmes. Estimates from the World Fertility Survey suggest an infertility rate of 4% in Bangladesh.[38]

Infertility is covered under the Strategic Plan for the HPNSDP 2011-2016. The government does not run any programmes on infertility. The Bangladesh DHS data provides a list of reproductive health care services in Bangladesh, but there is no mention of infertility services in the list. For a woman in Bangladesh, being childless carries a wide range of consequences, in terms of social stigma, familial violence, and psychological disadvantages.[39] Most biomedical private infertility care

[33] BRAC. Maternal Neonatal and Child Health Programmes in Bangladesh. 2007. (Research Monograph series no.23)
[34] BRAC. Maternal Neonatal and Child Health Programmes in Bangladesh. 2007
[35] BRAC. Maternal Neonatal and Child Health Programmes in Bangladesh. 2007
[36] BRAC. Maternal Neonatal and Child Health Programmes in Bangladesh. 2007
[37] BRAC. Maternal Neonatal and Child Health Programmes in Bangladesh. 2007
[38] NCBI. (Nahar, P.) Invisible women in Bangladesh: Stakeholders' views on infertility services. Facts Views Vis Obgyn. 2012; 4(3): 149–156 Accessed on 9th November 2014 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3991399/
[39] NCBI. Invisible women in Bangladesh: Stakeholders' views on infertility services. Facts Views Vis Obgyn. 2012

providers offer expensive treatment and as a result are affordable to the urban, wealthy population; the remaining population due to lack of options seek treatment from informal healers.[40]

Reproductive Tract Infections (RTI)

RTIs and STDs are a growing concern in Bangladesh. The country does not have national prevalence data on RTIs or sexually transmitted infections (STIs) but there are a few studies which point to a high number of women with confirmed infections.

One of the objectives of NPP 2004 is to reduce RTIs/STIs and prevent spread of HIV/AIDS by ensuring access to information and services among high–risk groups against RTIs and other diseases. Management of RTI/STD is one of the strategic priorities of the National Reproductive Health Strategy (1997).

Treatment seeking behaviour is poor because of the 'culture of silence', limited access to services and high costs involved. On account of lack of awareness of the risk of untreated infections, infected women may not seek treatment on time, thus increasing risk to their health.[41] Girls in Bangladesh are married early, which indirectly reflects early initiation of sexual activity, and hence poses a higher risk of contracting RTIs.[42] Training of service providers in RTI diagnosis and treatment has been found to be poor, and in need of improvement.[43]

Abortion

In Bangladesh, the proportion of maternal mortality attributed to unsafe abortion is 15–18%.[44] As per the Penal Code of Bangladesh, abortion can be accessed only to save the life of a woman. It requires the approval of two physicians and can only be performed by an obstetrician/gynaecologist in a hospital. The country however, provides Menstrual Regulation[45] (MR) services, termed as "an interim method to establish non-pregnancy". MR has been part of Bangladesh's national family planning programme since the 1970s. MR services are free of charge in all government facilities. It is required that the woman must consent undergoing an MR procedure, but in special cases (intellectual impairment or younger women) consent of the guardian/relative/husband is also obtained. The National Menstrual Regulation Guidelines were drafted in September 2011 which indicate the norms, policy statements and regulations to be adhered to by providers during medical management of clients for MR procedures.[46] Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Morbidity and Mortality in Bangladesh" was launched by the Netherlands Ministry of Development Cooperation in partnership with the GOB and WHO (December 2007– 2011).
Some issues to be addressed are as follows:

- Though the guidelines clearly state that the process of MR should be performed by a trained paramedic; in practice, many providers of menstrual regulation have received only informal training.[47]
- Preventing unsafe MR and abortion were prioritised under HPSP and the Population Policy of Bangladesh; however provision of post MR or abortion services and counselling were not emphasised.[48]
- Economic, cultural and social barriers limit women's access to safe MR services. Due to lack of awareness of the risks involved in unsafe MR, those women who seek services from untrained providers suffer from complications which sometimes may even lead to death.[49]

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[40] NCBI. Invisible women in Bangladesh: Stakeholders' views on infertility services. Facts Views Vis Obgyn. 2012
[41] Population Council. Policy Dialogue. Integration of RTI care into existing Family Planning Services. Number 3, October 1996
[42] Population Council. Policy Dialogue. Integration of RTI care into existing Family Planning Services.
[43] Population Council. Policy Dialogue. Integration of RTI care into existing Family Planning Services.
[44] WHO. Mapping abortion policies, programmes and services in the WHO South-East Asia Region. 2013.
[45] Menstrual regulation is defined as any procedure which disrupts the intrauterine environment so that embryonic implantation either cannot occur or cannot be maintained. The technique is also known as menstrual aspiration, menstrual extraction, interception, and uterine aspiration. It can be performed using drugs, physical agents, and surgical techniques.
[46] WHO. Mapping abortion policies, programmes and services in the WHO South-East Asia Region. 2013
[47] WHO. Mapping abortion policies, programmes and services in the WHO South-East Asia Region. 2013
[48] CPD- UNFPA. Bangladesh's Population Policy: Emerging Issues and Agenda. (Paper series, no. 23)
[49] WHO. Strengthening the National Menstrual Regulation Programme for Reduction of Maternal Mortality and Morbidity in Bangladesh. Mid-Term review report (2011).

- There are other barriers which may limit access of MR services, such as distance to health facilities and transportation costs, unofficial fees, lack of privacy, and the state of general cleanliness and maintenance in public health facilities, including the attitude of service providers.
- At the service provider level, there is gross under-reporting of cases by providers who do not wish to share unofficial fees, which indirectly affects monitoring and adequate provision of supplies related to MR.[50]

AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS

According to the 2011 National HIV Sentinel Surveillance[51] (NHSS) Round 8, HIV prevalence was estimated at 0.3% among female sex workers, 1.1% amongst transgender people and as 1.1% among people who use drugs. In Bangladesh the main routes of transmission of HIV/AIDS are through hetero-sexual unprotected sex, and sharing of used needles and syringes. International returning migrant workers are another risk group accounting for a bulk of passively reported cases of HIV.

Bangladesh Population Policy, 2004 talks about preventing the spread of HIV/AIDS. Section 7 of the Right to Information Act, 2009 protects the privacy of a person living with HIV/AIDS. The Directorate of Health Services in the MoHFW outlined a National Policy on HIV/AIDS and STDs in 1997.

The National AIDS Committee (NAC) formed in 1985 and reconstituted in 2010 is responsible for formulating major policies and strategies, supervising programme implementation and mobilising resources. National AIDS/STD Program (NASP), within the Directorate General of Health Services of the MOHFW, is responsible for coordinating with all stakeholders and development partners involved in HIV/AIDS programme activities throughout the country. HIV/AIDS Prevention Project (HAPP) 2004-2007 was the first major projects under NASP which was aimed at controlling the spread of HIV infection within high-risk groups and to limiting its spread to the general population, without discriminating and stigmatising the high-risk groups. The HIV/AIDS Targeted Intervention (HATI) 2008-2009 focused on intervention packages for six high risk groups: PWIDs, brothel based sex workers, street based sex workers, and hotel and residence based sex workers, clients of sex workers, men who have sex with men (MSM), male sex workers (MSW) and *hijras*. The Bangladesh AIDS Programme (BAP) 2005-2009 supports interventions for Most-At-Risk Populations (MARPs) by extending support to NGOs and groups addressing the needs of PLHIV, national serological and behavioural surveys, condom promotion, training of health providers in case management of STIs, STI studies, Voluntary Counselling and Testing (VCT) centres and training of VCT centre staff and advocacy. A National Strategic Plan for HIV/AIDS for 2011-2015 has been prepared by the Government of Bangladesh under the guidance of National AIDS Committee and involvement of different stakeholders.

Antiretroviral therapy (ART) has so far been provided to those living with HIV/AIDS by the Global Fund, the Swiss Red Cross and some private donors.

Despite the efforts to address the incidence of HIV/AIDS:

- Amongst the majority of the key affected populations, many lack comprehensive HIV knowledge, underestimate HIV risk, and do not seek STI treatment.[52]
- There are population groups among whom higher rates of risk behaviour or vulnerability have been clearly identified, which include international migrant workers, especially vulnerable children, adolescent and young, prisoners, heroin smokers and transport workers. Interventions on the ground for these groups are inadequate to achieve significant change.[53]
- There are limited treatment facilities available for people living with HIV in Bangladesh. ART is not available through the government health system as yet.[54]

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[50] Choudhary, SN. A situation analysis of the menstrual regulation programme in Bangladesh. Reproductive Health matters. 2004, November. 12; Accessed on 18th November 2014 at http://www.ncbi.nlm.nih.gov/pubmed/15938162

[51] It is recommended by WHO as the principal method of data collection for detecting the presence of HIV infection and its geographic, demographic and temporal extension.

[52] NASP, Ministry of Health and Family Welfare, Govt. of Bangladesh. 3rd National Strategic Plan for HIV and AIDS response (2011-2015).

[53] NASP, Ministry of Health and Family Welfare, Govt. of Bangladesh. 3rd National Strategic Plan for HIV and AIDS response (2011-2015).

[54] NASP, Ministry of Health and Family Welfare, Govt. of Bangladesh. 3rd National Strategic Plan for HIV and AIDS response (2011-2015).

- PLHIV have to face stigma and discrimination at several levels of society, both at the institutional and individual level. This may lead to harmful consequences which could manifest as delayed testing, unwillingness to reveal HIV status to sexual partners and restricted uptake of prevention programmes.[55]

Adolescent Sexual and Reproductive Health services – Youth Friendly Services

Adolescents and youth are a vulnerable group, susceptible to many health related issues. There are 28 million adolescents in Bangladesh. The adolescent fertility rate of the country is one of the highest in the world with 147 births per 1,000 women younger than 20 years of age.[56] Early marriage and motherhood is a common phenomenon in Bangladesh. Adolescent mothers are more likely than older women to suffer pregnancy-related complications and to die from childbirth. Further, adolescents engaging in premarital sex are especially vulnerable to unwanted pregnancy and diseases, including STIs and HIV infection. Moreover, the stigma and discrimination associated with either condition makes it much worse.

The government has included the issue of adolescent health in the HPSP (1998-2003) under the Essential Services Package (ESP). The NPP and the National Youth Policy (2003) talk about adequate availability and access of Reproductive Health Services, especially family planning services to all adolescents. In a January 2001 circular, the Director General of the Directorate of Family Planning declared adolescent health problems including unwanted pregnancy, problems related to menstruation, MMR, complications due to unsafe abortions, RTIs and STI, sexual abuse and violence as priorities, and recognised the lack of information and education on these subjects. HPNSDP (2011-2015) places adolescent health as a priority intervention. The Adolescent Health Strategy guides the services to be provided to the adolescents.
A few major barriers faced by the country with regards to ASRH are mentioned below:

- Low rates of educational attainment, limited focus on sex education activities, and inhibited attitudes of society, schools and parents toward sex contribute to ignorance regarding adolescents' own sexuality, physical well-being and health.[57]
- A study found that over 30% of the married teenage women surveyed were never contacted by a family planning worker. The plausible reason stated was that fieldworkers assume that a need for family planning services does not exist among the young and newlywed couples, and thus reduce contraceptive use by this group.[58]
- The physical access barriers include inadequate reproductive health service points; insufficient clinical services for RTIs/STIs and HIV/AIDS; absence of peer group approach in the service point; and lack of clinical instruments for screening RTI/STI and HIV/AIDS.[59]
- The quality barriers include the service environment, which is unable to provide privacy and confidentiality to adolescents seeking service; lack of skilled professionalism among staff; comparatively high service charges and inadequate supervision and monitoring of ARH services.[60]

Comprehensive Sexuality Education

Bangladesh has the highest reported rates of early sexual debut. Sex before 15 years is as high as 24.3% (Male: 11.8%, Female: 30.6%); however only 0.14% schools provided life skills HIV/AIDS based education in the past academic year, the lowest in the South Asia region.[61]

The HNPSDP (2011-16) includes increasing access to reproductive and adolescent friendly health services through school based programs, CCs and social/community mobilisation, and implementing the National Reproductive and Adolescent Health Strategies along with targeted intervention for out of school adolescent boys and girls.[62] The NPP (2005) urged the Ministries and universities to update their curricula on population, health sciences and life skills education through formal and informal schooling systems. Adolescent Reproductive Health Strategy (2006) recognizes the need for effective

[55] UNAIDS. UN Joint Programme of Support on HIV/AIDS: Work Plan and Budget- Bangladesh (2012-15). 2012
[56] USAID (POLICY project). Adolescent and Youth Reproductive Health in Bangladesh: Status, Issues, Policies and Programs. 2003.
[57] USAID (POLICY project, 2003.
[58] USAID (POLICY project), 2003.
[59] USAID (POLICY project), 2003.
[60] USAID (POLICY project), 2003.
[61] Plan, Sexuality Education in Asia: Are we delivering? (2010)
[62] MOHFW. Strategic Plan for Health, Population and Nutrition Sector Development Program (HPNSDP: 2011-2016)

dissemination of ARH knowledge and information through curricula and that concerted efforts will have to be made to reach adolescents who are out of school, married or in any kind of employment. It strategizes to review and revise existing curricula based on needs assessment and implement monitoring systems to ensure classroom teaching of the curricula.[63] Life Skills education has recently been integrated at secondary level in the country, and is also planned for primary level. The Department of Education rolled out a Life Skills Based Reproductive Health Education for In-School Youth & Adolescents through Peer Approach (2006-2010) project financed by UNFPA and executed by Directorate of Secondary and Higher Education.

Cultural sensitivities and personal beliefs/attitudes of teachers, combined with a lack of confidence and expertise, apparently result in low levels of implementation of sexuality education in schools even when the curriculum is in place.[64]

Early and Forced Marriage

Bangladesh has one of the highest rates of child marriage in the world[65], despite the fact that the minimum legal age of marriage for females is 18 years and for males is 21 years. A National survey on child marriage conducted by Plan and ICDDR-B (in 2013) showed that 64% of women aged 20–24 were married before the age of 18, with the proportion higher for women in rural areas (71%) as compared to those in urban areas (54%). Child marriage is often accompanied by early pregnancy, with much higher risks of maternal mortality and morbidity for girls who become pregnant at a young age. Moreover, child marriage restricts a young girl's access to educational provisions and consequently her employment opportunities. Young lack the opportunity to acquire other life skills and exhibit low confidence in their ability to become economically independent.[66]

The Child Marriage Restraint Act, 1929 (CMRA) is the principal law relating to child marriage in Bangladesh. In 1994, the Bangladesh government launched the Female Stipend Programme for girls in secondary school (grades 6-10) which requires parents to sign a statement of commitment that they will not marry off their daughters until they will reach the age of 18. As a result of this programme, girls' school enrolment doubled between 1994 and 2001, and girls' age of marriage increased. The Law and Local Government Ministry brought the Birth and Death Registration Act into force in 2004, which requires birth certificates as proof of age to be presented in order to apply for several major services throughout the country, one of which is marriage registration. National Child Policy 2011 mentions that it will protect adolescents' rights by protecting them from violence, marriage and trafficking. Dissolution of Muslim Marriages Act, 1939 allows a girl to repudiate a forced early marriage before attaining the age of eighteen years, provided that the marriage has not been consummated. The elimination of child marriage is one of the stated objectives under the 2002 National Plan of Action against Sexual Abuse and Exploitation of Children including Trafficking.

Despite the improvement in the situation and government' efforts to eliminate early marriage, there have been some natural and some long standing barriers that hamper the progress.

- Many parents give inaccurate ages of girls to conform to the marriage law, enabling early marriage to be legally acceptable. In rural areas, the situation is worse as many births were not registered in the first place.[67]
- The identified reasons for CMRA's ineffectiveness include the absence of systematic birth registration and marriage registration, and a lack of awareness among the community about the accompanying dangers of early marriage.[68]
- The religious personal laws (for Muslims, Hindus, and Christians) permit marriage at an earlier age than 18 years, which is in direct contradiction to the statutory laws in Bangladesh. The sustained application of personal laws acts as a major barrier to protecting girls against early and forced marriage.[69]

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[63] UNESCO. Review of Policies and Strategies to Implement and Scale up: Sexuality Education in Asia and the Pacific. 2012
[64] UNESCO, Review of Policies and Strategies to Implement and Scale up: Sexuality Education in Asia and the Pacific, 2012
[65] UNFPA, 2012
[66] Cornell Law School. Child Marriage in Bangladesh: Causes, Consequences, and Legal Framework. (Memorandum). Accessed on 23rd November 2014 at http://ww3.lawschool.cornell.edu/AvonResources/Child_Marriage_Judicial_Request_FINAL.pdf
[67] Plan and ICDDR,B. Child Marriage in Bangladesh: Findings from a National Survey. 2013
[68] Cornell Law School, Child Marriage in Bangladesh: Causes, Consequences, and Legal Framework. (Memorandum). Accessed on 23rd November 2014 at http://ww3.lawschool.cornell.edu/AvonResources/Child_Marriage_Judicial_Request_FINAL.pdf
[69] Ibid.

Prevention and Surveillance of Violence against women (Gender Based Violence)

Bangladesh features among the 15 countries with the highest global prevalence of physical intimate partner violence.[70] In view of the fact that violence against women remains one of the most under reported crimes in Bangladesh, it is understood that the reported figures are largely underestimated.

The Constitution of Bangladesh and Section 376 of the Penal Code mentions imprisonment for varying degrees and liability to pay fine as a punishment for rape. Prevention of Women and Children Repression Act 2000 provides for effective and efficient ways of dealing with cases of violence against women. The National Population Policy, 2004 in its objectives states ensuring and supporting gender equity and empowering women. The Domestic Violence (Prevention and Protection) Act (2010) criminalises domestic violence. The National Women Development Policy emphasises elimination of all forms of abuse of women both through prevention and response.

The government operates six divisional women support centres and safe custody homes providing shelter, health care, legal aid and training to female victims or witnesses of violence for six months. Multi-Sectoral Programme on Violence against Women (MSPVAW) by the Ministry of Women and Children Affairs (MoWCA) works towards consolidation and improvement of public services for women facing violence. It also runs public awareness campaigns, which include awareness training for media, religious leaders, government and non-governmental officials; anti-violence messaging in media outlets, and promotion of its services. MoWCA has set up One-Stop Crisis Centres (OCC) in 2001 in Dhaka and Rajshahi Medical College Hospitals to provide all necessary services to women and children who are victims of violence in one place. The MSPVAW also runs free 24-hour emergency hotlines to provide advice to women. The Police Reform Project, initiated by the Government in 2005 and extended to 2014, aims to improve the effectiveness of the Bangladesh Police by increasing understanding of gender and human rights issues and improving responsiveness to female survivors of violence. In addition, some police stations have Special Cell for Women at the national, district and *thana* levels.

Mentioned below are current challenges that hinder the efforts aimed at suppressing gender based violence.

- Bangladesh has acceded to CEDAW but with specific reservations under Article 2 and 16 (1) (c), “as they conflict with Sharia law based on Holy Quran and Sunna.”
- Patriarchal attitudes are deeply ingrained in society, particularly in rural areas, and are legitimised on the basis of tradition and orthodox religion.
- Although many laws are in place to protect women, enforcement of these laws is lax and ineffective. There are cases where law enforcement agencies often accept bribes, ignore serious complaints, lose evidence, and free criminals.[71]
- Statistics on GBV rely on victims reporting their crimes to the police and lodging complaints. Since police stations and courts are not properly equipped to maintain computer-based data, there remains significant doubt about the quality and accuracy of this data. More importantly, complaints which are sexual in nature are much likely to be under-represented in the number of incidents of violence against women. [72]

Sexual Orientation and Gender Identity (SOGI) Rights

Homosexuality is viewed as illegal in Bangladesh with members of the SOGI community facing major hurdles in gaining their rights. Various sections of the Penal Code 1860 effectively criminalise homosexual intercourse. In 2011, the Government formulated rehabilitation programmes for *hijras,* which included a monthly allowance, distribution of health cards and a micro credit programme[73]. Following are some of the barriers which inhibit the LGBT community in Bangladesh:

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[70] World Bank. Violence against Women and Girls: Lessons from South Asia. 2014

[71] Farouk, S. (Expert paper for a UN meeting) Violence against women: A statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them. 2005. Accessed on 28th November 2014 at http://www.un.org/womenwatch/daw/egm/vaw-stat-2005/docs/expert-papers/Farouk.pdf

[72] Farouk, S. (Expert paper for a UN meeting) Violence against women [Ibid]

[73] SAARCLAW, IDLO and UNDP. Legal Reference Brief- Bangladesh. Accessed on 21st November 2014 at http://www.aidsdatahub.org/sites/default/files/publication/rbap-hhd-2013-bangladesh-legal-reference-brief.pdf

- Section 54 combined with Section 377 of the Penal Code is the main instrument of intimidation used by the police.[74]
- Since section 376 of the Penal Code only penalises the rape of a woman and does not take into account the rape of a man, transgender men are put to risk of sexual exploitation.[75]
- Trans genders or *hijras* face harassment throughout their lives such as at school, at colleges, at their workplace and also within their homes.[76]
- Irrespective of their sexual preferences, young homosexual Bangladeshi men are often forced to marry heterosexual females leading to challenging circumstances.[77]

Human trafficking

The Penal Code of 1860 provides for trafficking under its various sections. The Suppression of Immoral Traffic Act, 1933 was enacted to suppress brothels and trafficking in women and girls for 'immoral' purposes The Women and Children Repression Prevention Act, 2000 (amended 2003) serves as the principal legislation for punishing trafficking in women and children in Bangladesh. The Human Trafficking Deterrence and Suppression Act 2012 prohibits and punishes all forms of human trafficking. Anti-trafficking inter-ministerial committee at the national level and committees in each district have been formed to monitor trafficking matters. Monitoring cells at the Police Headquarters have been set up, which focus on all forms of trafficking. A Taskforce for the rescue, recovery, repatriation and reintegration of children and women victims/survivors of trafficking has been established at the Ministry of Home Affairs (MoHA). The Ministry of Home Affairs and UNICEF have jointly developed a Standard Operational Procedure (SOP) to be followed by law enforcement agencies, development practitioners or rights activists who receive and send child victims.

In spite of the formulation of policies to combat trafficking, numerous barriers have been identified in the enforcement of the same such as:

- The Women and Children Repression Prevention Act, 2000 (amended 2003) does not incorporate any provisions for the security and protection of victims/witnesses in litigation involving trafficking, punishment for trafficking of adult males, punishment of sex industry clients, agents and brothel owners[78].
- The Suppression of Immoral Traffic Act does not apply to women above 18 years and does not apply to males[79]
- The Children Act, 1974 is inconsistent in the age that defines a child (16, as per this Act) and not in line with international standards[80]
- There have been incidences of Bangladeshi officials being involved in the act or trafficking[81]
- Bangladeshi women and children become more prone to trafficking due to their lack of awareness and their poverty stricken status[82]

Sex work

Data from 2004 suggests that there are up to 90,000 female sex workers in Bangladesh (National AIDS Committee, 2006)[83]

In Bangladesh, sex work in private is legal. However, it is an offence for third parties (e.g., pimps) to import, export, sell or hire a woman for sex work, under the Oppression of Women and Children (Special Enactment) Act, 1995. Suppression of Immoral Traffic Act, 1933 prohibits soliciting in public and brothel keeping. It is an offence under the Act for keeping a

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[74] University of Toronto (Faculty of Law). Bangladesh: Country Report for use in refugee claims based on persecution relating to sexual orientation and gender identity. 2011

[75] Rights in Exile programme. Bangladesh LGBTI resources. Accessed on 23rd November 2014 at http://www.refugeelegalaidinformation.org/bangladesh-lgbti-resources

[76] World Bank and UNAIDS. 20 years of HIV in Bangladesh: Experiences and Way forward. 2009

[77] World Bank and UNAIDS. 20 years of HIV in Bangladesh: Experiences and Way forward. 2009

[78] Winrock International and USAID. Review of Laws against Human Trafficking in Bangladesh (Prepared for ACT program, 2008-2014).

[79] Winrock International and USAID. Review of Laws against Human Trafficking in

[80] Winrock International and USAID. Review of Laws against Human Trafficking in

[81] UNAFEI. Chowdhury, M. Trafficking in Persons in Bangladesh. Resoure material Series no. 89

[82] Winrock International and USAID. Review of Laws against Human Trafficking in

[83] World Bank and UNAIDS. 20 years of HIV in Bangladesh: Experiences and Way forward. 2009

brothel or allowing premises to be used as a brothel, or living on the earnings of sex work and procuring a female for the purpose of sex work. Bangladesh's 3rd National Strategic Plan for HIV and AIDS Response 2011-2015 identifies a strategy to "conduct advocacy to strengthen an enabling environment", which includes advocacy for police and law enforcement agencies on working with and protecting the rights of members of vulnerable groups (sex workers among others).

Despite efforts being made by the Government to assist sex workers and to also reduce sex work in the country, there are several barriers to formulating policies and designing programs related to sex work such as:

- Like most South Asian countries, sex work in Bangladesh is either illegal or has an ambiguous legal state. Prostitution is not illegal but procurement of sex workers and soliciting in public is illegal. Sex workers therefore are vulnerable to harassment in the hands of the authorities[84].
- Law enforcement agencies have a critical role in making sex trade smooth or difficult. They are direct beneficiaries as they receive money through the trade[85]
- Sex workers regularly have to make payments to the different stakeholders in the sex trade such as the *dalals*, the madams and the local thugs. Often these people belong to local parties or gangs and extort money from the above. In case of street based sex workers, the thugs have been known to force sex without payments and without using condoms[86].

Migrants (Provision of Health Services)

To address gaps in migrant health interventions in Bangladesh, NASP, IOM, UNAIDS and other stakeholders have come together to formulate a Plan of Action (PoA) on Migration and Health with a special focus on HIV for 2013-2015. Diagnostic centres play a significant role in conducting health check-ups and medical screening for potential migrant workers.

Several barriers have been identified in the formulation and designing of the policies and programmes for the migrants such as:

- There are no policies that address the concerns of cross border mobility and HIV/AIDS.[87]
- Several people either leave the country undocumented or without fully disclosing the conditions of employment they would face overseas. Women migrants are vulnerable to sexual exploitation and violence while men might be prone to engaging in risky sexual behaviour[88]
- Migrant workers usually do not have access to suitable and affordable healthcare and HIV prevention services overseas[89]
- On being diagnosed as HIV positive, migrant workers are often deported back to the home country. The fear of the stigma attached to being detected is another inhibiting factor[90].

Conjugal rights (Marriage related rights)

Marital rape prevents individuals from being able to be in control of their own sexual and reproductive health, and exposes them to other health risks.[91] In Bangladesh, marital rape is excluded from the Penal Code and is not treated as rape. According to cultural and legal attitudes, wives should always be ready to meet the sexual "needs" of their husbands. The Penal Code 1860, Section 375 states the exception of marital rape. Beliefs rooted in traditional religious teachings serve to perpetuate the problem of marital rape by placing tremendous emphasis on a wife's responsibility to please and to remain

[84] WHO and the Global Coalition on Women and AIDS. Violence against sex workers and HIV prevention. Information Bulletin Series, Number 3. 2005. Accessed on 20th November 2014 at http://www.who.int/gender/documents/sexworkers.pdf
[85] WHO and the Global Coalition on Women and AIDS. Violence against sex workers and HIV prevention.
[86] WHO and the Global Coalition on Women and AIDS. Violence against sex workers and HIV prevention.
[87] UNAIDS and IOM. Situation Analysis: Migration and HIV in Bangladesh. 2013.
[88] UNAIDS and IOM. Situation Analysis: Migration and HIV in Bangladesh. 2013.
[89] IOM. HIV and Bangladeshi Women Migrant Workers: An assessment of vulnerabilities and gaps in services.
[90] IOM. HIV and Bangladeshi Women Migrant Workers: An assessment of vulnerabilities and gaps in services.
[91] IOM. HIV and Bangladeshi Women Migrant Workers: An assessment of vulnerabilities and gaps in services.

subordinate to her husband.[92] Women who are raped by their husbands are not even permitted to label their sufferings as rape which makes seeking redress from the law far-fetched.[93] The absence of a law recognising marital rape is the biggest barrier and reinforces the societal norms regarding the status of women.

Other harmful practices (Honour Killing)

No information available

[92] Measure Evaluation PRH. Law prohibits marital rape. Accessed on 29th November 2014 at http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/sgbv/law-prohibits-marital-rape

[93] Choudhury, N. in Financial Express (2012). Marital rape: Myth, relaity and failure of the Law. Accessed on 28th November 2014 at http://www.thefinancialexpress-bd.com/old/more.php?news_id=131575&date=2012-06-03

2.2.3 Highlights of the issues relevant from Advocacy perspective

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	▶ Effectively targeting young and newlywed couples for FP counselling and services ▶ Need for a private and confidential environment for adolescents seeking RH and FP services	▶ Raising awareness among adolescents about RH issues, during the early period of their married life ▶ Forming peer groups to increase outreach
HIV and AIDS	▶ Provision of ART through the government health system	▶ Awareness generation about HIV risk, comprehensive HIV knowledge and treatment and promotion of condom use, particularly among migrant population and sex workers
Abortion	▶ Better enforcement of National MR Guidelines in order to prevent service provision by untrained providers ▶ Provision of post MR or abortion services and counselling	▶ Awareness generation about the risks involved in unsafe MR
Access to services and information	▶ Need for an effective mechanism for procurement and distribution of different contraceptive methods ▶ Need for a pre departure orientation/briefing/training by the Government to prepare migrant workers for health related risk factors overseas	▶ Reducing stigma and discrimination, especially against transgender population, as this inhibits them to access health services
Others	▶ Better enforcement of laws addressing GBV ▶ Sensitization of government officials regarding trafficking laws	▶ Raising awareness among parents about laws prohibiting child marriage and the negative consequences associated with the practice ▶ Campaign for recognition of marital rape by the law

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies for Advocacy

- ▶ The socio-cultural environment needs to be considered while implementation of sexuality education curricula. Collaboration with certain religious groups and leaders can be an effective approach which can help to overcome cultural sensitivities, personal beliefs/attitudes of teachers and parents regarding sexuality education.
- ▶ Involvement of men and their participation in FP and RH initiatives can be significant in decreasing maternal mortality and morbidity.

2.2.4 Civil Society Organizations

S.No.	Name	Focus Thematic Areas
1	Family Planning Association of Bangladesh	▶ Healthcare- Family Planning and eradication of HIV/AIDS and other sexually transmitted diseases ▶ Woman rights Abortion related rights

S.No.	Name	Focus Thematic Areas
2	US Agency for International Development, Bangladesh	▶ Health ▶ Education
3	SpaandanB	▶ Health- Child care and nutrition aspect ▶ Education- Focus on developing rural talents
4	Reproductive Health Services Training and Education Program (RHSTEP)	▶ Sexual reproductive health and rights- Advocacy to promote SRHR and ASRHR in Bangladesh ▶ Health- Reduce maternal mortality, provide services to women, men, adolescents and children
5	Pathfinder International	▶ Sexual reproductive health and rights ▶ Education ▶ Health- Family planning, maternal and new-born care
6	Nari Maitree	▶ Women rights ▶ Healthcare- Family planning, HIV/AIDS, nutrition
7	Marie Stopes	▶ Sexual reproductive health and rights- RTI/STI management, antenatal and postnatal healthcare, menstrual regulation ▶ Women rights ▶ Healthcare- Family planning (LA/PM), child health care,
8	International Centre for Diarrhoeal Research, Bangladesh	▶ Healthcare- Neonatal care, HIV/AIDS
9	Population Council, Bangladesh	▶ Sexual reproductive health and rights- Expanding contraceptive method mix, reduce sexual and gender based violence, reduce adolescent fertility ▶ Women rights - Delay marriages ▶ Healthcare - Improve maternal and child health
10	BRAC	▶ Healthcare - Provision of vital medicines and services, maternal, neonatal and child service ▶ Women rights - social and financial empowerment of women
11	Plan B	▶ Healthcare- Child protection, community health
12	Bangladesh Women's Health Coalition	▶ Women rights- SRHR for the urban and rural poor, safe abortion projects ▶ Healthcare- STI and HIV/AIDS prevention projects
13	Steps Towards Development	▶ Women rights- Prevention of child marriage
14	Dushta Shasthya Kendra (DSK)	▶ Women rights ▶ Healthcare
15	Bangladesh Association for Prevention of Septic Abortion	▶ Healthcare- Reproductive health services, safe abortions
16	Bandhu Social Welfare Society	▶ Sexual and reproductive health rights- Service for HIV, promotion of sexual minority communities
17	HIV/AIDS and STD Alliance Bangladesh (HASAB)	▶ Healthcare- HIV/AIDS and STI, youth friendly health services

International Conventions

S.No	Name of the convention	Year of Signing
1.	Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others	Acceded in 1985

2.	Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages	Acceded in 1998
3.	International Covenant on Economic, Social and Cultural Rights	Acceded in 1998
4.	Convention on the Elimination of All Forms of Discrimination against Women	Acceded in 1984
5.	Convention on the Rights of the Child	Signed in 1990, ratified in 1990
6.	International Conference on Population and Development (ICPD), Cairo	Attended in 1994
7.	UN Fourth World Conference on Women, Beijing	Attended in 1995
8.	ICPD +5	Attended in 1999
9.	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	Signed in 1998, ratified in 2011
10.	World Summit	Attended in 2005
11.	London Summit on Family Planning	Attended in 2012
12.	Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery	Acceded in 1985
13.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Signed in 2000, acceded in 2000
14.	SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution	Attended in 2002
15.	ILO Convention 1999 (No. 182), Elimination of Worst Forms of Child Labour	Ratified in 2001
16.	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, 1999	Signed 2000, ratified in 2000

2.3 Bhutan

2.3.1 Situational Analysis

All Bhutanese avail free health services from primary to tertiary level health care as a right guaranteed by the Constitution of Bhutan. Health is also an important component for happiness and wellbeing. Bhutan's health care is founded on a three-tiered health care delivery model with primary health care as the backbone. In 1970s, the Maternal and Child Health (MCH) programme was started in order to address the problem of high maternal mortality rate (MMR), infant mortality rate (IMR) and high population growth rate in Bhutan. In 1994, this was reconstituted as the Reproductive Health programme which re-conceptualised reproductive health into the several categories one of which is family planning. The Draft Population Policy 2013 and the National Health Policy 2011 are the two main policies guiding reproductive and sexual health in the country.

Sexual and Reproductive Health Indicators

Indicators	Value	Year	Source
Total Fertility Rate	2.3 children born per woman	2012	UNICEF
Contraceptive prevalence rate (%)	65.6	2008-12	UNICEF
Delivery care (%), Skilled attendant at birth	64.5	2008-12	UNICEF
Delivery care (%), Institutional delivery*	63.1	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	97.3	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	77.3	2008-12	UNICEF
Maternal Mortality Rate (MMR)	150 per 1,00,000 live births	2008-12	UNICEF
Infant Mortality Rate (IMR)	36 per 1000 live births	2012	UNICEF
Health Budget (as % of GDP)	3.6	2013	World bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

2.3.2 SRHR Situation in the country

Family Planning

Bhutan began its family planning programme in 1971 and during the first decade, FP services had limited geographic coverage and a limited range of contraceptive methods were available. By 1980 family planning was integrated into the general health care system and in 1981 the National Institute of Family Health (NIFH) was created, which expanded family

planning throughout the country as an integrated service. In 1995, a Royal decree on population planning was issued, followed by the intensification and strengthening of family planning, included in the Reproductive Health programme (RH Programme 1994) and till date this programme receives great support from both highest political and religious authorities in Bhutan. Family planning in Bhutan has been covered under the Draft National Population Policy (NPP) 2013 which seeks to sustain declining trends in fertility rate to achieve a stable population growth by 2050. Its goal is to achieve a replacement level fertility rate of 2.1 births per woman by 2020, and maintain constant thereafter.

Family planning in Bhutan has been extensively covered under the National Reproductive Health Strategy (2012 to 2017) and Draft NPP 2013. In 2003, the Guidelines on Medical Standards for Contraceptives were updated and new sections added on female condoms and emergency contraceptives. Due to this effort, women were able to access female condoms and emergency contraceptives in all 29 hospitals and 7 Grade 1 Basic Health Units.

Today, FP services, including contraceptives, are available through the public health system, and condoms are available over the counter in retail pharmacies. Most forms of contraceptives (except Intrauterine devices (IUDs)) are available during monthly or twice-monthly outreach clinics and village health workers can dispense oral contraceptives and condoms to registered users. Free FP services, including free condoms have been expanded to include distribution of free condoms outside the health system at restrooms of bars, restaurants, hotels and gas stations. The most preferred forms of contraception, according to 2009 Ministry of Health figures, were DMPA injectable (48.1%), followed by male (24.6%) and female (8.1%) sterilisation and daily oral pills (9.4%). The use of IUDs and male condoms was found to be low, at 5.9% and 3.9% respectively, and the use of female condoms was negligible.

In spite of having a well-defined population policy and programmes to address FP, there continue to be a number of barriers. Some of the key problem areas are as follows:

- There is a need to make national contraceptive guidelines more understandable and 'user-friendly'[94].
- Low male participation in family planning programs[95]
- Even though there is a mention of the role of men in SRH in the National Reproductive Health Strategy (2012 to 2017), there is a need for further sensitisation and involvement of men and boys in the approach towards family planning policies.
- Inadequate and inefficient service delivery provisions
- Low contraceptive usage among young married women
- Misconception and lack of information on family planning issues and a consequent lack of confidence of family planning methods in the community

Reproductive Health Services

MCH clinics and Antenatal Care (ANC) clinics are conducted at all Hospitals and Basic Health Units (BHUs), and access for those in the most remote areas is available through monthly outreach clinics. However, performance on certain indicators such as MMR, compared to other countries in the region and the low allocations relative to health spending is still a cause of concern. Nearly two-fifth of deliveries are still attended by medically untrained personnel, increasing the risk of maternal and neonatal death. There is a need to invest heavily in this area.

Bhutan's 11th Five Year Plan (FYP) (2013-2018) talks about improved reproductive and chid health services, including increasing ANC coverage (at least 4 visits) to 80%, mothers attending 1st PNC visit (within 1 week) to 80%, increasing access to RH services to greater than 50% and increasing access to institutional delivery to greater than 80%. ANC, post natal care and safe deliveries have been covered under the RH Programme 1994, National Health Policy 2011, National Reproductive Health Strategy (2012 to 2017) and the Draft NPP 2013 of Bhutan.

The aforesaid interventions have contributed significantly to improve MCH, yet some challenges remain:

[94] UNICEF. "A Situation Analysis of Children, Youth and Women in Bhutan." 2012.
[95] Choda, Jamyang, and Jigme Nidup. "Determinants of Modern Contraceptive Use in Bhutan." 2012.

- While health services reach 95% of the population, gaps in the quality of healthcare exist. The deployment and retention of more female health workers is one of the necessary means to encourage women to use antenatal and postnatal services, and to deliver in health facilities. [96]
- There is a need to address the quality of infant care and child feeding needs in antenatal and postnatal care, nutrition and RH programmes. [97]
- Reproductive health information and services need to be improved amongst poor, rural, uneducated women. [98]

Prevention and Appropriate Treatment of Infertility

The extent of infertility prevalence in Bhutan is not known; however it is expected to be high and hence is an area that needs urgent attention. The RH programme 1994 includes a component on prevention and management of infertility. One of the objectives of this programme is to initiate infertility management and to improve infertility care services by establishing infertility clinics. The Draft NPP 2013 talks about prevention and management of infertility. The 11th FYP (2013-2018) talks about improving infertility management by establishing infertility clinics.

Reproductive Tract Infections (RTI)

Provision of Reproductive Tract Infections related services have been covered under Bhutan's RH programme 1994 and the National Reproductive Health Strategy (2012 to 2017). Obstacles in accessing healthcare facilities such as distance, cost, poor quality of services leading to low confidence and low level of awareness are some of the barriers which continue to hamper access to RTI services.[99]

Abortion

In 2004, as part of a national drive to strengthen democratic institutions and social conditions, Bhutan approved its first penal code which states that abortion is illegal except when it is conducted to save the life of the mother or when the pregnancy is a result of rape, or when the mother is mentally unsound. Abortion is permitted up to 20 weeks of gestational age provided the need for abortion is certified by at least two doctors (recognised by the Ministry and who have undergone training in obstetrics and gynaecology or have a certificate of required expertise by a competent institution), though in an emergency, certification by one doctor is permissible. In cases where abortion is sought for pregnancy resulting from rape or incest, the law requires that the case be proven in a court of law. The consent should be provided and signed by both the doctor and the client.

- Morbidity by abortion: 1066 (2011) (Statistical Yearbook for Bhutan 2012)

A Multi Sectoral Task Force (MSTF), set up in 2001, under the supervision of the Ministry of Health is engaged in prevention, raising awareness and carrying out advocacy programs on teenage pregnancy and unsafe abortion, among a host of other issues. Bhutan's National Reproductive Health Strategy (2012 to 2017), includes a component on prevention of unsafe abortion. However, there are no specific programs to facilitate abortions as they are deemed illegal by the country's law. The National Medical Standard for Contraceptive Services and Standard Guidelines on Management of Complications of Abortion Manual[100] serve as a basis for abortion provision requirements and prescribe standards to be followed. Post-abortion counselling is mandatory and focuses on the risks of unsafe abortion and on appropriate methods of contraception. MIS systems are in place and require that a report be submitted to the national Health Management Information System (HMIS) on a quarterly basis. Data are also collected through regular Maternal and Neonatal Death Reviews.

[96] UNICEF. "A Situation Analysis of Children, Youth and Women in Bhutan." 2012.
[97] UNICEF. "A Situation Analysis of Children, Youth and Women in Bhutan." 2012.
[98] UNICEF. "A Situation Analysis of Children, Youth and Women in Bhutan." 2012.
[99] Moving toward a common understanding of the key development challenges in the country. Common Country Assessment-Bhutan 2000
[100] These guidelines were not available online

While mifepristone and misoprostol are registered and included in the national Essential Drugs List, they are not available in the market. Manual vacuum aspiration syringes are available through the government procurement system[101].

Some issues to be addressed are as follows:

- Abortion as a method of contraception is socially unacceptable and illegal in Bhutan. Given the strong Buddhist beliefs and traditions, the taking of life of any sentient being is unthinkable – abortion is equated with the act of killing. On the other hand, the practice of birth control and family planning is acceptable as it is generally believed that "what is not conceived cannot be killed".
- The lack of a legal environment is a policy barrier in Bhutan. Those in need of an abortion but not fitting the required criteria stipulated by the law often find themselves going across the border to unsafe abortion clinics, particularly in Jaigaon, India, where abortions are conducted in unhygienic and deplorable conditions, many times leading to complications and deaths. Additionally, these women face the fear of social stigma, the risk of being conned and, most importantly, the possibility of needing serious medical care in the aftermath of such abortions.
- The Penal Code does not indicate the procedure required if a minor girl is pregnant or if the case of rape or incest cannot be proven in court.
- There is no proper study done on the number and causes of abortions and no reliable data on prevalence of unsafe abortion. The government must study this issue and undertake assessment studies to enable decision makers to formulate appropriate strategies to address the problem.
- Therefore, there is a need to carry out assessment studies for effective programmatic interventions.

AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS

HIV/AIDS cases in Bhutan have increased from 2 in 1993 to 321 in 2013. Since the first detection of HIV in the country, the annual reported cases have substantially increased with approximately 87% of the total HIV cases reported between 2004 and 2013. Mode of transmission is predominantly through heterosexual intercourse (90.5%) followed by mother to child transmission (7.8%) and less than 2% through blood transfusion and injecting drug use.

- Comprehensive knowledge of HIV among females: 21% 2008-2012 (UNICEF)
- Adult HIV Prevalence - 0.2% 2012 (UNICEF)

Five years prior to the detection of first case of HIV, recognising the adverse impact of HIV on national development, the Government initiated the establishment of the National STI and HIV/AIDS Prevention and Control Programme (NACP) in 1988.This was followed by the inception of National AIDS Committee (NAC) in 1993 to oversee and coordinate multi-sectoral efforts to ensure a harmonised response to HIV in the country. The NAC was later restructured to form the National HIV and AIDS Commission (NHAC) for policy formulation and strategic responses to mitigate the impact of HIV in the country. Following the institutional establishment, planned activities were implemented over the years with a major focus on prevention and improving access to care and treatment services for the PLHIV in the country. In 2005, the NHAC approved the provision of free ART for those infected, including pregnant women to prevent the vertical transmission of HIV.

The National Strategic Plan for HIV/AIDS and STI (NSP-I, 2008–2013) was launched in 2008, in line with the Government's 10th FYP. It provided the strategic direction for STI and HIV response in the country. To address the changing dynamic of the epidemic, the National Strategic Plan -II (2012-2016) was launched in 2012 with a goal to "reduce new STI and HIV infections and provide continuum of care to people living with and affected by HIV". This plan builds on past achievements, existing gaps, and focuses on scaling up of existing prevention interventions, and making them more cost effective in order to ensure accessibility to underserved and unreached most-at-risk populations (MARPs). The NSP-2 proposes the use of strong and coordinated partnerships to prevent the spread of HIV, and mitigate the impact of the epidemic, and to create a supportive environment for PLHIV.

Apart from coordinated government efforts, the high level concern and commitment is reflected in the top-level initiative from the Royal family. On May 24, 2004, Fourth King, His Majesty Jigme Singye Wangchuck, issued a Royal Decree to

[101] Mapping abortion policies, programmes and services in the South-East Asia Region, WHO

participate in HIV prevention and to respect the rights of PLHIV. This reinforces Bhutan's overall target to achieve the MDG of reversing and halting the spread of HIV and AIDS by 2015. This goal is in tandem with the national long term goal of Gross National Happiness.

HIV/AIDS and STI has been covered in the National Health Policy 2011, Draft NPP 2013 and National Reproductive Health Strategy (2012 to 2017). Apart from this, MSTFs initiated in 2001 by the Ministry of Health, aim to build partnerships between the government and civil society to address HIV at the district level. The MSTFs develop policy guidelines and HIV Action Plans and raise awareness about HIV among the public at the district level.

Despite the efforts to address the incidence of HIV/AIDS:

- According to a 2012 World Bank report, the usual approaches to reach MARPs are difficult to follow in Bhutan as it is a low prevalence setting. A concentrated epidemic will only be averted if MARPs are adequately reached. In most countries these interventions are implemented by NGOs and CBOs. However, there are limited NGOs and CBOs in Bhutan lack the necessary experience and capacity to deliver HIV prevention services. Even bringing PLHIV to work together is difficult given the lack of privacy and stigma.
- HIV services in Bhutan are mostly facility based. The system has limited outreach or linkages to vulnerable population and MARP groups.[102]
- The health system has limited capacities (technical and management) to address the specific treatment and care needs of MARPs.[103]
- The health system is not currently geared to deliver the (WHO recommended) "comprehensive package" of services essential for the prevention of HIV among MARPs.[104]
- The monitoring system is not integrated with the HMIS and is unable to capture access of MARPs to services adequately.[105]
- Assessing the true incidence of STIs in Bhutan remains a challenge, due to the limitations of sentinel surveillance, assumed gross under reporting, as well as non-disclosure of infections and self-treatment by many persons. Additionally, some people also seek treatment from border towns in India, and from Indian Military Training Team hospitals in Bhutan, thereby making the assessment of STI incidence difficult.[106]
- High risk of substance abuse which is associated with a higher risk of HIV infection as it can lower inhibitions and increase sexual risk-taking behaviour.[107]

Adolescent Sexual and Reproductive Health services – Youth Friendly Services

The reproductive health needs of adolescents/youths in Bhutan took a new turn after Her Majesty the Queen accepted the UNFPA Goodwill Ambassadorship in 1999. Her Majesty's frank discussion on adolescent sexuality and reproductive health concerns among the school population throughout the country has promoted acceptance of the subject in the school curriculum. This has greatly enhanced the understanding of sexuality and RH issues among young people.

- Comprehensive knowledge of HIV among adolescent females: 21.9%[108]
- Average age for marriage for both males and females: 24 and 20 respectively[109]
- Teenage fertility[110]: 1.9%[111]
- 50% of the HIV infected populations are within the age of 15 to 29 years strongly indicating the vulnerability of the youth population. (NPP, 2013)

[102] UNAIDS. "Global AIDS Response Progress Report for Bhutan." 2014
[103] UNAIDS. "Global AIDS Response Progress Report for Bhutan." 2014
[104] UNAIDS. "Global AIDS Response Progress Report for Bhutan." 2014
[105] UNAIDS. "Global AIDS Response Progress Report for Bhutan." 2014
[106] UNAIDS. "Global AIDS Response Progress Report for Bhutan." 2014
[107] UNAIDS. "Report on HIV/AIDS in Bhutan." 2008
[108] UNICEF, 2008-2012
[109] Bhutan Living Standards Survey, 2012
[110] It is defined as the proportion of women aged 15–19 years who gave birth in the past 12 months
[111] Bhutan Living Standards Survey, 2012

In order to ensure quality services for the youth, the RH programme 1994 re-conceptualised reproductive health into the several categories one of which is Adolescent Reproductive Health. The National STIs and HIV/AIDS Prevention and Control Program developed the "National Standards for Youth Friendly Health Services and Implementation Guide" in 2009 that enables all health workers to mainstream youth friendly services in their health delivery system. The National Health Policy 2011 identifies adolescents as a Special Needs Group and talks about addressing their health needs in particular. Objectives of the Draft NPP, 2013 with regard to adolescent health include promoting awareness about SRH rights, strengthening youth and adolescent friendly health and education services and increasing stakeholder participation in ASRH related decision making. The Youth Friendly Health Services program strategizes to reorganise the existing health system of the country in order to improve availability, accessibility, acceptability and use of quality health services by young people (10-24). The 11th FYP (2013-18) has a target of increasing the share of adolescents accessing ASRH services to 70%, and the share of health providers providing YFHS to 50%. Amongst the objectives of the National Adolescent Health Strategic Plan (2013-2018) is to guide the various stakeholders in the implementation of health and other social support services, including sexual and reproductive health for adolescents and youths in the country.

Even with several interventions, there are a few challenges faced by the ASRH sector in the country.

- According to a UNICEF report, the capacity to make policy and to plan for effective ASRH services is hampered by the lack of information about rates of STI.
- Although contraceptives are available free of cost in all hospitals and Basic Health Centres, these services are not adequately accessed by the young population.[112]
- A study by UNCEF[113] identified a limited number of behavioural change communication (BCC) materials on puberty, menstruation, teenage pregnancy, contraception, unsafe abortion, vaginal discharge and STIs, and nothing on sexual orientation, myths and misconceptions, safe sex, menstrual disorders, and sexual abuse available at health facilities in Bhutan.
- According to a 2012 UNICEF report on A Situation Analysis of Children, Youth and Women in Bhutan, for services that concern adolescents and youth like RTI and sexual health education especially for adolescent girls, there is a need for it to be integrated into and expanded in their school education. This will enable increased utilisation of health care services by young women.

Comprehensive Sexuality Education

Young people's knowledge, until recently, on sex and sexuality and RH in general has been vague and fragmented. Socio cultural norms and judgmental attitude of adults have left adolescents to explore their sexuality on their own. The reproductive health needs of adolescents/youths in Bhutan took a new turn after Her Majesty the Queen, Ashi Sangay Choden Wangchuck accepted the UNFPA Goodwill Ambassadorship in 1999. Her Majesty's frank and open discussion on adolescent sexuality and reproductive health concerns among the school population throughout the country has promoted acceptance of the subject in the school system. This has greatly enhanced the understanding of sexuality and RH issues among young people.
The Comprehensive School Health Programme (CSHP) 1998 covers the components on RH and well-being of students with regard to an increase of youth involvement in substance abuse, suicide, accidents, adolescent pregnancies and the threat of HIV and AIDS. One of the strategies in the National Adolescent Health an (2013-18), Adolescent Health Programme, is to review the existing curriculum on SRH in the formal and non-formal education sectors and incorporate age-appropriate comprehensive life skills based educational materials on nutrition, growth, menstrual health, sexual health, family planning, HIV/AIDS, STIs, alcohol and drug, interpersonal violence and conflict resolution skills, in the school curriculum. The National Youth Policy 2011 also talks about improving the understanding and knowledge of the youth on SRH.

As per the National Standards and Implementation Guide for Youth Friendly Health Services, the societal attitude towards sex and sexuality is known to be fairly tolerant. Premarital sex is not taboo in many rural communities. Despite this relatively open approach, it is not common practice to discuss adolescent sexual concerns with family members and siblings. Many adults are still under the notion that information on RH and sexuality may encourage young people to rush towards it.

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[112] National Standards and Implementation Guide, Youth Friendly Health Services
[113] "A Situational Analysis of Children, Youth and Women in Bhutan", UNICEF, 2012.

Secondly, there is a lack of awareness and knowledge, especially among adolescent girls, on SRH issues, lack of skills to negotiate unwanted sex or safer sexual relations and poor parental guidance. These barriers put young girls at very high risk of unwanted pregnancy and STIs.

Early and Forced Marriage

Unlike the rest of the region, premarital sex is common and accepted in Bhutan. But lack of information regarding RH, sexual activity and resulting consequences leads to an elevated risk of teenage pregnancies. Distinct from other Southern Asian countries, husbands in Bhutan sometimes move into the home of their wives' family. This provides an economic incentive for families to marry their daughters at younger ages, since the new husband will be able to contribute to the family's income.

The law pertaining to child marriage in Bhutan has evolved significantly over the last two decades. In order to comply with international standards, the government of Bhutan raised the minimum legal age of marriage to 18 years for both boys and girls in 1996[114]. If an individual is found guilty of marrying a child, he will be fined Ngultrums 300 – 1,000, and must return any properties received for the marriage. However, BMIS 2010 reported that 30.8% of the women aged 15-49 years were married before they turned 18, though the trend is found to be decreasing, especially in the urban areas. A 2013 UNICEF report found early marriage to be a major influencing factor in poorer outcomes during delivery of young women, even when skilled assistance and care is available. According to the Child Care and Protection Act (CCPA), marrying and having sex with a child is considered statutory rape. The main aim of the YFHS 2009 is to prevent early marriage by sensitising communities regarding the harmful consequences of child marriage.

Following are a few key barriers faced by the country with respect to early marriages:

- While the existence of laws is an important first step, enforcement remains weak in remote, rural areas. Unregistered and illegal underage marriages are still known to occur, especially in the rural areas.[115]
- Marriage registration is patchy and systems are unreliable, especially in regions were prevalence is deemed to be high
- The custom of men moving into the homes of their wives gives rise to a very strong economic incentive for the parents of the girl to marry her at an early age.[116]
- Due to ambiguity in the definition of marriage, accurate statistics on the incidence of child marriage are difficult to come by.[117]

Prevention and Surveillance of Violence against Women (Gender Based Violence)

According to the BMIS 2010, 68.4% of women in Bhutan felt that their husband/partner has a right to hit or beat them if they neglect children, argue with their partners, refuse sex, administrate their autonomy or burn dinner.
The Constitution of the Kingdom of Bhutan provides for the State to take appropriate measures to eliminate all forms of discrimination and exploitation against women including abuse, violence, harassment and intimidation at work in both public and private spheres and to ensure that children are protected against all forms of discrimination and exploitation. The National Commission for Women and Children (NCWC) was established in 2004 as part of the Ministry of Health. Due to the rising number of issues related to the welfare of women and children, NCWC was given an autonomous status under the Royal Government in 2008. The objective of NCWC is to protect and promote the rights of women and children; reform plans projects and activities from the perspective of gender equality and co-ordinate with NGOs and CSOs for the implementation of welfare and counselling services for the target group. The Women Division (WD) looks into the affairs relating to women and girl child with the motive of enhancing socio-legal protection of females, economic empowerment and awareness creation regarding gender equality. All ministries, government agencies and the private sector organisations have Gender Focal Points (GFPs) in their sectoral plans to ensure that gender concerns are mainstreamed.

[114] As an Amendment to the Marriage Act, 1980.
[115] Draft National Population Policy, 2013
[116] Child Marriage in Southern Asia, UNFPA, 2012
[117] Child Marriage in Southern Asia, UNFPA, 2012

The National Plan of Action on Gender was developed for the period 2008-2013 in consultation with National Gender Focal Points (GFPs) and other key stakeholders. It helped identify challenges and gaps in gender specific interventions, create awareness and sensitisation regarding gender equality and women's empowerment and assisted in conducting further research on the subject. National Plan of Action on Gender also created an enabling environment for the creation of a gender based policy. As a result, the parliament enacted the Domestic Violence Prevention Act in 2013, which authorises the NCWC to develop and implement programs to prevent domestic violence, rehabilitate survivors, and conduct studies. This Act introduced measures which seek to ensure that the relevant organs of the State give full effect to the provisions of this Act.

A Woman and Child Protection Division exists under the supervision of the Deputy Commissioner of Police, Crime and Operations Branch, Royal Bhutan Police to handle matters relating to protection of women and children.

Despite the many interventions aimed at empowering women, there is lack of evidence and in-depth analysis on the issue of domestic violence in the country. This makes it difficult for the authorities to understand the true scale of the issue. Even though Bhutan is a signatory to CEDAW, strong conventional assumptions on women's role and position still place women at an inferior level, and these remain steadfast with men and women both.

Sexual Orientation and Gender Identity (SOGI) Rights

There is very little information available about the MSM population and same sex sexual activity in Bhutan. There are no known epidemiologic studies focusing on MSM in Bhutan although there are anecdotes of sex between men in army barracks, prison cells and dormitories. There are no known community based responses to HIV among MSM in Bhutan. There are also no known national MSM networks either. There is little information on the extent to which Bhutan's national healthcare system is inclusive of MSMs and other sexual minorities.

The necessity to ensure universal access and equality in healthcare delivery were expressed in the Honourable Secretary for the Ministry of Health, Nina Wangdi's remarks at the Bhutan National Stakeholders Meeting on Advocacy and HIV Prevention among MSM and Transgender People in May 2012.

Clauses 213 and 214 in the Penal Code of Bhutan criminalise homosexuality. Since homosexuality is viewed as illegal in Bhutan, there are no known program interventions, no known community interventions, no known MSM networks or any epidemiologic studies regarding MSMs.

Several barriers have been identified:

- Even though no arrests have been made in spite of the legal provisions in Bhutan, the dormant law has impacted many gay and transgender Bhutanese who wish to remain hidden to avoid being discriminated against.
- The gay community is a high risk group to HIV/AIDS since they are inhibited in availing healthcare for both physical and mental issues
- Stringent Bhutanese beliefs regarding sexuality create further barriers for MSMs in accessing healthcare. In 2005, the King, His Majesty Jigme Khesar Namgyel Wangchuck advocated abstinence and urged Bhutan's youth to "use their strength of character to reject undesirable activities."
- The social stigma attached to homosexuality makes it difficult for MSMs to access condoms or avail counselling services. This results in the inability of programmers and public health practitioners to reach out to this category of people.
- Many MSMs are forced into heterosexual marriages and often father children with their wives. This results in the wife becoming prone to STIs in case the husband gets infected during sexual practises with multiple partners.

Human trafficking

Men, women and children are vulnerable to forced labour and trafficking and in spite of limited data it has been found that Bhutanese children are forced into labour and subjected to sex trafficking not only in Bhutan but also in India. Bhutanese women who work as entertainers or domestic servants are often subjected to trafficking through debts and threats of

physical abuse. An expanding construction sector has led to a noted increase in the number of low skilled foreign labour, particularly from India.

The Constitution of the Kingdom of Bhutan as well as various sections of the Bhutan Penal Code talk about combatting human trafficking. The NCWC is an autonomous agency which coordinates all policies and activities related to protection and promotion of rights of women and children, including human-trafficking. A Standard Operating Procedure on TIP is in the process of being developed by NCWC in collaboration with all relevant stakeholders. The NCWC will be working closely with the UNODC on a project to "Enhance Government and Civil Society Responses to Counter trafficking in persons in Bhutan" for a period of 3 years beginning early 2014. "

It has been found that the Government of Bhutan does not fully comply with the minimum standards for the elimination of trafficking. However, it is making significant changes to do the same. As per the Trafficking in Persons Report by the U.S Department of State 2014, there have been no known efforts made to combat trafficking. According to the same report, several barriers have been identified in relation to combat human trafficking:

- There is a need to train government officials on human trafficking and implementation of laws on the same
- Lack of shelters for trafficked victims on the border areas
- Need to develop proactive procedures to identify and help victims of trafficking
- Victims who have been trafficked are often punished for other crimes like prostitution
- Bhutan has not yet acceded to the 2000 UN TIP Protocol
- There is a need to amend Article 154 of the Penal Code to redefine trafficking so the purpose of the crime is 'exploitation' rather than 'illegal purpose'

Sex work

The Constitution of the Kingdom of Bhutan, provides that: "The State shall endeavour to take appropriate measures to eliminate all forms of discrimination and exploitation against women and children, including prostitution". Further, various articles of the Bhutan Penal Code criminalise prostitution. National Standards for Youth Friendly Health Services and Implementation Guide address youth involved in commercial sex work.

The National Strategic Plan II for STIs, HIV and AIDS, 2012–2016 is responsive to gender-based stigma and discrimination towards female sex workers (FSWs) and men who have sex with men (MSM), reviews the criminalisation of female sex work and sodomy (unnatural sex acts) and talks about enhancing access to SRH services for MSM. It also talks about effective inclusion of women and MSM among key stakeholders in national response program design, implementation and review.

- Due to the lack of policies relating to sex workers and sex work and the social stigma attached to the same there is no formal framework in place.
- Frequent police raids in the border area towns where sex work is conducted, drive sex workers underground thus making it difficult to reach them with prevention services.

Migrants (Provision of Health Services)

As per the available data the net migration as estimated by a 2010 World Bank Report is 10,000. There is a lack of information regarding the key policies, policy barriers and programs that have been formulated and implemented by the Government for the migrant population. As per a UNICEF report, the rate of urbanisation in Bhutan is about 6% and the urban component of the population grew from 21% to 35% in the four years until 2008. This has resulted in pressure being put on the limited urban social services including healthcare.

Conjugal rights (Marital Rape)

In Bhutan, the practice of polygamy is legally dependent on the consent of the first spouse and is socially acceptable, but there is no legal recognition granted to polygamous spouses under civil law or customary law. The dowry system does not exist in Bhutan and inheritance is matrilineal.

The Marriage Act, 1980 (amended in 1996) covers marriage, separation, adultery, sexual assaults, divorce, child custody and child support. Marital rape is a sexual offence according to the Bhutan Penal Code. Anyone engaging in sexual intercourse without the spouse's consent or against the will of the spouse is considered guilty. However, it is classified a 'petty misdemeanour'.

Other harmful practices (Honour Killing)

No information available

2.3.3 Highlights of the issues relevant from Advocacy perspective

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to SRH:

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	▶ Increase in access to contraceptives among adolescents ▶ Need to develop BCC material on sexual orientation, myths and misconceptions, safe sex, menstrual disorders, and sexual abuse for use at health facilities ▶ Integration of sexual health education, especially for adolescent girls, in their school education	▶ Awareness generation particularly among adolescent girls on SRH issues, such as teenage pregnancies, abortions, contraceptive use and gender-based violence
HIV and AIDS	▶ Provision of training CBOs to work with MARPs and gradually scale up interventions ▶ Provision of WHO recommended "comprehensive package" of services essential for the prevention of HIV among MARPs ▶ Strengthening district level capacity to maintain an information base on risk behaviour and epidemic trends	▶ Formulation of communications programs to reducing stigma among PLHIV ▶ Increase outreach activities (work with peer educators, and outreach workers) to promote community empowerment, mobilisation, and ownership of programmes
Abortion	▶ Need to carry out assessment studies for effective programmatic interventions	▶ Advocacy on more liberal and comprehensive laws
Access to services and information	▶ More inclusive health policy on migrants and sexual minorities ▶ Involve men and boys as a stakeholder while formulating FP policies	▶ Provision of health services, particularly contraceptives to sexual minorities ▶ Sensitisation and involvement of men and boys in FP activities
Others	▶ Enforcement of laws regarding legal age of marriage in rural areas ▶ Provision of training to government officials on implementation of laws regarding human trafficking ▶ Make national contraceptive guidelines more understandable and 'user-friendly'	▶ Promotion of marriage registration in rural areas ▶ Need for research studies in order to understand the issue GBV ▶ Accession to the 2000 UN Palermo Protocol on human trafficking

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies for Advocacy

- Her Majesty the Queen Mother Ashi Sangay Choden Wangchuck is the Good Will Ambassador for UNFPA and President of an NGO (RENEW). She interacts regularly with policymakers and communities on various SRH issues. It is important to engage individuals with high political and cultural standing in the country such as the Queen so that relevant issues are put forth the decision makers to enable and maintain momentum of existing good work and advocate for what needs to be done.
- Counselling parents about the importance of Adolescent Reproductive Health (ARH), involving them as members of advisory committees that review programme content on adolescent SRH issues and gaining their support in this regard can help to promote adolescent healthcare services in Bhutan.
- Greater emphasis on evidence based advocacy, such as epidemiological studies on health seeking behaviour, prevalence patterns, motivators and barriers to health services, can provide inputs to the ongoing advocacy efforts – policy advocacy, people centred advocacy and media advocacy. Regional co-operation across countries will also lend voice to ongoing advocacy.

- It is important to ensure that there is adequate participation of men in all the initiatives.

2.3.4 Civil Society Organisations

S.No.	Name	Focus Thematic Areas
1	Lhak-Sam	▶ PLHIV and their families
2	Bhutan Youth Development Fund	▶ Youth development and empowerment, including their rights
3	Renew Bhutan	▶ Women's rights ▶ Domestic and gender-based violence
4	National Women's Association of Bhutan (NWAB)	▶ Gender ▶ Poverty reduction
5	The International Bhutan Foundation	▶ Child Survival, Safe Motherhood and Primary Health Care
6	APCOM (Asia Pacific Coalition on Male Sexual Health)	▶ MSM and HIV

International Conventions

S.No	Name of the convention	Year of Signing
1.	Convention on the Elimination of All Forms of Discrimination against Women	Signed in 1980, ratified in 1981
2.	Convention on the Rights of the Child	Signed in 1990, ratified in 1990
3.	International Conference on Population and Development (ICPD), Cairo	Attended in 1994
4.	UN Fourth World Conference on Women, Beijing	Attended in 1985
5.	ICPD +5	Attended in 1999
6.	World Summit	Attended in 2005
7.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Signed in 2005, acceded in 2009
8.	SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution	Attended in 2002

2.4 India

Section I – Situational Analysis

In India, while the National Health Policy[118] provides a roadmap to achieving acceptable standard of good health, it is the National Population Policy 2000 that provides a policy framework for advancing goals and prioritizing strategies. The National Policy for the Empowerment of Women 2001 has also played a vital role in promoting SRHR issues. It is based upon the need to simultaneously address issues of child survival, maternal health and contraception, while increasing outreach and coverage of a comprehensive package of reproductive and child health services by the government, industry and the voluntary non-government sector, working in partnership. Situation of India on key SRH issues is presented in the table below.

Sexual and Reproductive Health (SRH) Indicators

Indicators	Value	Year	Source
Total Fertility Rate	2.3	2013	Sample Registration System (SRS), Census of India
Contraceptive prevalence rate (%)	49	2011	Family Welfare Statistics in India, Ministry of Health and Family Welfare
Delivery care (%), Skilled attendant at birth	46.6	2005-06	National Family Health Survey – 3
Delivery care (%), Institutional delivery*	74	2013	Sample Registration System (SRS), Census of India
Delivery care (%), C-section	8.5	2005-06	National Family Health Survey – 3

* Institutional delivery of youngest child

Indicators	DLHS-2 (2002-04)	DLHS-3 (2007-08)	CES 2009
Mothers who had received any ANC (%)	73.6	75.3	89.6
Mothers who had 3 or more ANC (%)	50.4	51	68.7
Mothers who had full ANC check-up (%)	16.5	19.1	26.5
Institutional Delivery (%)	40.9	47	72.9
Safe Delivery (%)	48	52.6	76.2
Mothers who received PNC within 2 weeks of delivery (%)	NA	50.8	60.1*

*-PNC within 10 days

In the following sections, key issues related to SRHR in each of the identified 15 areas are discussed.

[118] National Health Policy was formulated in 1986 and 2002.

1.1 Family Planning

SITUATIONAL ANALYSIS:

With 2.4% of the world's land mass, India has about 17.5% of the world's population, which is the combined population of USA, Indonesia, Brazil, Pakistan, Bangladesh and Japan. While there has been a decline in the growth rate of about 4% from 2001 to 2011, India is expected to be the most populous country in the world by 2024. In India, the need for family planning (FP) was recognised since 1952, when a nationwide Family Planning Programme was launched. While the National Population Policy (1976) reflected on the need to focus on population stabilization among the policy makers, the 2000 revision additionally addressed the unmet needs for contraception, and affirmed the commitment of the government towards voluntary and informed choice and consent of citizens, while availing reproductive health-care services, and continuation of the target-free approach in administering family planning services. The NPP 2000 also aims to achieve population stabilization by 2045.

FAMILY PLANNING SCENARIO (NFHS, DLHS AND AHS)

The last survey figures available are from NFHS-3 (2005-06) and DLHS-3 (2007-08), which are being used for describing current family planning situation in India. Nationwide, the small family norm is widely accepted (the wanted fertility rate for India as a whole is 1.9 (NFHS-3) and the general awareness of contraception is almost universal (98% among women and 98.6% among men: NFHS-3). Both NFHS and DLHS surveys showed that contraceptive use is generally rising (see adjoining figure). Contraceptive use among married women (aged 15-49 years) was 56.3% in NFHS-3 (an increase of 8.1 percentage points from NFHS-2) while corresponding increase between DLHS-2 & 3 is relatively lesser (from 52.5% to 54.0%). The proximate determinants of fertility, like age at marriage and age at first childbirth (which are societal preferences), are also showing good improvement at the national level. .

BUDGET OUTLAY FOR FAMILY PLANNING:

The Family Planning programs have undergone a paradigm shift and emerged as one of the interventions to reduce maternal and infant mortalities and morbidities. It is well-established that the States with high contraceptive prevalence rate have lower maternal and infant mortalities. Greater investments in family planning can thus help mitigate the impact of high population growth by helping women achieve desired family size and avoid unintended and mistimed pregnancies. Further, contraceptive use can prevent recourse to induced abortion and eliminate most of these deaths. Studies show that if the current unmet need for family planning could be fulfilled over the next 5 years, we can avert 35,000 maternal deaths, 1.2 million infant deaths, save more than Rs. 4450 crores; and save Rs. 6500 crores, if safe abortion services are coupled with increased family planning services. This strategic direction is the guiding principle in implementation of family planning programme in future.

MINISTRIES AND DEPARTMENTS INVOLVED:

Ministry of Health and Family Welfare
Ministry of Women and Child
Social Welfare Departments

Other significant milestones which have contributed to family planning are:

- Decentralised planning and programme implementation through the 73rd and 74th Constitutional Amendments Act, 1992, made health and family welfare, among other things, a responsibility of village panchayats.
- Method-specific contraceptive targets for FP were abolished and the emphasis shifted to the implementation of programmes aimed at fulfilling unmet needs.

With the new phase of National Health Mission(NHM), 2012 -2017, A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) has been introduced. The NHM encourages focus on promotion of spacing methods and prioritises post-abortion and post-partum contraception to leverage the increase in institutional deliveries, while ensuring appropriate counselling and quality of services. It also talks about promotion of male involvement; including male sterilization. It also reiterates the need to focus on the most vulnerable and underserved sections of the population.

EXISTING GAPS

In spite of having a well-defined population policy and several programmes to address FP there continue to be a number of operational, functional and social barriers. Some of the key problem areas are as follows:

- Public Private Partnership (PPP) in family planning has not been adequately promoted across most states in India. Evidence suggests that 3 out of 4 users of condoms or pills access private sector, whereas 76% users of modern contraceptive methods access public sector. Reluctance to accredit private providers at state/district level adversely affects the possibility of providing choices of family planning services to clients.
- There is a huge potential to offer post-partum contraception with the increasing number of institutional deliveries. However, this opportunity has not been tapped adequately due to lack of planning, lack of trained post-partum family planning service providers and lack of infrastructure in most of the high focus states[119] (NPP, 2000).
- The current basket of choices offered to the clients is still limited, and there are many contraceptive methods that have not found a place in the national FP programme.
    - Evidence suggests that the suggested allocation of funds under NRHM is highly focused on permanent methods (80 per cent) as compared to only 20 per cent for spacing methods.
    - Injectable contraceptives are not part of the public health programme due to resistance from many health activists and women's groups in India centred around concerns of adverse health consequences for women and inadequate public health infrastructure for counselling and follow-up.
    - Unavailability of the progesterone-only pill (POP) in the national FP programme, although the Drug Controller General of India (DCGI) has already approved the use of POP in the private sector.
- Underutilisation of allocated funds for Family Planning.
- In both rural and urban areas, there continues to be unmet need for contraceptives, supplies and equipment for integrated service delivery, mobility of health providers and patients, and comprehensive information.

AREAS FOR ADVOCACY:

Policy level: Increase allocation for family planning, including an expanded choice for spacing methods of contraception, and ensure access to quality family planning information, care and services.

Apportion the budget correctly to match the existing need. For instance, the funds given to NRHM should be divided proportionally between permanent contraception methods and spacing methods. Within the health budget, increase the funding for components that will lead to improved quality of care in services, such as infrastructure, skill development and counseling.

Systemic level: Identify select private providers and have an MOU with them under a public private partnership to provide choice of family planning services to the clients. There should be a system put

[119] States with high TFR

in place to identify, train and accredit private providers so that they can provide contraceptive services.
Post partum family planning services should be incorporated into the medical college education.
Provide enough infrastructures at the PHCs and Block PHCs, maternity hospitals as well as to private healthcare providers.

Service Delivery Level: Under utilisation of funds is a major area of concern. Clear targets should be given to the different healthcare facilities and infrastructure should be improved so that people seeking Family Planning services will get the desired services. On the other hand, a whole system of creating awareness on the importance of family planning to motivate people to come the FPAI clinics for FP services should be put in place.

1.2 Reproductive Health Services

SITUATIONAL ANALYSIS:
Reduction of mortality of women is an area of concern for the Governments across the globe. India accounts for a quarter of all maternal and child deaths. Good antenatal care reduces the risk of childbirth complications. The maternal mortality ratio in India showed a decline from 560 deaths per 100,000 live births in 2001 to 190 deaths in 2013, but the ratio still lags behind the MDG target of 109 by the year 2015. The NPP 2000 highlights maternal mortality as a matter of social injustice. Furthermore, the National Policy for the Empowerment of Women 2001 explicitly recognizes and prioritises maternal mortality as a "sensitive indicator of human development."

The Integrated Child Development Services (ICDS) initiated by the Department of Women and Children focuses on improving the nutritional and health status of children in the age-group of 0-6 years. Under this scheme, supplementary nutrition is provided to pregnant and lactating mothers to ensure good health for the mother and the child. Under the NHM (2012-2017), several other initiatives have been taken to achieve the goal for reduction in maternal mortality. Some of these interventions are as follows:

- Village Health &Nutrition Day (VHNDs)
- Janani Suraksha Yojana 2005
- Vandemataram Scheme
- Janani Shishu Suraksha Karyakaram (JSSK) 2011
- Indira Gandhi Matritva Sahyog Yojana (IGMSY)
- Web Enabled Mother and Child Tracking System
- Joint MCP Card

EXISTING GAPS

The aforesaid interventions have contributed significantly to improve mother and child health, some challenges still remain:

- **Early age of marriage** and teenage pregnancy.
- **Ante-partum haemorrhage**: In rural India, the scope of diagnosing placenta previa is limited. Often, pregnant women are unaware and do not take vaginal bleeding seriously. This can lead to huge blood loss and death.
- **Post-partum haemorrhage (PPH)** mainly occurs during home delivery or delivery by untrained birth attendant and the main causes are uterine atony and retained placenta.
- **Shortage of supply of drugs** through public institutions.

MINISTRIES AND DEPARTMENTS INVOLVED: Ministry of Health and Family Welfare

AREAS FOR ADVOCACY:
Policy Level: It is not sufficient to speak of achieving MDG-5 in India as a whole. The differences between States, places of residence, age groups, social status and economic background are simply too great to allow such generalizations. A very focused campaign of action delivery services to the most disadvantaged, to reduce inequities in health, particularly in maternal and reproductive health, will be necessary at the national, state, and district levels to have a significant impact on the most disadvantaged populations. An hoilistic policy taking into consideration the disparities is the need of the hour.

The Government of India and state governments should consider following specific steps to reduce the inequity gap. There has to be substantial improvement of services in terms of capacity and quality in the public system where the poor and vulnerable live. Maternal and healthcare needs to be

provided close to their homes, thus reducing the distance barrier. The Indian Government should develop and annually publish special rates of infant mortality rate, maternal mortality rate, and still birth rate for marginalized groups, such as the poor and tribals, through an expansion of the Sample Registration System already implemented.

Systemic Level: Structural determinants prevent reduced maternal mortality and increased access to reproductive health for women belonging to disadvantaged populations. Interventions that target maternal mortality and increased access to reproductive healthcare need to take into account how these structural determinants operate in the Indian society and how this may influence access to health care for certain groups of women.

Service Delivery Level: One of the reasons that services are poor in remote rural and tribal areas is difficulties in recruiting doctor or health workers to these areas, thus creating barriers to service delivery or health education. This can be reduced by creating a special cadre or force of doctors, nurses, and health staff to run the health centers in remote and poor areas. The staff recruited will have to be specially selected based on commitment and attitude for serving the poor and marginalized. Furthermore, incentives, in the form of high salaries and other benefits such as better housing, need to be provided to recruited staff. A special strategy in regards to services during delivery will be needed to reachout to the most vulnerable and marginalized.

1.3 Infertility

SITUATIONAL ANALYSIS:

Infertility remains a neglected issue in India – even though the primary infertility rate among women aged 15-49 is 6.3% (DLHS-3). While the 10th and 11th Five Year Plan discussed access to essential clinical examination, investigation, management and counselling services for infertility, such services are, in effect, rarely available in the public sector. The 12th Five Year Plan does not mention it at all.

The problem of infertility has not been given its due attention in India because it is not a life-threatening condition. Infertility is a life crisis with invisible losses, and its consequences are manifold. WHO (1991) defines infertility as failure to conceive despite two years of cohabitation and exposure to pregnancy. Infertility affects a relatively large number of couples at some point in their reproductive lives - globally, between 50 and 80 million couples (WHO, 1994). Moreover, in pro-natalist cultures such as those of India, the consequences of infertility for women can be devastating.

Based on the census reports of India 2001, 1991, 1981 researchers show that childlessness in India has risen by 50 per cent, since 1981. It is not because couples are choosing not to have children, but primarily due to growing infertility. Around 95 percent of couples desire to have children at some point of time in their lives. Therefore, even in urban Indian context, childlessness is not due to women opting to remain single or childless by choice. Marital childlessness rate (number of ever-married women aged 15-44 with no children ever by total population of ever-married women in the same age group) has gone up from 11 to 16 per cent, 'permanent childlessness' has zoomed from 3.89 to 7.47 per cent.

Though the International Conference on Population and Development (ICPD) Programme of Action states that reproductive health services should include the prevention and appropriate treatment of infertility (United Nations, 1994), there is inadequate focus on infertility in India’s reproductive health programme. Traditionally, childless women in India experience stigma and isolation. Infertility can threaten a woman’s identity, status and economic security and consequently, be a major source of exploitation for women.

EXISTING GAPS

While there has been an achievement in terms of the Assisted Reproductive Technologies (Regulation) Bill, 2010 which provides a national framework for the accreditations, regulation and supervision of assisted reproductive technology (ART) clinics, this is yet to be tabled in Parliament. Moreover, the National Guidelines for Accreditation, Supervision and Regulation of ART Clinics in India 2005 are legally non-binding, and hence are not very effective.
Apart from this, the role of the public sector in infertility management is weak and there is lack of information and training, absence of clear protocols at all levels.

AREAS FOR ADVOCACY:

Policy Level: Streamlining the system at all levels and co-ordination between different levels and facilities should also yield better services. Facilities should be upgraded at the tertiary and secondary levels, and medical colleges could play a more positive role, as they have the capacity. Existing protocols for standardization for infertility management should be implemented to enhance knowledge and skills, and establish clear referral systems

Systemic Delivery Level:*Management of infertility* in the public health context by providing adequate services and having effective systems for higher level care Interventions need to be inexpensive, practical, efficient, effective and sustainable.

Service Delivery Level:. Developing effective services for infertile couples requires an approach that includes education about the causes and treatment of infertility at the community level; training of health care providers for thorough assessment of infertile couples; recording histories, conducting physical examinations of both partners and following standard protocols; establishing firm diagnoses, and counselling of couples about infertility, treatment options and the likelihood of pregnancy; and managing psychosocial and sexual problems

KEY MESSAGES:

- The role of the public sector in infertility management is weak. Basic investigations and services are limited or incomplete; there is inadequate infrastructure and management, lack of information and training, absence of clear protocols, private practice by public health doctors, preoccupation with other health issues and lack of regulation.
- Realistic and low-cost management, streamlining and regulation of services, counseling couples, providing information, and raising awareness of patients, health personnel and policy makers are recommended.

1.4 Reproductive Tract Infections (RTIs)

SITUATIONAL ANALYSIS:

RTIs including STIs and HIV/AIDS are increasingly being recognized as a serious public health problem all over the world, including India. RTIs cause suffering for both men and women, but their consequences are far more devastating and widespread among women. Amongst women, RTIs often go undiagnosed and untreated, and when left untreated, they lead to complications such as infertility, pelvic inflammatory disease, ectopic pregnancy, miscarriage, cervical cancer, and an increased risk of HIV transmission. Adolescents too are vulnerable to RTIs due to their ignorance of risk factors, inadequate accessibility to services, and social powerlessness.

In India, the magnitude of prevalence of reproductive tract infection is anywhere between 48% and 92% among women in different parts of the country. It is also seen that less than 20% of these women seek medical care for the problems. Studies have shown that RTIs are important reasons for the poor acceptance and low continuation rates of contraceptive methods such as the IUD. Bhatia and Cleland found a higher incidence of gynecological symptoms among women who had undergone a tubectomy than the other women.

Several policies and programs – including the National Population Policy 2000, the National Health Policy 2002, the National Rural Health Mission 2005, the RMNCH+A programme under NHM (2012-2017) and the National AIDS Control Programme Phase Ill and IV-have stressed the need for expanding women's access to services for prevention, screening and management of RTIs.

EXISTING GAPS

However, several small and large scale studies have documented a high prevalence of RTIs among women and shown that significant proportions of symptomatic women do not seek treatment[120]. According to the NRHM, RCH II, 8th Joint Review Mission 2011, it was noticed that provision of RTI/STI services was limited to District Hospitals. There is an identified need to train Medical Officers and Nurses in Sub-District facilities on syndromic management of RTI/STI.

MINISTRIES AND DEPARTMENTS INVOLVED: Ministry of Health and Family Welfare, National AIDS Control Organisation.

AREAS FOR ADVOCACY:

Policy Level: Reproductive Tract Infections in women should be recognied as a major healthcare hazard which is the second largest cause of death and adequate budgetary allocations should be made to address the problem.

Systemic level: The Family Planning Services can serve as an entry point for screening women for RTI. This can be one way of intergrating the services and making them cost effective. Lessons on menstrual hygiene should become an intergral part of the school/college curriculum for adolescent girls.

Service Delivery Level: Training for healthcare providers to give stigma free treatment for all the clients irrespective of their age/marital status.

Special care should be taken to include marginalised women – like sex workers – into the RTI healthcare programs.

[120] Sabarwal, Shagun, and K.G. Santhya. "Treatment-Seeking for Symptoms of Reproductive Tract Infections Among Young Women in India." 2012.

1.5 Abortion

SITUATIONAL ANALYSIS:

The Indian abortion laws falls under the Medical Termination of Pregnancy (MTP) Act, which was enacted by the Indian Parliament in the year 1971, with the intention of reducing the incidence of illegal abortion and consequent maternal mortality and morbidity.The Medical Termination of Pregnancy Act of 1971 (amended twice in 1975 and 2002) has significantly liberalized abortion laws in India, which until then were being viewed from a moralistic framework.

Today, abortion policy in India is consistent with safeguarding reproductive rights as envisaged by International Conference on Population and Development (ICPD) and other international agreements. It does not advocate abortion as a family planning measure. Rather, it encourages the promotion of family planning services to prevent unwanted pregnancies and at the same time recognises the importance of providing safe, affordable, accessible and acceptable abortion services to women who need to terminate an unwanted pregnancy[121]. Abortion policy within the 'rights framework' emphasises not only the woman's 'right' to seek safe abortion, but also her 'right' to access safe abortion services as well as information about the availability of such services.

Pregnancies not exceeding 12 weeks may be terminated based on a single opinion formed in good faith. In case of pregnancies exceeding 12 weeks but less than 20 weeks, termination needs opinion of two doctors. The Medical Termination of Pregnancy (MTP) Act of India clearly states the conditions under which a pregnancy can be ended or aborted, the persons who are qualified to conduct the abortion and the place of implementation. Some of these qualifications are as follows:

- Women whose physical and/or mental health were endangered by the pregnancy
- Women facing the birth of a potentially handicapped or malformed child
- Rape
- Pregnancies in unmarried girls under the age of eighteen with the consent of a guardian.
- Pregnancies in "lunatics" with the consent of a guardian.
- Pregnancies that are a result of failure in sterilization.

Despite all these measures some of the challenges that remain include:
Unsafe abortions which are killing one woman every two hours in India (which is approximately 4000 deaths a year, according to estimates and correlating data on maternal mortality ratio (MMR) and Sample Registration System (SRS) data by Ipas, India, an international NGO working on increasing access to safe abortion services. A Lancet paper in 2007 said there were 6.4 million abortions, of which 3.6 million or 56 per cent were unsafe. Ipas has calculated this based on the latest population and crude birth rates (CBR) which peg the number of induced abortion at 5,007,932. According to Census 2011, abortion taking place in institution varies from 32.0% in Chhattisgarh to 73.9% in Assam.

EXISTING GAPS

Some issues to be addressed are as follows:

- While the MTP Act, 1971 came as a boon for women's health and healthcare, the state has failed to effectively implement the provisions of the Act. At one level the state has not invested adequately to make available safe abortion services in adequate numbers to women, and at another level its bureaucracy has made things difficult for the private sector to come forward and register under the act to provide legal and safe abortion services.
- Though abortion law allows for termination of pregnancy for a wide range of reasons construed to affect the mental and physical health of the woman, it remains with the doctor (and not the woman) to opine in good faith, the need for such a termination. Such a provider-dependent policy

[121] Hirve, S. "Abortion Policy in India: lacunae and Future Challenges. Abortion- Project India."(CEHAT Mumbai) 2004.

might result in denial of abortion care to women in need, especially the more vulnerable amongst them, for various reasons, including conscientious objection. This may also compel a woman to lie about the situation surrounding her unwanted pregnancy. (and try crude methods by quacks)

- While the MTP Act permits women to seek legal termination of an unwanted pregnancy for a wide range of reasons, the clause about contraceptive failure applies only to married woman.
- While the abortion policy allows for monitoring of quality of abortion care in the private sector, its recognition of all public health institutions as abortion facilities by default exempts the public sector from certification. This raises a potential 'moral hazard' in that public sector abortion facilities are not constrained to adhere to the physical standards and quality of abortion care expected of the private sector.
- The MTP Regulations define procedures to ensure confidentiality and anonymity in provision of safe abortion services. However, there are no guidelines for ensuring the privacy and dignity of the woman.

AREAS FOR ADVOCACY:

Policy level: The total expenditure on family planning under the NHM is Rs 396.97 crores (2013-14). Of this, the expenditure on spacing methods is a mere Rs 5.76 crores (1.45%). Given India's young population, the budget for spacing methods should be much higher. The Government of India has estimated that if the current unmet need for family planning could be fulfilled within the next five years, India can avert 35,000 maternal deaths and 12 lakh infant deaths. If safe abortion services are coupled with increase in family planning, the savings made to the country could be to the tune of Rs 6,500 crore.

Systemic level: Identify healthcare providers both in the government and private set up who can be trained to provide stigma free abortion services to everyone who seeks it.

Most of the abortion services are being provided by private players, due to which the women accessing government healthcare system are unable to avail abortion services. Hence, more public healthfacilities should be equipped to provide abortion services.

Service Delivery Level: Abortion Clinics should be established in all block PHCs and the infrastructure should be put in place for safe abortions.

Agency of women within the MTP Act should be revamped and the choice to abort should be left to the woman.

1.6 AIDS

SITUATIONAL ANALYSIS:
HIV prevalence has decreased from 0.41% in 2001 through 0.35% in 2006 to 0.27% in2011. Similarly, the estimated number of PLHIV has decreased from 23.2 lakh in2006 to 20.9 lakh in 2011. India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) from 2.741akh in 2000to 1.161akh in 2011, reflecting the impact of scaled up prevention interventions. Declines in adult HIV prevalence and new HIV infections are sustained in most of the state, including all the high prevalence states of South India and North East. It is estimated that the scale up of free Anti-Retroviral Treatment (ART) since 2004 has saved over 1.5 lakh lives till 2011 by averting deaths due to AIDS-related causes. Wider access to ART has led to 39% reduction in estimated annual AIDS-related deaths from 2.071akh in 2007 to 1.48 lakh in 2011, highlighting the impact of scale up of free ART services in the country.

In 2009, India established a National HIV and AIDS Policy and the World of Work, with the ratification of ILO Convention No 11 on Discrimination (Employment and Occupation). As a result of this policy, India expanded its HIV and AIDS policy and programmes in the workplace as a key component of the mainstreaming strategy of the NACP-111.

The GOI's current National AIDS Control Programme, NACP-IV, is co-ordinating the 2012-2017 national response to the HIV epidemic. It aims to accelerate the process of epidemic reversal and further strengthen the epidemic response in India through a cautious and well defined integration process over the five-year period.

A recent development in the sphere of HIV / AIDS is the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Bill, 2014 which was first submitted to the National AIDS Control Organisation (NACO) in August 2006 and introduced to parliament in early 2014. The Bill seeks to protect people carrying the HIV virus from discrimination in the public and private sectors and puts an obligation on the state to provide them complete treatment free of cost.

MINISTRIES AND DEPARTMENTS INVOLVED: Ministry of Health and Family Welfare, National AIDS Control Organisation

EXISTING GAPS
Despite the efforts to address the incidence of HIV/AIDS:

- There is a need for improved co-ordination between AIDS control societies and district health departments. The district health authorities are often not aware of the implementation of the programme and the policies set up by the government.
- There is an emerging epidemic in certain low prevalence states and districts due to migration to high prevalence areas. This is increasingly being identified as an important factor driving the epidemic in several north Indian districts, and epidemics related to IDU, MSM, Transgender and young sex workers.
- International finances for HIV/AIDS programme are shrinking. NACP-III had less than 10% of domestic budgetary support. NACP-IV will require a significantly greater element of domestic budgetary support – budgetary support and PPP
- Regions with different maturity levels of the epidemic will require different resources and services. Emerging epidemics in selected regions will need greater prevention focus, while care and support in the setting of matured epidemic, particularly management of 2nd line ART, will need a robust management and financing strategy, which need to be mapped out.
- There is a need to provide social protection schemes for people infected and affected with HIV/ AIDS through mainstreaming of HIV/AIDS with other ministries.

- There is a need to address the stigma and discrimination that is still prevailing against the vulnerable population, persons and families infected and affected with HIV, especially at work place, healthcare settings and educational institutions, by enacting an anti-stigma policy in the work place and education institutions.
- Infrastructural issues related to location of the ART centres at a long distance, in sufficient number of ART centres to cater a large population, non-availability of transport and travel time. Link ART Centers and ART Plus Centre.
- There is a need to improve the coverage of sex workers. Outreach also needs to be modified to focus more on new and young female sex workers.

AREAS FOR ADVOCACY:

Policy level: The Government of India has taken a policy level decision to slash the Health budget, most of which is from the Targeted Intervention , adversely impacting the intervention. . This is time when the government should be focusing on the HIV intervention to consolidate the gains made in the last decade.

Systemic level: Punitive laws, polices and practices increase the vulnerability of People Living with HIV and affect their ability to access voluntary testing and treatment. Evidence shows that fear of stigma and discrimination discourages and delays a person from seeking an HIV test. The Government of India has been completely silent on this fundamental issue.

Service Delivery level: The level of stigma and discrimination against People Living with HIV, against sex workers, sexual minorities and Injecting Drug Users have not reduced at government service delivery points. This is a hindrance towards accessing services by these marginalised groups.

1.7 Adolescent Reproductive and Sexual Health

SITUATIONAL ANALYSIS:
In India we have about 230 million adolescents in the age group of 10-19 years, which forms the largest cohort of young people, who are in the threshold of making a transition to adulthood. Combinations of biological, psychological and social forces influence an adolescent's development. During these developmental processes, they experience distinct changes physically as also emotionally, establishing a new sense of who they are and who they want to become. While paying attention to 'creating a future' and 'planning a career' an adolescent's reproductive and sexual health takes a back seat.

In India, data collected by National Family and Health Survey (NFHS) 31 indicates that:

- Births in the age group of 15-19 years contribute to 17 per cent of the total fertility rate.
- Among women aged less than 20 years, 14 per cent pregnancies are unplanned.
- 34 per cent of ever-married adolescent girls (15-19) had experienced physical, emotional or sexual violence perpetrated by their spouses.
- Among person aged 15 to 19, only 3 per cent of girls and 19 per cent of boys who had had sex reported using a condom the first time they had sexual intercourse.
- Among women aged 15-19 years, 16 percent have already begun childbearing
- Unsafe abortions account for half of all maternal deaths of girls between 15 and 19 years. (Data from CEDPA 2001)

The data indicates a paucity of sexual and reproductive information and equitable outreach of skilled services among adolescents in the country. The socio-cultural milieu in India restricts public discourse on sexuality, thereby, limiting young people to freely access basic sexual and reproductive information.

Further, it was noted that in India, laws, policies and social actions have interchangeably used the terms 'adolescents', 'children', and 'minors'. Multiplicity of definitions for 'youth' and 'adolescent' might be a significant deterrent towards the programming and interventions in the sector.

Though a clear definition is yet to be formulated, the sensitivity and complexity towards this age group is being increasingly recognised by GOI. Nationally adolescents have been acknowledged as individuals in a transient phase of life, who require focused nutrition, education, counselling and guidance to ensure their development into healthy adults[122]. Over the last two decades policies in India are increasingly streamlining the focus upon person of age between 13-35 years.[123]

The National Population Policy (2000) and the National Policy for the Empowerment of Women (2001) both recognize adolescents as an underserved and vulnerable population group with special sexual and reproductive health needs. Focus however is limited towards protecting the age group from unwanted pregnancies and sexually transmitted diseases. A National Adolescent Reproductive and Sexual Health strategy has been designed in 2014. It provides a framework for a range of sexual and reproductive health services to be provided to the adolescents.

It was noted that though independent Ministries are increasingly directing focus upon adolescents, a co-ordinated policy and/or program initiating a holistic approach towards the empowerment of adolescents in the country is limited.

[122] http:IInrhm.gov.in/nrhm-components/rmnch-a/adolescent- health/adolescent_health/background.html
[123]National Policy on Education (1986, modified in 1992); National AIDS Prevention and Control Policy (2000); National Health Policy (2002); National Youth Policy (2003)

Key Adolescent Health programmes include the following priority interventions: Anemia screening, Iron and Folic Acid **(WIFS)** supplementation, facility-based adolescent health services, community based health promotion activities, information and counselling on sexual and reproductive health (including menstrual hygiene), substance abuse, mental health, non-communicable diseases, injuries and violence including domestic violence.

EXISTING GAPS

From an overview of GOI's policies and programs in this sector, the following can be broadly noted:

Policy barriers	Programmatic barriers
► Limited attention towards affirmative sexual rights to pleasure. Focus is drawn primarily through a disease and/or fertility control model	► A clear definition for adolescents is not available thereby affecting the scope and focus of the programs. Adolescents are assessed as a homogenous group. Limited ► interventions are initiated to identify adolescent needs through a participatory approach
► Since official recognition of adolescent sexuality is limited, particularly for unmarried adolescents, restricted policy level attention is drawn towards issues such as teenage pregnancy among unmarried girls, child prostitution, sexual violence among adolescent couples etc.	► Socio-cultural stigma on sexual and reproductive discourse limits the free exchange of sexual and reproductive information. Inhibition has been documented [among unmarried adolescent girls and boys, particularly in the rural districts, to seek assistance and guidance on sexual and reproductive rights and healthcare
► Girls are the primary focus of sexual and reproductive health policy initiatives. Limited attention/initiatives are drawn towards the young boys.	► There has been limited acknowledgement of sexual desires and different sexual behaviours including considerations for the affirmative right to pleasure. Initiatives for young boys are primarily designed towards their orientation to women's sexual and reproductive rights and status.
► Coordination among Ministries (Health/Education/Youth &sports) in developing a holistic policy for adolescents is limited	► Limited resources such as skilled health personnel at the rural health facilities have been raised as key concerns

AREAS FOR ADVOCACY:

Policy level: Limited attention paid towards affirmative sexual rights to pleasure. Focus is drawn primarily through a disease and/or fertility control model, is a policy barrier that needs to be addressed.

Systemic level: There has been limited acknowledgement of sexual desires and different sexual behaviours, including considerations for the affirmative right to pleasure. Initiatives for young boys are primarily designed towards their orientation to women's sexual and reproductive rights and status; should be made a component of the sex education curriculum. Limited resources such as skilled health personnel at the rural health facilities are key concerns, which should be looked into.

Service delivery level: Sex education should be made a compulsory part of the school/ college curriculum, and teachers and counsellors should be trained to help with issues that emerge during adolescence.

1.8 Early and Forced Marriage

SITUATIONAL ANALYSIS:

According to the UNICEF, India ranks 131st in the world, with 47% of girls getting married before the age of 18. Major factors perpetuating child marriage are economic considerations (poverty, marriage-related expenses, dowry), gender norms and expectations, concerns about girls' safety and family honour, and a lack of educational opportunities for girls. Early and forced marriage has many health consequences for girls – increased maternal and infant mortality, premature pregnancy, health risks in child birth, obstetric fistulas, increased chances of contracting HIV / AIDS and cervical cancer, greater exposure to domestic and sexual violence, feelings of isolation and abandonment etc.[124] The offspring of young girls are also at a higher risk of illness and death. One of the biggest impacts of child marriage for both the boy and the girl is the deprivation of childhood and an extremely uncertain future. In most cases, a married girl is not allowed to pursue education or employment of any kind.

The Government of India has many laws, policies and programmes in place to address the issue of child marriage. The Government brought into force a progressive legislation namely the Prohibition of Child Marriage Act, 2006 (PCMA), repealing the Child Marriage Restraint Act (CMRA) of 1929, which prohibits child marriages rather than only restraining them. In July 2007, the Supreme Court of India reiterated its earlier judgment that marriages of all citizens of India, irrespective of their religion, have to be compulsorily registered in the State where the marriage is solemnized. This is a major step forward to prevent child marriage, as it makes it mandatory to give age at the time of marriage.

Several national policies such as the National Population Policy 2000, the National Youth Policy 2003 and the National Adolescent Reproductive and Sexual Health Strategy have advocated delaying the age at marriage and age of conceiving the first child. The long-term goal of the National Plan of Action on Prevention of Child Marriage 2013 is that children in India should be free from child marriage and live a life of dignity. The 2013 National Strategy on Prevention of Child Marriage aims to provide an overall strategic vision to eliminate this practice. It has suggested ensuring linkages with the Integrated Child Protection Scheme (I CPS) structures and statutory bodies to ensure detection and prompt referral of cases that require care.

EXISTING GAPS

Despite the several interventions, policies and programmes implemented by the Government, there are barriers to elimination of child marriage and areas requiring attention.

- Implementation of the law for minimum age of marriage remains a challenge as child marriages continue to be seen as a social evil instead of a crime, and indeed continue to take place.
- Various courts continue to uphold the customary practices and personal laws of different religious communities which govern family matters.
- The PCMA 2006 creates confusion by declaring some marriages void and some others voidable.
- The National Strategy on Child Marriage does not address early marriage of boys. It is important to develop action plans document the problems faced by boys who get married at an early age in order to create evidence and take necessary action.
- There are no programmes or schemes directed specifically to address the issue of child marriage. Most of the schemes intend development of the girl child and address the problem of child marriage only as an indirect benefit.
- The only child protection scheme capable of addressing child marriage too fails to do so. The target group for ICPS does not mention victim of child marriage or potential child marriage explicitly. -1. Get faith-based leaders involved. 2. Get community leaders involved. 2. UC Code, 3.

[124] The Causes, Consequences, and Solutions to Forced Child Marriage in the Developing World- A. Malhotra, International Center for Research on Women, July 2010. Available at: http://www.icrw.org/files/images/Causes-Consequences-and%20Solutions-to-Forced-Child-Marriage-Anju-Malhotra-7-15-2010.pdf

Money/help for delayed pregnancies, 5. Education support to child brides. 6. Opt out of forced marriages.

AREAS FOR ADVOCACY:

Policy level: Early marriages have been prohibited under the Indian Law. However, the social pressure and cultural practices, combined with poverty and lack of security encourage early marriages..

Systemic level: Early marriage should not be seen in isolation and should be addressed as a holistic problem, the roots of which lie in centuries of cultural practice

Service delivery level: Create consistent awareness against the evils of early and forced marriages.

1.9 Prevention and Surveillance of Violence against Women (Gender Based Violence)

SITUATIONAL ANALYSIS:

Domestic or spousal violence is one of the most common forms of gender-based violence experienced by women across the world (United Nations, 2006). In India, a significant number of women face physical, emotional or sexual violence by their current husbands. In 2013, the NCRB reported 1, 18,866 cases of cruelty on women by husband or his relatives.[125] The total number of IPC crimes against women reached 2,44,270.[126] Marital rape is still widespread, primarily due to lack of laws and the personal nature of a marital relationship. The root of the problem is the fact that marital rape is not considered a criminal offence. According to **Section 375 of the Indian Penal Code (I PC) 1860,** "Sexual intercourse by man with his own wife, the wife not being under 15 years of age, is not rape." Though in 1983, Section 376-A was added in the Indian Penal Code which criminalizes the rape of a judicially separated wife, it does not in any way condemn marital rape. The situation is worsened because the victims themselves often abstain from reporting the act, either due to the social stigma attached to it or due to their dependence on their husbands.

Gender based violence has serious effects on a woman's physical, sexual, reproductive, mental and behavioural health. An increasing amount of research highlights the health burdens, intergenerational effects, and demographic consequences of such violence.[127]Moreover, since women bear the brunt of domestic violence, they disproportionately bear the health and psychological burden as well. Although psychological abuse is often considered less severe than physical violence, health care providers around the world are increasingly recognizing devastating mental health effects of domestic violence, including anxiety, posttraumatic stress disorder, and depression.

The Indian constitution has a number of Articles of the Constitution which reiterate the commitment of the constitution towards the socio economic development of women and upholding their political right and participation in decision making. In 2001, the National Policy for Empowerment of Women was formulated with the objective of "Elimination of discrimination and all forms of violence against women and the girl child" by curbing any form of domestic violence, sensitizing the judicial system and ensuring speedy redress of grievances. The Protection of Women from Domestic Violence Act, 2005 provides for more effective protection of the rights of women guaranteed under the Constitution who are victims of violence of any kind occurring within the family. The Government also has programs such as SWADHAR and Scheme of Short Stay Homes for Women and Girls to cater to victims of gender based violence.

EXISTING GAPS

While there are laws and codes in place to protect the rights of women and prevent any form of violence, there are areas that require further consideration and attention:

- While marital rape has not been criminalised, sexual abuse is considered as an act of violence against women under the Protection of Women from Domestic Violence Act 2005 (PWDVA). Under this Act, a woman can go to the court to obtain judicial separation on the basis of having suffered sexual abuse. However, this is only a piecemeal legislation in regard to marital rape and does not justify the true suffering of the woman.
- The implementation of Dowry Prohibition Act and provisions on harassment faced for dowry has been weak and very few cases have been filed so far. In many parts of the country. Dowry Prohibition Officers have not been appointed. The police and other law enforcement bodies have

[125] National Crime Records Bureau, Annual Report, 2013
[126] National Crime Records Bureau, 2012
[127] Domestic Violence- NFHS III {http://hetv.org/india/nfhs/nfhs3/NFHS-3 Chapter-15-Domestic-Violence.pdf, accessed on 31 March 2013)

shown apathy in recording and investigating complaints relating to dowry related harassment and dowry deaths.

128. There are no concrete provisions or schemes for providing emotional and psychological relief and counselling to the victims.

- Despite a number of laws and policies in place, the number of incidences of violence against women has been increasing each year, with cruelty against women by husband accounting for the largest proportion of these crimes. This is indicative of poor implementation of the Protection of Women from Domestic Violence Act 2005[129]
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AREAS FOR ADVOCACY:

Policy level: Make marital rape punishable by law. Women who are victims of marital rape should be treated on par with other rape victims and the same procedure of providing justice should be applied.

Service delivery level: Counselling and rehabilition should be provided to victims of marital rape.

[128] Source: Report of the Working Group on Empowerment of Women for the XI Plan MWCD

[129] source: Domestic violence victims protest poor implementation, Oct 27, 2014 as accessed at htt.Q://timesofindia.indiatimes.com/city/bhopal/Domestic-violence-victims-protest-poor-implementation/articleshow/44945655.cms on Oct 27,2014

1.10 Sexual orientation and gender identity rights (SOGI)

SITUATIONAL ANALYSIS:

The SOGI community in India have faced several barriers in gaining acceptance in society and in also gaining their basic rights. Several laws have been passed with regard to recognising and granting the SOGI community their rights including the Recognition of the Third Gender in April 2014 and the overruling of the Section 377Indian Penal Code Judgement in 2014, which criminalized homosexual acts of sex between consenting adults. In spite of increased awareness amongst the general public and work being done for the integration of the SOGI community by authorities, it is to be noted that India is not a signatory of the statement of the General Assembly declaration of LGBT Rights, 2008, which confirmed that International Human Rights Protection include sexual orientation and gender identity.

Although policies are yet to be formulated for SOGI rights, the MSM population have been identified as the highest priority group in the intervention programmes due to a high level of exposure to HIV. Along with being identified as a group that requires integration into mainstream society, the Government of India has also acknowledged the fact that the transgender community faces a lot of health issues which need to be effectively addressed.

Several barriers exist that inhibit the SOGI group from being granted equal treatment and are also responsible for discrimination against the different categories in this group. Of these the biggest barrier has been the criminalization of homosexuality which inadvertently results in cases of violence aimed at homosexuals. Other barriers include misuse of the Section 377 Penal Code by authorities in their own favour and also the health risks that homosexuals are directly exposed to. A major deterrent in obtaining healthcare is the fear of social stigma that is often attached to homosexuality.

EXISTING GAPS

Several barriers have simultaneously been identified within these programs which include:

- The lack of specific programs addressing the SGOI community.
- The lack of focusing on the mental health of those affected by HIV within the SGOI group.
- Increasing sensitivity in the personnel providing healthcare services.

AREAS FOR ADVOCACY:

Policy level: Lack of SOGI policy at a National and state level, there is a need to come out with a policy.

Systemic level: Homosexuality is still seen as a criminal offences or a Western phenomenon. Lack of knowledge about the diversity within the LGBT spectrum needs to be addressed and policy makers and others should be congnisant of these differences before making policy.

Service delivery level: Take measures to fight against stigma and discrimination . Counseling services for the young community members.

1.11 Human Trafficking

SITUATIONAL ANALYSIS:
Human trafficking is fast emerging to be a growing concern in India as has been indicated by the Global Slavery Index 2013 which ranks India as having the highest number of estimated modern slaves in the world. The table below is indicative of the current situation.

Number of trafficked persons: 4566 (2013 only)
Number of trafficked person rescued/repatriated: 4306 (2013 only)
The United States' Trafficking In Persons (TIP) report 2014 places India at Tier 2 - indicating that Indian government does not fully comply with the Trafficking Victims Protection Act's (TVPA)'s minimum standards
Global Slavery Index Report 2013 ranked India at the fourth position among 162 countries

As has been identified, the ultimate objective of the **Integrated Plan of Action to Prevent and Combat Human Trafficking with Special Focus on Children and Women2008** by the GOJ is to mainstream and reintegrate all victims of trafficking in society. To address and combat trafficking several laws and policies have been passed which include:

- **The Immoral Traffic Prevention Act, 1956 (ITPA)** and is the main legislative instrument providing a legal framework to prevent trafficking in India through avoidance of organized prostitution.
- **The Indian Penal Code, 1860** has over 20 provisions that are applicable for human trafficking related offences and penalizes unlawful actions such as kidnapping and abduction.
- **The Criminal Amendment Act, 2013** made amendments to the Indian Penal Code, 1860 and Section 370 of the India Penal Code was substituted with new sections 370 and 370(A) which criminalizes all forms of human trafficking.
- **Karnataka Devdasi (Prohibition of Dedication) Act, 1982.**
- Other collateral laws relevant to trafficking include **Bonded Labour System (Abolition)Act, 1976** and the **Indecent Representation of Women (Prohibition) Act, 1986.**

Provisions on Trafficking in the Constitution of India
Article 23 Fundamental Right prohibiting trafficking in human beings and forms of forced labor.
Article 39(e) Directive Principle of State Policy directed at ensuring that health and strength of individuals are not abused and that no one is forced by economic necessity to do work unsuited to their age or strength.
Article 39(f) Directive Principle of State Policy stating that childhood and youth should be protected against exploitation
India has a written Constitution, and though the above provisions make India's mandate on trafficking clear, penalizing and tackling trafficking is dealt with by legislation. The Constitution specifically mentions trafficking in human beings as well as forced labor and also indicates the special protection to be provided to vulnerable groups in society. The Constitution of India discusses provisions on trafficking at two levels - one, at the level of Fundamental Rights which are basic rights available to all, irrespective of caste, creed, sex, place of birth, etc., and two, at the level of Directive Principles of State Policy. Fundamental Rights are justiciable and can be directly enforced in a court of law,

whereas Directive Principles of State Policy are non-justiciable and cannot be directly enforced in a Court of Law. However, Directive Principles play a major role in shaping the policy of the State and may sometimes be the basis that legislation is built on. As a Fundamental Right in Article 23, trafficking in human beings is prohibited as are all forms of forced labor. According to Directive Principles of State Policy in Articles 39(e) and (f), the health and strength of workers should not be abused. It prohibits exploitation of persons to perform work which is unsuitable for them. It also specifically protects children and youth against exploitation of any kind. While the provisions in the Directive Principles of State Policy do not mention trafficking, it mentions exploitation which is a key element in trafficking

To curb trafficking in India the Government has ratified several international treaties, the most important being the **Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children,** supplementing the United Nations Convention against Transnational Organised Crime (Trafficking Protocol) adopted in the year 2000 and coming into force in December 2003. In April 2013, Section 370 of the India Penal Code was amended based on the UN Trafficking Protocol. However an important point to be noted is that India has not yet ratified two international treaties that are relevant for trafficking i.e. Worst Forms of Child Labour Convention and the Domestic Work Convention.

Several programs have been put in place to assist victims of human trafficking. However, a number of barriers have been reported in implementing these programs that aim at improving information about sex offenders to help create awareness and building the capacity of and empower the Anti-Human Trafficking Units under the Crime Investigation Department.

EXISTING GAPS

Key gaps in the legal framework have an impact on all three areas of prosecution, protection and prevention. These include:

• Non-ratification of UNTOC and Protocols, which is a major stumbling block as many enabling provisions of the treaties cannot be availed of.

• Lack of a comprehensive definition of trafficking either as a common minimum platform for the States to work on with each other, or even for punishing all forms of trafficking within the countries. While the SAARC definition is there, it is limited to trafficking for sexual exploitation and only covers women and children. While there is a definition in the Goa Children's Act, 2003 this only covers children and is not applicable beyond the boundaries of the State.

• Gender sensitivity is missing; even though there are laws for women, this does not translate into a sensitive law. There are provisions in the ITPA, which penalize the victim, for instance.

Key Gaps in Prosecution

• There is no uniform definition of who is a child/ minor in terms of age. It varies in different statutes; both civil, e.g., marriage or labor, and criminal, e.g., trafficking. Even within fields of law like labor law, the definitions of a child/ minor vary according to the legislation.

• Trafficking is not often seen as an organized crime, and provisions relevant to organized crime 136 are not made use of in trafficking cases.

• Co-operation mechanisms are ad hoc or non-existent, as far as cross border trafficking is concerned. Especially concerning:

a. Legal assistance

b. Providing information

c. Transfer of sentenced persons

d. Joint investigations

• Prosecutions overall are not satisfactory.

Key Gaps in Protection

• There is sometimes no adequate distinction drawn between the trafficker and the victims; e.g., in the case of prostitution or in the case of unsafe migration without documents. Sections 4 and 8 of the ITPA, have been used against the victim herself in some cases.
• There is no positive duty cast upon States to provide sufficient shelters or for rehabilitation or rescue although enabling provisions exist in a number of legislations such as the ITPA and the Juvenile Justice (Care and Protection of Children) Act, 2000. The conditions in the homes that do exist need improvement.
• Civil remedies in tort law are not used against employers who violate labor standards or force employment, though remedies are available in the Criminal Procedure Code and as established by case law, and though there are a number of initiatives now being taken on bonded labor.
• Financial support for existing programs is often insufficient.
• A conducive atmosphere to make it safe for victims to testify is not created. There is no witness protection program too. Many witnesses turn hostile as a result. The lengthy proceedings and delays add to this.
• The proceedings are not often gender sensitive and a woman victim is often unaware of proceedings in her own case. She is not involved, nor does she have the services of legal counsel to advise her. Women victims may also be put into protective homes against their will and separated from their children.

Key Gaps in Prevention
• Trainings of government personnel as well as community awareness are done sporadically and materials are not revised systematically.
• Awareness programs among the general public have to be strengthened along with widely publicized helpline numbers. Community initiatives especially in vulnerable areas must be stepped up with the cooperation of NGOs.
• Licensing of recruitment agencies is currently not done, though there is a need to do so.
• Law reform, policy and prevention measures are slow to respond to newer forms of trafficking. There have been several critiques even on the proposed amendments to the ITPA, currently under consideration.
• There are often no set guidelines for safe migration; pushback is sometimes resorted to in cases of women and others from Bangladesh
Systems like referrals and identification of support staff and service providers or authorities at different levels is absent, although there are a number of NGOs who do support these activities.

AREAS FOR ADVOCACY:
Policy level: Human trafficking needs to be seen from a wider spectrum than just sex work. Adequate laws should be put in place to deal with human trafficking.
Systemic level: Safe migration guidelines should be put in place to prevent trafficking.
Service delivery level: Support systems and counselling and rehabilitation should be enforced for victims of human trafficking.

1.12 Sex Work

SITUATIONAL ANALYSIS:
Studies and surveys sponsored by the Ministry of Women and Child Development (MWCD) estimates that there are about three million prostitutes in the country, of which an estimated 40 percent are children. There are a number of reasons for women taking up sex work including economic, cultural practices and a social structure where there is lack of protection for women. Several policies and laws have been passed by the Government to protect the rights of sex workers in India. These include the

- **Immoral Traffic (Prevention) Act** also known as PITA (1986). It is the basic instrument which aims to limit and abolish prostitution in India.
- The **National Policy for the Empowerment of Women, 2001** talks about addressing the needs of specially disadvantaged groups of women, including prostitutes, and aims to provide them with special assistance.

India has also ratified several international conventions and treaties pertaining to sex work. To effectively assist sex workers in India the target as per the NACP IV (2012-2017) is to increase the percentage of female sex workers who report using a condom with their last client by 80% to 85% by 2017. Schemes like Swadhaar and Ujjawala are especially aimed at women in difficult circumstances and child victims of trafficking.

EXISTING GAPS:
Despite the prevalence of laws and policies there have been reported several barriers, which include:

- Rather than protecting women Section 8 of the ITPA has often been misused and misdirected against sex workers while people who abuse or exploit them remain out of bounds
- The laws under ITPA create an environment in which the sex trade is driven underground and sex work happens in unsafe environments and hence making sex workers more prone to marginalization, violence and HIV / AIDS.
- The lack of flexibility in training women who have been rescued due to the pressure to live in the corrective homes
- The prevalence of social barriers such as the lack of education, the social stigma and the moral lens attached to sex work often drives sex workers to criminal activities.
- Accessing healthcare is a major concern for women sex workers. Besides the stigma attached, the fear of the medical establishment makes them vulnerable to exploitation and extortion.

AREAS FOR ADVOCACY:
Policy level: The rights of sex workers and the right to sex work should be enshrined in the law and sex work should be treated as a legitimate source of livelihood, for people who choose it as such.
Systemic level : The rights of sex workers to do sex work should not be confused with forced human trafficking, which is a common mistake that is made while addresing the problem of trafficking.
Service Delivery level: Stigma and discrimination and moralistic attitudes around the concept of sex work should be addresses and eliminated.

1.13 Migrants

SITUATIONAL ANALYSIS:
The NSSO (2007–2008) estimates the number of internal migrants in India at 326 million or 28.5 per cent of the population. The World Bank 2011 estimates Indian emigrants to be at 11.4 million. The migrant population is vulnerable because regulations and administrative procedures exclude migrants from access to legal rights, public services and social protection programmes accorded to residents because of which migrants are treated as second class citizens.

India is neither a signatory nor has ratified the UN Convention of Migrant Workers (CMW), which provides the formal sanction for protection of the migrants. This Convention clearly articulates the human rights of migrants and puts the global focus on their issues, but India has not adopted these conventions and hence interests of migrants are not protected, including most importantly their health.

The Inter-State Migrant Workmen Act applies to only migrants crossing state boundaries. It articulates no guidelines for inter-state co-operation. It covers only regulation of employment and conditions of service of migrants and does not address access to social protection of migrants, their right to the city and the special vulnerabilities of children and women migrants.

There are programmes like the **Jivan Madhur Yojana 2006; Rashtriya Swasthya Bima Yojana (RSBY)** to provide health insurance coverage for BPL families. RSBY is a smart-card based health insurance system with unique portability of access to health care services. To enable greater utilization, there is the facility to get a 'Split Card' for migrant families, which can be used by migrant workers at destination as well as at source by family members of the migrants.

Yet it is observed that health care utilization rates among migrants are often found to be poor (NUHM 2008). To some extent, this can be attributed to migrants' feeling alienated from the government health system at temporary destinations and private facilities being too expensive. Migrant populations often cannot access the services/programmes on account of their migration status, timings of their work and distance to services.

One of the serious constraints in framing an effective policy response to internal migration is lack of credible data on the volume of migration. While the latest 64th Round NSS survey puts a figure of 30 million on internal migration, various estimates based on micro-level studies suggest that the figure is close to 100–120 million. Concerted efforts are required to address this knowledge gap on migration.

AREAS FOR ADVOCACY:
Policy level: Make it compulsory for employers/contractors and migrants to register themselves under the Inter-state Migrant Act, barring which penalty will be levied on the employers and labour contractors.
Systemic Level: Create an integrated migrant management structure by combining the existing regulatory and welfare structure across all commercial and industrial establishments in the country.
Service Delivery Level: Conduct sensitization programmes and public campaigns to inform employers, workers, agents and labour unions on the existing social security and welfare schemes and benefits of registration as per the Act.

1.14 Other issues (Honour killing)

SITUATIONAL ANALYSIS:
There is no accurate data available with any of the governmental or non-governmental agency. But the studies conducted by various civil society organisations reveal that approximately 1000 people (both females and males) are killed every year in India owing to alleged honour killings. **According to statistics from the United Nations, one in five cases of honour killing internationally every year comes from India.**

In India, due to its complex socio-cultural patterns, there are various causes behind honour killings. Intolerance of Indian upper castes to inter-caste matrimonial/pre-marital relationship of females being the prime cause. Even marriages into same gotra (lineage, clan) have emerged as the causes of honour killings in the northern parts of India.

The Constitution of India has ample provisions allowing an individual to exercise his/her choice independent of caste, religion or gender and protection from honour related crimes including honour killings. As signatory to several international Declarations and Conventions, India is dutybound to protect men and women who have the right to marry with his/her choice.India, as a state party to CEDAW has the legally binding obligation to "eliminate discrimination against women by any person, organization or enterprise," as enumerated in article 2e.

The Prevention of Crimes in the Name of 'Honour' & Tradition Bill, 2010 proposes imprisonment up to 10 years. Prior to this Bill, there were no laws which punish the illegal and often barbaric acts of *khap* or community panchayats or other caste or religious associations.

Although there is a legal provision is in place to prosecute the guilty of honour killing, there is lack of effort to implement the laws. The criminal justice system in which laws dealing with harmful practices are enforced, is rife with problems such as judicial delays, overburdening of courts, lack of training and gender sensitization of members of the judiciary, law enforcement officials and implementing agencies. Besides constituting rigorous laws and rigid punishments, it is necessary to change the mind-set of bigoted patriarchal societies to become tolerant to matrimonial choices of their daughters especially towards inter-caste and interreligious marriages.

AREAS FOR ADVOCACY:
Policy level: Honour Killing should be treated as first degree murder and should invite the same punishment that is given for first degree murder.
Systemic level: All quasi-judicial organisations like khap panchayat should be disbanded and everyone should be brought within the purview of the Indian lw
Service delivery level: Awareness among young people about the evils of cultural hegemony and its relation to honor killing. Make help accessible to people who are in the danger of being victims of honour killing.

1.15 Comprehensive Sexuality Education

SITUATIONAL ANALYSIS:

Evidence suggests that age-appropriate, gender-sensitive and life skills-based comprehensive sexuality education can provide young people with the knowledge and efficacy to make informed decisions about their sexuality and lifestyle. India has 243 million young people (10-19) as per 2011 Census and an adverse Sex Ratio (0-6 years) of 914 females per 1000 males. About 44% of the reported AIDS cases in India, are in the age group of 15-29 years. All of these point towards the need to focus on sexual education among adolescence.

A study commissioned by the Indian Ministry of Women and Children Development and carried out by UNICEF and *Prayas*, a non-governmental organization revealed that 53% of children between the ages of 5 and 12 have been sexually abused and more than half of the cases of sexual abuse and rape go unreported. The study reaffirms the need for an educational intervention that includes age-appropriate sexuality education.

The health needs, and particularly the reproductive and sexual health (ARSH) needs of adolescents, continue to be ignored and neglected. It has also been accepted in the National Population Policy 2000 of Government of India.

EXISTING GAPS:

"Though the Government of India and its agencies have advocated sexuality education and prepared a program, AEP, the inhibition associated with the word "sex" as well as preconceived irrational fears and increasing resistance from political opponents have scuttled the said programme. Twelve Indian State Governments had gone against the Adolescent Education Programme introduced by the Central Government in association with the National AIDS Control Organization (NACO) and the United Nations Children's Fund (UNICEF). The Central Government in India did not taken any further action with respect to states banning sexuality education program proposed by it.

AREAS FOR ADVOCACY:

Policy level: Limited attention paid towards affirmative sexual rights to pleasure.

Systemic level: There has been limited acknowledgement of sexual desires and different sexual behaviours including considerations for the affirmative right to pleasure. Initiatives for young boys are primarily designed towards their orientation to women's sexual and reproductive rights and status should be made a component of the sex education curriculum. Limited resources such as skilled health personnel at the rural health facilities are key concerns, which should be looked into.

Service delivery level: Sex education should be made a compulsory part of the school/ college curriculum and teachers and counsellors should be trained to help with issues that emerge during adolescence.

1.16 Conjugal rights (Marriage related rights)

SITUATIONAL ANALYSIS:

Marital rape is particularly complicated because the complex, personal nature of marital relationships makes it hard for the victim to even see herself as a victim, let alone reporting the offending act to the authorities, which is why Marital Rape is one of the highly under-reported violent crimes. Even the women who do consider themselves victims are disinclined to approach the authorities because they are financially dependent upon their husbands, and reporting the matter could very well result in withdrawal of financial support leaving them and their children without food and shelter. The lack of laws and abundant social stigmas against the act of marital rape is one of the primary reasons that the evil of marital rape is still hidden behind the sacrosanct notion of marriage. For instance, according to **Section 375 of the Indian Penal Code (IPC) 1860** "Sexual intercourse by man with his own wife, the wife not being under 15 years of age, is not rape."

On December 23, 2012 a three member Committee headed by Justice J.S. Verma, former Chief Justice of the Supreme Court was constituted. Following are the Committee's recommendations with regards to marital rape:

- The exception for marital rape be removed.
- The law ought to specify that:
    a. A marital or other relationship between the perpetrator or victim is not a valid defence against the crimes of rape or sexual violation;
    b. The relationship between the accused and the complainant is not relevant to the inquiry into whether the complainant consented to the sexual activity;
    c. The fact that the accused and victim are married or in another intimate relationship may not be regarded as a mitigating factor justifying lower sentences for rape.

AREAS FOR ADVOCACY:

Policy level: Make marital rape punishable by law. Women who are victims of marital rape should be treated on par with other rape victims and the same procedure of providing justice should be applied.

Service delivery level: Counselling and rehabilitation should be provided to victims of marital rape.

MAJOR GAPS IN THE SEXUAL AND REPRODUCTIVE HEALTH SYSTEMS IN INDIA:

By looking at all the programmes, policies and barriers in the 15 areas, it maybe concluded that :

1. There is lack of information to understand the magnitude of some issues such as the health issues of migrants, adolescent health.
2. Despite India being a signatory to most of the International Declerations and Conventions, the corresponding national policies need to be addressed.
3. Good policies exist but the implementation on ground is found wanting.
4. One of the reasons for this is lack of awareness among people about the existing legislations.
5. There are a number of social, cultural barriers to be overcome, especially when it comes to issues like adolescent reproductive health, sex education in schools and colleges, rehabilitation of sex workers etc.
6. Special focus should be paid to cultural practices that become a basis for the exploitation of women such as early and forced marriages,rape within marriage,definition of conjugal rights etc.
7. Thus the Advocacy agenda for Sexual and Reproductive health can be guided by the observations through this study.

Section II: Strategic Framework for Advocacy

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	• Implementation of Adolescent Education Programme • Advocacy to include sex education in government schools (as outlined in the NCF 2005 also)	• Campaign to include sex education for students in schools
HIV and AIDS	• Advocacy for offering schemes for social protection for people infected and affected by HIV/AIDS • Campaign to empower AHTU and improve access to the ART centres • Implementation of National Adolescence Reproductive and Social Health strategy • Increased budgetary allocation for NACP-IV	• Awareness about social protection for people infected and affected by HIV/AIDS • Remove stigma against HIV/AIDS at workplace • Support government to implement National Adolescence Reproductive and Social Health strategy
Abortion	• Standards for clinics – both private as well as public • Sub District level centres to create awareness and treatment for Reproductive Tract Infections	• Sub District level centres to create awareness and treatment for Reproductive Tract Infections
Access to services and information	• Special programme to promote health of migrants • Address health issues of transgender population	• Develop pilot programmes/scale up programmes to promote access to health by migrant population • Campaign against social stigma for transgender

		population.
Others	• Effective implementation of Protection of Women for Domestic Violence Act. • Greater focus on spacing than permanent methods • Advocacy to sign statement of General Assembly Declaration of LGBT Rights 2006	• Awareness about minimum age of marriage. • Awareness about Protection of Women for Domestic Violence Act. • Awareness about spacing methods • Advocacy to sign statement of General Assembly Declaration of LGBT Rights 2006

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies

1. **Include other stakeholders in advocacy initiatives** such as members from *Khap*, private practitioners and migrant homeless people. The healthcare system in India is largely dominated by the private medical sector; the NFHS Survey-3 indicates that private healthcare providers are the primary source of healthcare of 70 percent households in urban areas and 63 percent of households in rural areas. Similarly migration across districts, states and countries is increasing. It is found that their access to health facilities has several barriers. Therefore, involving these categories of people in advocacy efforts as stakeholders would help in better understanding of ways to address the problems.

2. **Increased use of media advocacy**: A more in-depth analysis of media coverage of issues related to sexual and reproductive health is required. Mapping of existing media coverage was undertaken mostly of national dailies. Coverage of relevant issues in regional dailies, electronic media and social media should be understood to design a strategy for advocacy.

3. **Greater engagement with Policy makers** may be needed at this stage. There have been changes in the political landscape in the country. It is therefore important to engage with the Parliamentarians and members of the newly formed *Niti Ayog* so that relevant issues are put forth the decision makers to enable maintain momentum of existing good work and advocate for what needs to be done. It is also important to ensure that financial allocation for the programmes is not compromised.

4. **Greater emphasis on evidence based advocacy** - Conduct research to be able to provide inputs to the ongoing advocacy efforts – policy advocacy, people centred advocacy, media advocacy. Regional co-operation across countries will also lend voice to ongoing advocacy. It is important to ensure that there is adequate participation of men in all the initiatives.

5. **Advocacy for effective implementation of policies and programmes** – As seen in the discussion in the previous section a number of progressive policies and programmes have been initiated in the last decade. While it is important to continue to contribute to these policies, it is vital that the existing policies and programmes are implemented effectively. In many areas it is seen that implementation on the ground is not effective due to a number of issues related to supply chain, capacity of human resource and lack of accountability. A close watch on the implementation of programmes and constructive suggestions for their improvement may help in effective implementation of programmes.

2.5 Iran

2.5.1 Situational Analysis

Iran has a unique political system, based on the 1979 constitution. The Constitution mandates a 12-member council called the Guardian Council who reviews all legislation passed by the *Majles* (parliament) to determine its constitutionality. If a majority of the council does not find a piece of legislation in compliance with the constitution or if a majority of the council's Islamic canon lawyers find the document to be contrary to the standards of Islamic law, then the council may strike it down or return it with revisions to the *Majles* for reconsideration[130].

The health status of Iranians has improved over the last two decades. Iran has been able to extend public health preventive services through establishment of an extensive Primary Health Care Network. As the Constitution entitles Iranians to basic health care, hence majority of them receive subsidised prescription drugs and vaccination programs. An extensive network of public clinics offers basic care at low cost, and general and specialty hospitals operated by the Ministry of Health and Medical Education (MoHME) provide higher levels of care.

Sexual and Reproductive Health (SRH) Indicators

Indicators	Value	Year	Source
Total Fertility Rate (TFR)	1.9 children born per woman	2012	UNICEF
Modern contraceptive prevalence rate (%)	77.4	2008-12	UNICEF
Delivery care (%), Skilled attendant at birth	96.4	2008-12	UNICEF
Delivery care (%), Institutional delivery	95.3	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	96.9	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	94.3	2008-12	UNICEF
Maternal Mortality Rate (MMR)	24.6 per 100,000 live births	2008-12	UNICEF
Infant Mortality Rate (IMR)	15 per 1,000 live births	2012	UNICEF
Health Budget (as % of GDP)	6.7	2013	World bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

2.5.2 SRHR Situation in the country

Family Planning

In Iran, family planning services have been provided through the public health system in the past. However, recently there have been policy changes and family planning services are no longer provided free of cost under government interventions. However, the government still provides free of charge services related contraception for the high risk groups (IDUs, sex workers etc.)

[130] Council of Guardian (Iranian government) --Encyclopedia Britannica. http://www.britannica.com/EBchecked/topic/247932/Council-of-Guardians (accessed December 2, 2014).

Some of the key indicators for Iran are as follows

- Unmet need of family planning (%): 5.69 (2010)[131]

The evolution of Iran's Family Planning Program has been described below in detail.

- Before 1979 Islamic Revolution: The Imperial Government of Iran adopted a national family planning policy in 1966, and launched an active family planning programme in the ministry of health in 1967. The 1967 Tehran Declaration acknowledged family planning as a human right and emphasised its social and economic benefits for families and society. By the mid-1970s, 37% of married women were practicing family planning, with 24% using modern methods.
- Islamic Revolution: Soon after the 1979 Iranian Revolution, the family planning programme was closed as it was seen to be associated with the Iranian royal family and was viewed as a Western innovation.
- During the eight-year conflict of Iran and Iraq that followed in 1980, a large population was considered an advantage, and hence, population growth became a major propaganda issue.
- After the war with Iraq ended in 1988, government began to prepare its first national development plan. Realising that dwindling resources could not both support the high cost of reconstruction and provide the social and welfare services stipulated by the new constitution, a three-day Seminar on Population and Development was held in *Mashad* in September 1988 to convince many top policymakers of the importance of family planning. In December 1988, the High Judicial Council declared that there is no Islamic barrier to family planning. The Expediency Council[132] agreed "that family planning and population policies were legitimate areas for government involvement, paving the way for the reintroduction of a national population policy and the family planning programme[133]".
- The family planning programme was introduced in December 1989 with three major goals namely, to encourage families to delay the first pregnancy and to space out subsequent births; to discourage pregnancy for women younger than 18 and older than 35; and to limit family size to three children.
- In 1990, the High Judicial Council declared that sterilisation of men and women was not against Islamic principles or existing laws. In 1993, a family planning Bill was passed that removed most of the economic incentives for large families. The government through its public health system offered choices of family planning method like pills, condoms, and injections to the community. Along with this, awareness sessions were organised for mobilising the community on family planning methods. Population education was introduced as a part of the curriculum at all educational levels as well as through adult literacy campaigns. Couples who were planning to marry had to participate in government-sponsored family planning classes before their marriage license.
- The first official target of the revitalised family planning programme, as reflected in the government's first five-year development plan, was to reduce the TFR to 4.0 births per woman by 2011. By 2000, the rate was already down to half the stated goal, at 2.0 births per woman.
- In July 2012, the former Minister of Health stated that the MoHME will no longer provide all the routine public FP services through the public health sector. The motto changed from "two children are enough" to "at least two children is ideal[134]".
- Iran's parliament has outlawed vasectomies and tubectomies, except to save a person's life.

Some of the key problem areas are as follows:

- Since 2012, FP services are no longer provided by the public sector. All the contraception methods are still readily available on the private market, but no subsidies are provided on these anymore.
- Young Iranian couples have been accustomed to the idea of a small family and the benefits that come with it. This was proven when the government's programme to pay women to have children largely failed[135].

[131] Islamic Republic of Iran's Multiple Indicator Demographic and Health Survey (IrMIDHS) 2010

[132] Expediency Council resolves disputes between parliament and the Guardian Council.

[133] Mehryar, A. et al. 'Repression and revival of the family planning programme and its impact on the fertility levels and demographic transition in the Islamic republic of Iran. Working Paper 2022'.

[134] Karamouzian, Mohammad, Hamid Sharifi, and Ali Akbar Haghdoost. "Iran's shift in family planning policies: concerns and challenges." *International journal of health policy and management* 3, no. 5 (2014): 231.

[135] Roudi.F. "Iran Is Reversing Its Population Policy". Population Reference Bureau. *(2012).*

Reproductive Health Services

Maternal and child health (MCH) in Iran has improved significantly over the years. MMR has decreased from 91.0 per 1000 live births in 1989 to 37.4 in 2000[136]. According to the 2000 DHS, more than 90% of pregnant women receive at least two prenatal check-ups, 95% of births are attended by a doctor or trained midwife, and childhood vaccination is almost universal. Almost 85% of all deliveries take place in health facilities and almost 90% of babies are delivered by trained health attendants[137].

Since 1979, a Primary Health Care (PHC) network has been established in Iran, under which a Health House, staffed by trained "*Behvarz*" or community health workers has been established in rural areas which provides MCH and FP services in the target communities. In addition, Rural Health Centres have been set up where a physician, a health technician and an administrator are present to deal with more complex health problems. On similar lines, urban health posts and Health Centres have been established in urban areas. The second level of the system is the district health centre, which is responsible for the planning, supervision, and support of the PHC network and district hospitals. The third level of the system consists of the provincial and specialty hospitals[138].

Various reproductive health and FP services including ANC, MCH services and PNC services are provided through the public health network system.

All the FYDPs stress on improving public health and reducing child and maternal mortality. In addition, to the constitutional guarantee to free natal care, an Integrated Management of Childhood Illness (IMCI) strategy was introduced in teaching centres in 2002. A three day training workshop was conducted in hospitals to teach the students on aspects of health problems in a sick child[139].

The aforesaid interventions have contributed significantly to improve MCH, some challenges still remain:

- Need for establishing an appropriate monitoring system for maternal care programmes[140]
- Improving the quality of services rendered by mid-wives[141]
- There is a need for increasing the number of the cities to be under the umbrella of the IMCI programme and strengthening implementation of standard protocols for prenatal and postnatal care[142].
- There is a need to make operational the standard protocols for providing pregnancy, delivery and post-delivery services, producing sufficient information on the side-effects resulting from pregnancy and childbirth, promoting the quality of reproductive health including family planning services, ensuring reproductive health commodity security, creating a comprehensive national system to prevent maternal deaths, bridging data and information gaps on certain concepts of reproductive health such as the breast and cervical cancer and abortion, and addressing some aspects of reproductive health regarded as sensitive in the past, such as adolescent reproductive health'[143].

Prevention and Appropriate Treatment of Infertility

[136] Office of the Deputy for Social Affairs, Management and Planning Organization. Islamic Republic of Iran. "The first millennium development goals report 2004: achievements and challenges ". (2004)
[137] Mehrdad, Ramin. "Health system in Iran." *JMAJ* 52, no. 1 (2009): 69-73.
[138] Mehrdad, Ramin. "Health system in Iran." *JMAJ* 52, no. 1 (2009): 69-73.
[139] Roodpeyma, Shahla. "Integrated Management of Childhood Illness in Outpatient Department of a University Hospital." *Iranian Journal of Pediatric Society* 2, no. 1 (2010): 20-25.
[140] MDG 5: Improve Maternal Health. UNDP webpage. Available at:
http://www.ir.undp.org/content/iran/en/home/mdgoverview/overview/mdg5/
[141] MDG 5: Improve Maternal Health. UNDP webpage. Available at:
http://www.ir.undp.org/content/iran/en/home/mdgoverview/overview/mdg5/
[142] Office of the Deputy for Social Affairs, Management and Planning Organization. Islamic Republic of Iran. "The first millennium development goals report 2004: achievements and challenges ". (2004)
[143] "The first millennium development goals report 2004: achievements and challenges ". (2004) [Ibid]

According to media reports on 2014, Iran is planning to provide support packages in the form of insurance coverage to infertile couples, allowing them to get medical procedures done. This is in line with the country's general policy to increase population and preventing Iran's fertility rate from dropping under the replacement level.

Reproductive Tract Infections (RTIs)

No information available

Abortion

Abortion in Iran has been a contentious issue. After the establishment of the modern legal system in Iran, the laws of the country have gone from formal criminalisation of the act of abortion in 1926 to a gradual decriminalisation in the period 1969-79. In 1979 there was an Islamic revolution in Iran, when Iran entered another phase of a conservative and restricted approach towards abortion. It was only in the late 1990 and the early 2000s that the process of gradual decriminalisation of the act of abortion started[144]. 1998 was a milestone year for the abortion laws in Iran. In this year, the Iranian government introduced a programme for screening couples before marriage for detecting endemic disease of thalassemia. Increasing public requests for pre-natal diagnosis of the foetus and aborting thalassemia foetuses led the supreme leader of Iran and subsequently the government to allow for abortion of such foetuses. In 2003, the Iran Legal Medicine Organization (LMO) released a list of 29 foetal abnormalities and 22 maternal diseases for which therapeutic abortion was allowed. Finally a separate law for medically indicated abortions was passed by the Iranian parliament in 2005 namely the Therapeutic Abortion Act (TAA). This act permits the act of abortion by a physician if the foetus is retarded or malformed or life-threatening for the mother. The diagnosis has to be confirmed by three specialist medical doctors and verification of the LMO. Also, the abortion is permissible only before 'ensoulment' which is considered to be 18 weeks after conception. Post abortion care is provided as part of primary health care[145]. Under the Penal Code (1991), abortion for any other reason is a punishable offense.

There is lack of official data on the number of abortions in Iran; however there are multiple research studies which have estimated the number of abortions in the country. A journal article[146] which analyses data from the 2009 Tehran Survey of Fertility estimates that abortion rate in Tehran was 0.16 abortions per woman, and the annual general abortion rate was 5.5 abortions per 1,000 women; the general abortion rate peaked at 11.7 abortions among those aged 30–34. An estimated 8.7 of every 100 known pregnancies ended in abortion.

Some issues to be addressed are as follows:

- Because abortions are highly restrictive in Iran, it has given rise to illegal and sometimes unsafe abortions. There are cases of health code violations, some resulting in the permanent impairment of the woman's reproductive system or causing irreversible damage to her internal organs due to infections, improper or unprofessional usage of surgical tools or an incomplete abortion procedure.
- As abortion is illegal in Iran, there is lack of reliable and accurate data about abortions.
- In case of rape and aggression, ending of pregnancy is not allowed. This leads the women to conduct illegal and unsafe abortions.[147]
- While abortion is legal in the case of the life of the mother, it may not always be easy for her to access an abortion. In order to get the abortion she must first seek the approval of two doctors. Getting access to the doctors could be difficult, particularly for women in rural areas. In addition, the doctors' personal views of abortion could cloud his judgement on the issue.

[144] Abbasi, Mahmoud, Ehsan Shamsi Gooshki, and Neda Allahbedashti. "Abortion in Iranian Legal System." Iranian Journal of Allergy, Asthma and Immunology, 2014: 71-84.
[145] Vakilian, Katayon, Khadijeh Mirzaii, and NajmAbadi. "Reproductive Health in Iran: International Conference on Population and Development Goals." Oman Medical journal 26, no. 2 (March 2011).
[146] Erfani, Amir. "Induced abortion in Tehran, Iran: Estimated rates and correlates." International perspectives on sexual and reproductive health 37, no. 3 (2011): 134-142.
[147] As mentioned by Dr. Shahram Zarrabian, Chief Executive Officer, Family Health Association of Iran (FHA Iran)

- There is lack of awareness about the abortion laws in Iran, family planning methods and consequences of unsafe abortions. A study which investigated knowledge of young women about abortion laws concluded that nearly 50% of participants were not informed about national abortion legislation and its criminal law, and more than 66% of participants were not aware of unsafe abortion consequences.[148]
- There is a lack of a comprehensive intervention abortion reduction programme which may be prepared through the collaboration, with all stakeholders.[149] However, education and counselling programs for the public are provided by NGOs.

AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS

In Iran, the HIV/AIDS epidemic is classified as being concentrated. The number of women and men living with HIV in 2014 was about 23040 and 55250, respectively (totalling 78290). In Iran injection drug use (IDU) has been the most significant factor contributing to the spread of the virus.

- After detection of the first HIV positive case in 1987, a national response was commenced by holding the AIDS Supreme Council in 1988 which focused on providing safe blood, proposing some treatment services and precaution measures and establishment of registration system to record the detected cases. In 2001 for the first time within a nationwide programme, a five year strategic plan was developed for the years 2002-2006 by the MoHME which emphasised on partnership of all stakeholders including governmental and non-governmental sectors. The National AIDS Committee was formed in the same year. In order to reduce the harm related to IDU and to prevent the spread of HIV/AIDS among injecting drug users, the National Harm Reduction Committee was established as a sub-committee in 2002 who was responsible for the initiation of harm reduction interventions throughout the country. In 2005, the Head of the Judiciary issued a circular to all courts in support of harm reduction programmes for drug users.
- The second strategic plan (2007-2009) was developed which included establishing, consolidating, strengthening and coordinating multi-sectoral, multilateral harm reduction interventions; and reducing drug injecting-related harms. The third strategic plan (2010-2014) highlighted the “prevention of sexual transmission of HIV”.
- Iran's strategic plan includes a support system for people with AIDS. The system includes "Positive Clubs" or support groups for those with the disease.
- As part of the strategic plan, Iran has instituted several new programmes targeted at different key demographics. Educational activities for female sex workers are organised. Information and education for IDUs is delivered at Triangular Clinics, outreach programmes, drug treatment centres, community based educational centres, prisons, DICs and NGOs.
- As part of the Declaration of Commitment on HIV/AIDS, Iran submits its country progress report to the UNAIDS Secretariat every two years.

Key among important accomplishments in implementing HIV/AIDS prevention and care in Iran are:

- the establishment of a large number of triangular clinics providing services related to drug users, sexually transmitted infection services and care and support for people living with HIV/AIDS;
- the acceptance of methadone maintenance treatment as an important drug treatment and HIV prevention component for opiate-using populations, and enhanced delivery at a variety of settings, including closed settings such as prisons;
- the establishment of triangular clinics in the prison system for providing care and support to high-risk and HIV positive prisoners;
- HIV information, safe sex education and health education related to HIV targeting all inmates in Iranian prisons.

[148] Jarahi, Lida, Majid Reza Erfanian, and Rahil Mahmoudi. "Knowledge about abortion law among young women in Iran." Health 6 (2014).
[149] Rastegari, Azam, et al. Iranian Red Crescent Medical Journal (Kowsar) 16, no. 10 (October 2014).

- Involvement of NGOs in HIV/AIDS related decision making and planning the national level program. In this regard, the Country Coordinating Mechanism includes two seats for NGOs.
- The government provides free contraception services for PLWHIV.

Despite the efforts to address the incidence of HIV/AIDS:

- According to media reports in 2012, the Iranian government body that sets the country's official cultural policy has reportedly removed World AIDS Day from the state calendar[150]. However, negotiations are in progress by MoHME for reinsertion of this Day into the calendar.
- Social stigma among PLHIV is a key barrier. While the government has some laws to prevent discrimination, these can sometimes be hard to enforce[151].
- Inadequate human resources for implementing programmes[152]

Adolescent Sexual and Reproductive Health services – Youth Friendly Services

According to the Iranian national population census, adolescents represent 15.6 million (21.8%) of the Iranian population.[153] In the Iranian culture, an adolescent girl's health is considered more important than an adolescent boy's health.

- Average Age for marriage for males and females is 26 years and 24 years, respectively[154]
- The adolescent (15-19) fertility rate: 26.8 children per 1000 women in 2000[155]

In May 2014, the Supreme Leader of Iran announced the general policies on population on the basis of the first clause in Article 110 of the Constitution and these include the following policy for youth:[156] "Removing the obstacles of marriage, facilitating marriage, promoting the formation of family and giving birth to more children, encouraging youth to marry at a younger age, supporting young couples and enabling them to afford the cost of living and to raise righteous and competent children." The Iran National Youth Organization (INYO) is the main formal organisation responsible for adolescent and youth programming and welfare in Iran. This high-level, well-organised body plans to develop evidence-based programmes to improve adolescents' quality of life. Pre-marriage counselling on reproductive health is provided and is mandatory for those who are get married.

Despite the efforts to address the health needs of the adolescent population:

- Girls face social and cultural, structural and administrative barriers like inappropriate structure of the health system and political barriers such as lack of an adopted strategy by the government in accessing SRH information[157]
- There is a lack of awareness among adolescents about the reproductive health issues, including unwanted pregnancies during the early period of their married life

[150] Radio Free Europe Radio Liberty. *Iran Reportedly Removes World AIDS Day From State Calendar.* March 17, 2012. http://www.rferl.org/content/iran_takes_world_aids_day_off_calendar/24518879.html (accessed November 28, 2014).
[151] USAID. "Islamic Republic of Iran AIDS Progress Report." 2012.
[152] 2014 Iran AIDS Progress Report by USAID
[153] Shahhosseini, Zohreh, Masumeh Simbar, Ali Ramezankhani, and Hamid Alavi Majd. "Supportive family relationships and adolescent health in the socio-cultural context of Iran: a qualitative study." *Mental Health in Family Medicine* 9, no. 4 (December 2012): 251-256.
[154] Office of the Deputy for Social Affairs Management and Planning Organization; Institute for Management and Planning Studies andUnited Nations in Islamic Republic of Iran. *The first Millenium Development Goals Report 2004: Achievements and Challenges.* Tehran: The Management and Planning Organization of Iran and the United Nations, 2004.
[155] Ibid.
[156] "Supreme Leader Announces General Policy on Population", The Centre for Preserving and Publishing the Works of Grand Ayatollah Sayyid Ali Khamenei. May 2014. Available at: http://english.khamenei.ir//index.php?option=com_content&task=view&id=1911&Itemid=16 as accessed on December 2, 2014
[157] M, Shariati, Babazadeh R, Mousavi SA, and Najmabadi KM. "Iranian Adolescent Girl's Barriers in Accessing Sexual and Reproductive Health Information and Services: A Qualitative Study." *Journal of Family Planning and Reproductive Health Care* 40, no. 4 (October 2014): 270-5.

Comprehensive Sexuality Education

Due to the sensitivity of adolescent reproductive health, efforts are being made to address this issue through formal and non-formal education channels such as Parent-Teacher Associations. [158]

A study[159] analysing the challenges to sexual health education (SHE) for female adolescents in Iran demonstrated that the main socio-cultural challenges to provide SHE are affected by taboos surrounding sexuality, which itself resulted in many challenges in policy-making realm, programme designing and implementation and also sexual education in the families. These challenges are:

- Denial of premarital sex in adolescents is a significant barrier to manage adolescents' sexual-related complications
- Social concern about negative impact of sexual education to adolescents: Most adults believed that sexual knowledge especially about sexual relationship causes distortion and premature sexual activity before marriage
- Reluctance to discuss sexual issues in public – Some adults believed that providing sex education publicly can interfere with modesty and public chastity of society
- Due to fear of parents' objections and lack of advocacy and legal support, schools prefer to restrict SHE trainings
- There is an inter-generational gap between adolescents who are influenced by western culture and its social freedom and the older generations. So developing a model for SHE considering the perspective of both generations seems difficult
- There is lack of a programme for parents as part of a comprehensive strategy to improve the health and development of adolescents. Counselling parents about their role in adolescent health promotion should be an important focus of assessment and management in adolescent healthcare services.[160]

Early and Forced Marriage

Statistics indicate that in 2012, at least 1,537 girls below the age of 10 were forced to marry. During the same year, 29,827 girls between the ages of 10 and 14 faced the same fate[161]. As part of his 14 point decree to double Iran's population by 2050, Supreme Leader - said he hoped to have Iranians marry at a younger age in the hope to increase the population. He asked officials to remove obstacles to marriage and encourage larger families by assisting with childbirth costs and male infertility treatments. In his judicial decree, the leader of the Islamic revolution, the previous Supreme Leader Ayatollah Rouhollah Khomeini disallowed (rejected) any kind of sexual pleasure from immature girls i.e. girls under the age of nine years.

Iran's Civil Code severely restricts the right of women to freely choose a spouse and to enter into marriage with their free and full consent. According to this Code, the legal age of marriage in Iran is set at 13 for girls and 15 for boys. However, According to the 1041st article of civil law, the marriage of girls before the age of 14 is only permitted by the authority of her father or grandfather in the condition that the righteous legal court diagnose her benefits from the marriage. Due to the 50th article of the new law to support family and its remark, if the marriage takes place without regard to the 1041st article , the husband, parents and someone who do the formality of marriage would punished.
In September 2013, the Iranian Parliament revised and approved Article 27 of the Bill of Adopted and Neglected Minors and legalised marriage between adoptive parents and adopted children. At the same time, many articles in Iran's Child Protection Law clarify the protection of individuals under the age of 18 from any "exploitation" leading to physical, mental or moral damage to the child.

- There is a significant discrepancy between Iran's national codes and its international obligations. -

[158] Office of the Deputy for Social Affairs Management and Planning Organization; Institute for Management and Planning Studies and United Nations in Islamic Republic of Iran. *The first Millennium Development Goals Report 2004: Achievements and Challenges.* Tehran: The Management and Planning Organization of Iran and the United Nations, 2004.
[159] Robab Latifnejad Roudsari1 Ph.D., Mojgan Javadnoori2, 3 Ph.D., Marzieh Hasanpour2 Ph.D., Seyyed Mohammad Mehdi Hazavehei4 Ph.D., Ali Taghipour. "Socio-cultural challenges to sexual health education for female adolescents in Iran." *Iran Journal of Reproductive Medicine* 11, no. 2 (2013): 101-110.
[160] Shahhosseini, Zohreh, Masumeh Simbar, Ali Ramezankhani, and Hamid Alavi Majd. "Supportive family relationships and adolescent health in the socio-cultural context of Iran: a qualitative study." *Mental Health in Family Medicine* 9, no. 4 (December 2012): 251-256.
[161] Justice for Iran (2013) "Stolen Lives, Empty Classrooms: An Overview on Girl Marriages in the Islamic republic of Iran".

- Children can be married before they reach puberty, irrespective of their choice, at the will of their father. The Civil Code of the Islamic Republic practically sets no legal minimum age for marriage, meaning that a child of any age may be legally married with no real consequences for the parties involved. Such practices are condoned by Islamic Republic laws with reference to Sharia law, despite studies by scientists that point to the harmful results of marriage at such a young age[162].
- In addition to there not being a law to prevent early marriage, there are no programmes to discourage it either which only aggravates the issue.

Prevention and Surveillance of Violence against Women (Gender Based Violence)

In the Iranian society, women are subject to harsh treatment by an authoritative state. Ruling every aspect of their public life also provides the arena and encourages the control of their private lives. There are some state institutions for single women, prostitutes, drug addicts and children and young people who have run away from home run by the national welfare organisation, and offer protection, welfare services and rehabilitation programmes of varying quality for a transitional period.

According to the 1115th article of the civil law of Iran, a married woman can leave her home due to domestic violence. Moreover, she need not return if she fears physical or financial damages. During this period, her husband is responsible for bearing all her costs such as housing, clothing, food and medicine (alimony). In addition, if husband commits violence against his wife, he is punishable under the Islamic penal code.

Following are some of the policy and programmatic barriers[163] existing in Iran:

- Iran has not ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Optional Protocol thereto.
- There is lack of knowledge about shelter home facilities, mentioned above, which decreases their effectiveness.

Sexual Orientation and Gender Identity (SOGI) Rights

Homosexuality is viewed as illegal in Iran under the Islamic Penal Code. Transsexuals and men who have sex with men (MSMs) have been identified as one of the target groups for HIV testing and counselling under the HIV/AIDS third strategic plan (2010-2014). Even then one of the key barriers to policy making for SOGI rights in Iran is that since Iran offers no programmes for homosexuals with AIDS, the disease has become a very serious issue in the LGBT community.
The MoHME provides services to all men and women without making any judgement on their sexual orientation.

Human trafficking

The 2013 Human Trafficking Report by the US Department of State ranks Iran in its Tier 3 Category which is defined as countries whose governments do not fully comply with the minimum standards for human trafficking.

In 2004, Iran's Anti Human Trafficking Legislation was first introduced in the Iranian Parliament (*Majlis*) and passed. This punishes those convicted of engaging in trafficking with a sentence of 2-5 years imprisonment. Further, according to Article 639 Section 3 of the Islamic Penal Code, the persuasion of women to prostitution or sexual trafficking shall be punished by imprisonment for 1 to 10 years.

Additionally, several barriers have been identified such as:

- Iran's Anti Trafficking law is more crime oriented than victim oriented.
- Iran is yet to ratify the UN Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children 2000 and CEDAW.

[162] Women Living Under Muslim Laws. "Child, Early and Forced Marriage: A MultiCountry Study, A Submission to the UN Office of the High Commissioner on Human Rights (OCHCR)." 2013.
[163] Women Living Under Muslim Laws (WLUML), UN Universal Periodic Review of Iran, 20th Session of the UPR Working Group 2014 titled 'IRAN: Gender Discrimination at Its Worst'

Sex work

As per the Article 287 of the Penal Code of Iran, sex work is illegal. In Iran sex outside marriage is a crime and is punishable.

Since sex work is viewed as illegal, sex work and sex workers are driven underground and are unable to access health services easily. This restricts the treatment of HIV and other STIs and allows the continued spread of the virus. To prevent the spread of HIV the Government holds regular prevention programmes to educate them about the disease. Female sex workers (FSWs) have been identified as a key target group for HIV testing and counselling under the HIV/AIDS third strategic plan (2010-2014). Under the partial support of the government, some NGOs are running drop-in centres in which the sex workers can receive the services they need.

Migrants (Provision of Health Services)

Iran has always had a steady influx of both immigration and emigration, which has mainly been driven by key political events. In recent times, Iran claims to have produced the highest rates of brain drain in the world while topping the list as the biggest refuge haven particularly for Iraqis and Afghanis. Iran also exhibits a very high rate of urban growth rates mainly due to internal migration from rural areas[164].

Iran allows migrants, who are mainly from Iraq and Afghanistan in as refugees. Prior to 2001, these refugees were issued "pink cards" or *Amayesh* status. The so-called *Amayesh* registrations give them legal residence in Iran. Registered Afghans with health insurance have access to public health services. The Iranian authorities regard all Afghans who arrived in Iran after 2001 as illegal immigrants. Unregistered Afghans cannot take out health insurance, and Afghans staying illegally in Iran do not have access to the public health service either. However, they have access to private services and some NGOs provide free of charge services to this group of immigrants. A new law passed by Iran's parliament in May 2012 provides children born to Iranian mothers and foreign fathers with permanent residency rights and allows them to access the same social, health, and educational benefits that other Iranians enjoy.

There have also been identified several barriers that inhibit policy making such as:

- The Iranian system does not provide free healthcare and unemployment benefits to a significant portion of the migrant population.[165].
- Iran has not ratified the UN International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families 1990.

Conjugal rights (Marital rape)

Marital rape is not recognised, or is effectively permitted under the Iranian law. Marriages in Iran are carried out through a contract. At the core of the marriage contract is the wife's *tamkin* (submission), defined as an unhampered sexual availability that is regarded as a man's right and a woman's duty. The wife has to be sexually available to him at all times, such that he has total control over her, including her movements to and from the home. In return, he is required to provide her *nafaqa* (maintenance). Without an acceptable excuse, the wife's failure to comply with the lawful wishes of her husband constitutes *nushuz* (disobedience) and means that she may lose her right to maintenance. A wife is *nashezeh* (disobedient) when she, for instance, refuses to have sex with her husband or leaves her husband's home against his will. As soon as the wife repents and obeys the lawful wishes and commands of her husband, she ceases to be nashezeh. This legal framework is reflected in Iran's family law[166]. Marriage rights and responsibilities are laid out in detail in Book 7 Chapter 8 of the Iranian Civil Code.

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[164] Hakimzadeh, Shirin. "Iran: A Vast Diaspora Abroad and Millions of Refugees at Home." Migration Policy Institute. September 1, 2006. Available at: //www.migrationpolicy.org/article/iran-vast-diaspora-abroad-and-millions-refugees-home; accessed December 2, 2014.
[165] LandInfo. "Afghan citizens in Iran." 2012.
[166] Nayyeri, Mohammad H. Gender inequality and discrimination: The Case of Iranian Women. Iran Human Rights Documentation Center, 2013.

Other harmful practises (Honour Killing)

Honour killings have been found to be more common amongst the tribal minorities in Iran than amongst the less conservative Persian majority. Groups such as Kurdish, Lori, Arab and the Baluchi are considered to be more conservative and discrimination against women is deeply rooted in the tribal culture. Majority of these groups are Sunni Muslims and live in the isolated and socioeconomically lesser developed areas[167].

Article 220 of the Islamic Penal Code of Iran says that if a father, or his male ancestors kill their children under the pretext of "honour killing", they will not be prosecuted for murder. They only have to pay *Deyah*[168] (blood-money) to the descendants of the killed children. Article 1179 of the Civil Code states, "Parents have the right to punish their children within the limits prescribed by law. There are state run institutions that cater to women who are threatened with honour killings or other forms of violence[169].

Following are the barriers in this regard:

- Article 220 legally immunises fathers who kill their children. This has opened the door to increased honour killings without any effective and deterrent punishment.
- The Islamic *Shari'a* gives the victims' next of kin (*awliyā-al-dam*) the right to determine whether the condemned should be sentenced to death or be forgiven when another family member, such as the victim's brother, kills a girl or woman in the family making conviction difficult[170].

2.5.3 Highlights of the issues relevant from Advocacy perspective

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	▶ Need for formulating programmes addressing SRH issues of adolescents	▶ Raising awareness among adolescents about RH issues, including unwanted pregnancies during the early period of their married life ▶ Need for involving parents as part of a comprehensive strategy to improve the health and development of adolescents
HIV and AIDS	▶ Formulation of laws to reduce stigma and discrimination especially to the MARPs	▶ Campaign to eliminate social stigma against HIV/AIDS
Abortion	▶ Enforcement of guidelines for service providers, in order to curtail unsafe illegal abortions	▶ Need for reliable and accurate data about abortions in the country ▶ Awareness generation about the abortion laws and consequences of unsafe abortions. ▶ Education and counselling for public.

[167] Land Info. "Honour killings in Iran." 2009.
[168] "Deyeh" is defined as a sum of money that the victim's family has to pay to the assailant's family for the physical damages, dismemberment, or death of the assailant.
[169] Land Info. "Honour killings in Iran." 2009.
[170] Nayyeri, Mohammad H. Gender inequality and discrimination: The Case of Iranian Women. Iran Human Rights Documentation Center, 2013

Access to services and information	▶ Ratification of the CEDAW and the Optional Protocol thereto ▶ Reinforce victim identification procedures to proactively identify victims of trafficking, especially amongst vulnerable populations such as migrants	▶ Raise awareness about shelter home facilities for victims of violence
Others	▶ Accession to the 2000 UN Palermo Protocol on human trafficking ▶ Collaborate with international organizations or NGOs to combat trafficking ▶ Formulate laws/programmes to address the issue of honour killings	▶ Campaign for a legislation to prevent, prohibit and punish domestic violence ▶ Increase Government accountability and transparency in implementation of anti- trafficking policies

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies for Advocacy

- There is relatively less focus on adolescent SRH in Iran by policymakers. There is a need to identify innovative approaches such as evidence based advocacy efforts to promote provision of these services in a way that is consistent with the community's cultural and religious values.
- In the socio-cultural and political context of Iran, involving and engaging community leaders such as religious people can be a powerful strategy in bringing out social change and positively influencing community opinion regarding culturally sensitive issues.
- Reinforcement of key messages is also important to sustain interest among various stakeholders. Regular dialogue and discussion about an important topic helps to keep the momentum around that particular area of concern, and leads to greater impact.
- There is a difference in opinion between adolescents who seem to be influenced by western culture and its social freedom and the older generations. Developing a model for sexual health education that incorporates the perspective of both generations can help to bridge this gap in perception.
- Educating and counselling parents about the importance of Adolescent Reproductive Health (ARH), involving them as members of advisory committees that review programme content on adolescent SRH issues and gaining their support in this regard can help to promote adolescent healthcare services in Iran.

2.5.4 Civil Society Organisations

S.No.	Name	Focus Thematic Areas
1	Defenders of Human Rights Centre	▶ Human rights
2	Society for Protecting the Rights of the Child (SPRC)	▶ Child rights
3	Centre for the Intellectual Development of Children and Young Adults (Kanoon Parvaresh Fekri-e Koodakan va Nojavanan)	▶ IEC initiatives such as movies to tackle issues like poverty, social issues, educational conduct, natural disasters and war, amongst others.
4	Iran Human Rights Documentation Centre	▶ Human Rights
5	Family Health Association of Iran	▶ Reproductive health, including raise awareness among the general public and the under-served, such as the youth, people using drugs, and FSWs
6	Hami Association	▶ Women's Rights Advocacy
7	Women's Forum Against Fundamentalism in Iran	▶ Women's Rights
8	Arseh Sevom	▶ Human right's
9	Iran Human Rights	▶ Human Rights

International Conventions

S.No.	Name of the convention	Year of Signing
1.	Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others	Signed in 1953
2.	International Conference on Human Rights, Tehran	Attended in 1968
3.	International Covenant on Economic, Social and Cultural Rights	Signed in 1968, ratified in 1975
4.	Convention on the Rights of the Child	Signed in 1991
5.	International Conference on Population and Development (ICPD), Cairo	Attended in 1994
6.	UN Fourth World Conference on Women, Beijing	Attended in 1995
7.	ICPD+5	Attended in 1999
8.	World Summit	Attended in 2005
9.	Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery	Acceded in 1959
10.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Acceded in 2007
11.	ILO Convention 1999 (No. 182), Elimination of Worst Forms of Child Labour	Ratified in 2002

2.6 Maldives

2.6.1 Situational Analysis

The health care delivery system of Maldives is organized into a four-tier referral system comprising of island, atoll, regional and central level services. The health care provided by the private sector is popular among the people. The Indira Gandhi Memorial Hospital in Malé serves as a tertiary-level hospital at the central level of the referral system. At the regional level, health care is delivered by regional hospitals in six locations across the country. Each of the six regional hospitals serves as the referral centre for 2 to 4 atolls. Pharmacy services are predominantly provided by the private sector, except for the pharmacy operated by the State Trading Organization (STO).

In 2009, Maldives initiated a divided and corporatized healthcare delivery system. However, this system was not successful largely because of the dispersed nature of the population leading to diseconomies of scale. By 2014, the health facilities were brought under the ambit of the newly formed Ministry of Health and Gender.

Sexual and Reproductive Health (SRH) Indicators

Indicators	Value	Year	Source
Total Fertility Rate	2.3 children born per woman	2012	UNICEF
Contraceptive prevalence rate (%)	34.7	2008-12	UNICEF
Unmet need for family planning (%)	28.6	2009	DHS
Delivery care (%), Skilled attendant at birth	94.8	2008-12	UNICEF
Delivery care (%), Institutional delivery	95.1	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	99.1	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	85.1	2008-12	UNICEF
Maternal Mortality Rate (MMR)	140 per 1,00,000 live births	2008-12	UNICEF
Infant Mortality Rate (IMR)	9 per 1,000 live births	2012	UNICEF
Health Budget (as % of GDP)	10.8	2013	World bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

2.6.2 SRHR Situation in the country

Family Planning

The Maldives Demographic Health Survey (MDHS) report (2009) by Ministry of Health states that the policy to implement programs in family planning in Maldives was adopted in 1986 and by 1990 the programs had reached the intended population in all islands. A Child-Spacing Policy was enacted in the late 1980s to legalise the use of natural methods, barrier methods, pills, injectables and IUDs for the first time in the Maldives. The target population for the Child-Spacing Programme and the policy were restricted to married couples (WHO SEARO, 1988).

Private pharmacies are registered to provide contraceptives prescribed by private physicians. Contraceptives are also available through the Society for Health Education, an NGO. All contraceptive methods offered by government health facilities and SHE are provided free of charge. According to the survey data, 63.1% of current family planning users in Maldives received their method of contraception from governmental sources including IG Memorial Hospital, regional hospitals, atoll hospitals, health centres, health posts, community/family health workers, etc. and 31% received their method of contraception from a private source. The survey also revealed that the most commonly used modern methods are female sterilization (10%) and male condom (9%) while male sterilization and implants being the least common methods among currently married women.

The National Population Policy (2004) recognises the right of the individuals and couples to decide voluntarily and responsibly the number and the spacing of children. The 7th National Development Plan (2006-10) identifies promotion of gender equality (including promotion of sexual and reproductive health and right to information and family planning) as a guiding principle. The Health Master Plan 2006-2015, addresses the issue of family planning by proposing to undertake capacity development and behaviour change programmes for different target groups, including pregnancy and family planning; adolescents and youth on reproductive health. The master plan also identifies family planning as a priority area under MCH services in the strategic action #2 under the policy goal #3 wherein family planning is identified as a priority area. Within the Health Protection Agency (previously called Centre for Community Health and Diseases Control), the Population Health Division (PHD) is responsible for planning, distribution and provision of FP services in the country including logistics management of the RH commodities (mostly FP methods).

In spite of having a well-defined population policy and several programmes to address FP there continue to be a number of social barriers. Some of the key problem areas are as follows:

- There is a need to increase knowledge on various contraceptive methods in Maldives; this can be done through raising public awareness which will further allow people to make informed decisions
- A RH and population programme has to be developed to reflect the sensitivity of issues such as reluctance to some methods such as male sterilisation

Reproductive Health Services

The majority of births (95.1%) in the five years preceding the Demographic and Health survey (2009) were delivered in a health facility; 85% were delivered in a public facility, and 10.2% were delivered in a private health facility.

The Health Master Plan 2006-2015 identifies delivery care as a priority area under MCH services (in including maternal and child health, nutrition, chronic diseases, and communicable diseases of public health concern. MCH services include but are not restricted to essential new-born care, immunisation and management of childhood illnesses; growth monitoring and supplementation; antenatal, intranasal and postnatal care as well as emergency obstetric care; reproductive and family planning services). The National Development Plans (NDPs) also highlight the importance of reproductive health services. According to the reproductive health knowledge and behaviour of young unmarried women in Maldives (2011) by UNFPA, RH services are available to married couples who seek family planning services or pregnancy and maternal health care services through established health service facilities. According to a country report by UNESCAP, improvements have been made in the provision of RH services at the primary health care level, especially for antenatal care (ANC) including recruitment of gynaecologists in regional and national hospitals and construction of more health centres and health posts.

Prevention and appropriate treatment of infertility

No information available

Reproductive Tract Infections

No information available

Abortion

According to a report by UNFPA, unsafe abortion is a key issue among young women in Maldives as abortion is the most common option taken by young women who fall pregnant outside marriage. Maldivian laws permits abortion only to save the life of the woman (including to preserve the physical health of the woman), for any other reason abortion is not permitted. The law also requires mandatory authorisation by the spouse/partner or relative for abortion services.

- Unsafe abortions (per 100 live births): 19

According to a Centre for Health and Social justice study, SHE Maldives' advocacy efforts resulted in legalising abortion for suspected thalassemia majors up to 120 days of the pregnancy. The new penal code (chapter 410, section 416) criminalizes abortion only if done after the first 120 days. In December 2013, Government of Maldives' Council of religious scholars, Maldives Fiqh Academy, under the Ministry of Islamic Affairs, released a progressive fatwa legalising abortion in cases of rape and incest in Maldives. According to the Mapping Abortion Policies, Programmes and Services in the South-East Asia Region 2013 report by WHO, abortion services in Maldives are highly restrictive and can be provided only by registered obstetricians/gynaecologists for recommended cases. A report by WHO indicates that there are penalties for illegal provision of abortion, both for the service providers as well as for those who access these services. Abortion can be performed only in selected health facilities and the procedure is covered under the national health insurance scheme.

Some issues to be addressed are as follows:

- According to a WHO report, there is lack of availability of essential drugs and equipment particularly for medical abortion in Maldives. While Misoprostol is a registered drug, being used for medical termination of pregnancy in a health facility, the drug remains as a restricted drug due to misuse leading unsafe abortions and risky health consequences.
- The WHO report also indicates that there are no national standards and guidelines or specialised trainings regarding abortion methods
- According to the Study on IPPF-SARO MA Provider Attitudes to Abortion and Abortion Services, there was no debate on access to abortion services in country barring few among the medical profession indicating limited focus on the subject

AIDS - Prevention, care and treatment of STIs and HIV/AIDS

Although there is low HIV prevalence in Maldives, the 2009 Joint Mid-Term Review of the National Response to HIV in the Maldives (JTMR) concluded that data gathered shows an epidemic characterised by low overall prevalence but with high vulnerability and risk, i.e. high epidemic potential. According to the Department of National Planning, 2013, Maldives has a HIV prevalence of less than 0.1%. The first case of HIV in the Maldives was reported in 1991. Through 2013, 19 HIV-positive cases had been reported among Maldivians (16 male, 3 female) and 332 cases among expatriates. All have been identified through case reporting and majority of the infections were reportedly acquired through heterosexual transmission. The National AIDS Programme (NAP) under the Centre for Community Health and Disease Control (formerly Department of the Public Health) in the Health Ministry of Maldives is responsible for developing and carrying key programmes for HIV/AIDS and STIs for key population groups. In 2010, a Risk Behaviour Mapping was conducted at selected islands and atolls, which estimated that within Maldives there are around 1139 FSWs, 1199 MSMs and 793 IDUs.

In 2007, Maldives received the GFATM grant of about USD 4 million from the Global Fund which enabled NAP to initiate and carry out awareness campaigns at targeted workplaces such as resorts, implementing provision of ARV treatment and starting safe practice project in the health care system. In 2009, a JMTR[171] was conducted which highlighted the need for targeted intervention in Maldives.

[171] References from other report, actual JMTR report not available online, will require IPPF support

Maldives has high rates of hepatitis B and C, while STI rates are average for the region[172]. Stigma and taboos related to sex work and MSM are widespread, putting the country at risk of spread of STIs, HIV and Hepatitis. With few resources currently required for treatment, Maldives has the opportunity to focus on better understanding risk factors, such as unsafe sexual practices and drug use, and focus on prevention among the most-at-risk-populations (MARPs). It can also address accessibility to health services, linking HIV with other STIs, and improve action in the ongoing HIV/AIDS program. The National Strategic Plan on HIV and AIDS 2007-11 (NSP) also has a specific strategy to provide HIV prevention services in the workplace for highly vulnerable workers (expatriate workers, seafarers, resort workers, police, and MNDF). Majority of the HIV tests are mandatory for pre-surgery, medical, work permit and screening blood donors. Mothers under ANC are screened for HIV with informed consent, signing a declaration form with a provision allowing them to opt out.

According to the UNGASS Country report, since 2007 Maldives has provided a number of interventions to prevent HIV in IDUs such as aftercare and outreach programmes via NGOs including Journey, SWAD and SHE. HIV/STI prevention and treatment services are provided free of charge by the government health facilities. Additionally, contraceptives, SRH and HIV related services (such as Voluntary Counselling and Testing) are provided free of charge at SHE. Using the GFATM funding Maldives has reached out to several IDUs through peer education. The National AIDS Committee (NAC), formed in 1987 provides oversight to the NAP. It has successfully advocated for HIV related issues.

Despite the efforts to address the incidence of HIV/AIDS:

- Prison inmates are categorised as a high risk population category for HIV/AIDS, however according to the JMTR (as stated in the UNGASS Country report) there has been no comprehensive intervention to reduce the risk of infection among persons in penitentiaries.
- According to the UNGASS Country report, there is a need for further strengthening the STI surveillance system and reporting mechanism for medical practitioners. The report also highlights that there are no special clinics available for MARPs.

Adolescent Sexual and Reproductive Health services – Youth Friendly Services

The population of Maldives is largely young with over 60% of the total population under the age of 25 years.

The youth population in Maldives have been a centric point of concern for several debates and discussions including decisions to reappropriate health services in order to make them more youth and adolescent friendly.

The Health Master Plan 2006-15 identifies adolescent and youth as one of the key target groups for undertaking behaviour change programmes. The Operational Plan on HIV 2010-11 (draft) aims to provide services to reduce and prevent vulnerability to HIV infection to 50% vulnerable adolescents and young people. In 2010, the Ministry of Health (MoH) and Ministry of Education (MoE) updated their 10 year plan to provide a 'policy umbrella' for more specific policy and programmatic actions that can reduce the vulnerability of young people and risk behaviours among particular groups in Maldivian society. The MoE is committed to ensure that the national curriculum will include health and well-being as a core subject from kindergarten to grade 12 and this had been included under strategy 7.1 of the School Health Policy[173]. The Youth Health Café (YHC) is a programme by the Ministry of Human Resources, Youth and Sports programme, supported by UNFPA, which undertakes awareness generation activities, provides services for adolescent and youth on SRH and refers young people for counselling and health services. These services are also provided by the youth kiosk established at SHE in 2004.

Despite the efforts to address the health needs of the adolescent population:

- Despite the fact that several surveys and reports have shown increased vulnerability of Maldivian adolescents and youths to risky behaviours[174], there is lack of a policy on access to contraceptives among adolescents, youth and unmarried couples/individuals. This leads to a large number of adolescents without access to FP services.

[172] The World Bank. 'HIV/AIDS in the Maldives.' 2012. Accessed on 12th June 2015 at http://www.worldbank.org/en/news/feature/2012/07/10/hiv-aids-maldives
[173] Ministry of Education and Ministry of Health and Family, 2010
[174] Narcotics Control Board, 2003; Ministry of Youth and Sports, 2005; UNDP, and MOH, 2008; SAP, 2009

- The Reproductive Health Knowledge and Behaviour of Young Unmarried Women in Maldives (2011) report by UNFPA identifies the need to incorporate ASRH and SRH awareness as a public health priority. The report also recommends strengthening the Health Master Plan and RH Strategy to include SRH goals and programmes for adolescent and youth.

Comprehensive Sexuality Education

Considering the religious and cultural background, sex education programs in schools is a controversial subject in Maldives. According to a Youth Ministry survey (2005), 14% of males and 5% of females under the legal age of 18, admitted to being sexually active.

The Health Master Plan (HMP) 2006-15 by MoH identifies youth and adolescent population of Maldives as a key demographic group. Under its first policy goal, the HMP aims to ensure that adolescent have appropriate knowledge and behaviours to protect and promote their health. In 2011, MoE issued a new National Policy on School Health with an overarching goal 'to mainstream health and wellbeing into the education system of the country by 2015'. The Youth Health Café (YHC) is a programme run by Ministry of Human Resources, Youth and Sport (MHRYS) and is supported technically by UNFPA to provide information about reproductive health including HIV, contraception, STIs and Life Skills Education which covers modules such as STIs/HIV, Conception, contraception and pregnancy, gender and sex.

According to a UNFPA study, none of the outcome indicators of the National Policy on School Health are connected to reproductive health outcomes. The study concludes that reproductive health information and services is not a policy priority in the school education sector in Maldives. The Reproductive health knowledge and behaviour of young unmarried women in Maldives (2011) report by UNFPA identifies the need to incorporate ASRH and SRH education in the school curriculum.

Early and Forced Marriage

Early and forced marriage threatens the lives and futures of girls, and has harmful consequences for even the next generation. By denying them freedom, chance at an education and their childhood, it has a detimental effect on both girls as well as boys.

The legal age for marriage has been set at 18 according to the Civil Law of the country. As reported by ICRW[175] in 2013, over the past 10 years there has been no record of children under 15 being married in Maldives. The government in the country has established Children's Court and Units for the Rights of the Children (URC) to work towards child protection and violence against children.

It is important to note that although the age of marriage is set to 18, this cannot be implemented strictly due to religious barriers, as islam allows young men and women to get married when they attain puberty. The Government tries to regulate such practices by limiting marriages to be conducted only through the Family Court, after an assessment of the situation, and gaining parental consent. Although only anecdotal, it is known that underage marriages between Maldivians do happen in neighbouring countries abroad. These marriages may not be registered in Maldives, which may put young women and children born into such marriages into risk of losing their right to education, inheritance, etc.

Violence against women (Gender Based Violence)

According to a study by the Ministry of Gender, Family Development and Social Security (MGFDSS), no comprehensive quantitative research has been undertaken to assess the prevalence of gender based violence in Maldives.

The Government of the country has undertaken several initiatives to address GBV. The HMP 2006-15 identifies Gender Based violence as one of the key strategic actions with the goal to integrate care for cases of GBV victims into health services. GBV is also recognised as a priority area for capacity building and behaviour change programmes. The MGFDSS is mandated to formulate policies, implement activities and to monitor the situation with respect to women and violation of

[175] "Child Marriage in South Asia: Realities, Responses and the Way Forward", ICRW, 2013

their rights. The Domestic Violence Act of 2012[176] aims to provide adequate protection to victims of domestic violence and undertake proper implementation of programmes to ensure recovery of victims of domestic violence. GBV cases reported to the MPS are managed by the Family and Child Protection Department (FCPD). They operate under a standard procedure to assist the investigating officers in managing domestic violence, sexual abuse of children and gender based sexual assault cases.

A major challege in this area is that a large proporiton of violence against women is underreported due to a variety of reasons, including the stigma surrounding the issue and the fear of retribution. Such violence is often considered a private matter rather than an infringement of human rights.

Sexual Orientation and Gender Identity (SOGI) Rights

Homosexuality is viewed as illegal in the Maldives under the Sharia law and a strong social stigma and taboo is attached to it. The behaviour change communication (BCC) Strategy for HIV Prevention Maldives by MoH and Global Fund indicates that men who have sex with men (MSMs) hide their sexual preferences since not only is sodomy considered illegal under the Sharia law but, if arrested MSMs are subjected to public flogging, imprisoned or even banished. Further, Maldives opposed the LGBT Rights Resolution in the United Nations Rights Council both in 2011 and 2014. There is limited information about the key policies, programs and the barriers for these with regard to SOGI rights.

Human trafficking

According to the 2013 Trafficking in Persons report by US Department of State, Maldives is placed on Tier 2 Watch List for human trafficking for the fourth consecutive year. The Anti-Human Trafficking National Action Plan[177] which was endorsed by the cabinet in February 2013 was formulated to eliminate or significantly reduce the incidences of trafficking in Maldives. An Anti-Trafficking Steering Committee has been established under the Ministry of Gender, Family and Human Rights to improve coordination.

The Child Sex Abuse Act, 2009 criminalises the prostitution of children. But Article 14 of the same act provides that if a person is legally married to a child under Islamic Sharia then none of the offences specified in this act, including child prostitution would be considered a crime. Several programs have been implemented by the government to combat trafficking such as the Anti – Human Trafficking Unit[178] set up by the Government of Maldives has in turn set up a hotline and opened a shelter for female victims of human trafficking. The Government has also undertaken various awareness raising campaigns such as “The Blue Ribbon Campaign: Stand against Human Trafficking” launched to educate masses on how to identify and help victims of trafficking.

As per the 2013 Trafficking in Persons report by US Department of State, the Government of Maldives is yet to fully comply with the minimum standards for the elimination of trafficking however, it is making significant efforts to do so.

Sex work

Sex work is viewed as illegal in the Maldives and hence remains largely hidden and runs underground. The NSP by the Ministry of Family and Health has identified female sex workers (FSWs) as a high risk group for HIV/AIDS. The Risk Behaviour Mapping survey 2010 estimated the number of FSWs in the country to be 1139.

[176] Unofficially translated version by UNFPA

[6] Written statement made by a Maldivian representative at the General Assembly on Migration and Development, plan document not available online, will require IPPF support

[7] Written statement made by a Maldivian representative

Since prostitution is viewed as illegal[179] in the Maldives, expatriates who engage in prostitution are deported while the locals involved can be sentenced to prison. The NSP by the Ministry of Family and Health provides a financial plan[180] that aims to achieve a target of having 80% people equipped with the adequate knowledge and skill set to protect them against AIDS. No corresponding programs exclusively targeting sex workers have been formulated.

The BCC Strategy HIV/AIDS Maldives 2009 report by the MoH and Global Fund identifies two key concerns about female sex workers (FSW) in Maldives:

- 1/3rd of the Maldivian FSW reported that they inject drugs which then puts two corresponding populations at risk i.e. the IDUs and the clients of the FSW's who are linked to a larger female population of the country.
- Reaching expatriate FSWs is a challenge which results in difficulties in planning and implementing communication and services for them.

Migrants (Provision of Health Services)

Internal migration continues to be an important demographic factor that impacts the growth of the population. As per the Youth Migration – Moving development forward (Maldives) 2013 by UNFPA, it has been estimated that majority of the migrants in Maldives are involved in the construction industry and most expatriates are from Bangladesh (56%) and India (23%). The current expatriate growth rate is 20% and research indicates that unless any policy reforms are undertaken shortly, the expatriate population will soon outnumber the local population. As identified in the MoH Country Progress Report 2008-09, fishermen, resort workers and construction workers are at a risk of HIV/AIDS.

The HMP 2006-15 does not address migrants under any of the policy goals or strategies. In spite of the lack of any formal policies addressing the needs of the migrant population, there are certain programs targeting this group such as the AIDS prevention program, which also focuses on addressing the needs of the migrant workers. Peer education and outreach services have been extended, to reach the expatriate migrant workers. BCC materials are developed in their native languages, and peer educators from the representing nationalities are trained, and regular health camps are organised. VCT services have also been setup primarily for migrant population.

Conjugal rights (Marital rape)

The Marriage Act, 1980 (amended in 1996) covers marriage, separation, adultery, sexual assault, divorce, child custody and child support, but does not mention marital rape is a separate issue requiring focus. According to media articles in 2014, the President of Maldives rejected the ratification of a bill that seeks to partially criminalise marital rape, since this action would be considered 'un-Islamic'. This itself poses a very huge problem regarding lack conjugal rights in the country and exaggerates the suffering of women. With the issue not identified, there would not be any laws, acts, policies or programmes in place to address it. The recently passed new Penal Code criminalizes marital rape as per chapter 130, section 130.

Other harmful practices (Honour Killing)

No information available

2.6.3 Highlights of the issues relevant from Advocacy perspective

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health

[179] References from other report, the actual law is not available online, will require IPPF support
[180] Details about ccorresponding plans / programs not available online, will require IPPF support

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people		▶ Campaign for provision of FP services to adolescent/unmarried population ▶ Campaign to include education on SRH for students in schools
HIV and AIDS	▶ Strengthening the STI surveillance system and reporting mechanism for medical practitioners	▶ Interventions, including awareness generation for prison inmates, who are categorised as a high risk population category for HIV/AIDS
Abortion	▶ Sensitizing stakeholders and service providers on abortion services, especially in light of amendments in the new penal code ▶ Provision of essential drugs and equipment for medical abortion ▶ Formulating national standards and guidelines and specialised trainings on abortion methods	
Access to services and information		▶ Campaigning for provision of health services to sex workers ▶ Awareness on the rationale for having a minimum age of marriage by engaging religious scholars and health professionals
Others	▶ Enforcement and practice of legal age of marriage	▶ Reducing stigma faced by victims of GBV ▶ Need for a comprehensive quantitative research to assess the prevalence of GBV in Maldives

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies for Advocacy

- Advocacy and lobbying efforts need to be more concentrated as the political structure of Maldives is new and fairly complex due to multiple stakeholders and opinion leaders. This can be done by developing evidence-based advocacy materials for specific target groups and tailor made exposure visits of key stakeholders to relevant countries.
- Since Maldives has a huge youth demographic, building a strong network of young peer educators, participation in international and national youth conferences and representation at global forums can help to raise issues specially related to SRHR of adolescents.
- Since there are limited number of CSOs working in the area of SRH in Maldives, building the advocacy capacity of these CSOs as well as other stakeholder groups can be effective to influence policy makers in order to bring about targeted change.
- Using the media for advocacy and public dialogues organized by CSOs to address sensitive issues can help to overcome socio-cultural barriers.

2.6.4 Civil Society Organisations

S.No.	Name	Focus Thematic Areas
1	Voice of Women	Women rights including gender equality and equity, violence against women, women's empowerment and involvement in development including economic, social and political dimensions.
2	Hope for women	Women rights including gender injustice and violence against women
3	Society for Women Against Drugs (SWAD)	Women rights; protecting abuse of children and women by drug users

4	Society for health education (SHE)	Women rights including reproductive health rights
5	Journey	Drug abuse and HIV

International Conventions

S.No.	Name of the convention	Year of Signing
1.	Convention on the Elimination of All Forms of Discrimination against Women	Maldives acceded in 1993
2.	Convention on the Rights of the Child	Signed in 1990, ratified in 1991
3.	International Conference on Population and Development (ICPD), Cairo	Maldives attended in 1994
4.	UN Fourth World Conference on Women, Beijing	Maldives attended in 1995
5.	Special session of the United Nations General Assembly (ICPD+5)	Maldives attended in 1999
6.	World Summit	Maldives signed in 2005
7.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Maldives signed in 2002, ratified in 2002
8.	SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution	Maldives attended in 2002
9.	ILO Convention 1999 (No. 182), Elimination of Worst Forms of Child Labour	Maldives ratified in 2013
10.	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, 1999	Maldives acceded in 2006

2.7 Nepal

2.7.1 Situational Analysis

Nepal's population is highly dominated by rural dwellers with more than 80% of people living in rural areas. Nepal has a high rate of migration due to lack of employment opportunities in the country. The National Population and Housing Census 2011 reported that one in every four households (25.42%; 1.38 million households) have at least one member of their household absent or living out of the country. Almost half of the absent population (44.8%) belongs to the age group of 15 to 24 years. This trend of migration makes it easy for the young population to fall prey to human trafficking.

Nepal was a monarchy for most part of its history. However, since the past two decades, Nepal has been facing a political turmoil. There was a communist movement in Nepal asking for the removal of monarchy. This movement ended in 2006 when an interim constitution was formed and the monarch gave up his powers. In 2007 democracy was finally established in Nepal. Being a recent democracy, Nepal is still undergoing a lot of social and economic changes. Over the years, Nepal has improved certain public health aspects such as reducing the maternal, child and infant mortality rates. The United Nations conferred Nepal with the MGD Award in 2010 to acknowledge its improvement in the area of reproductive health.

Sexual and Reproductive Health (SRH) Indicators

Indicators	Value	Year	Source
Total Fertility Rate	2.4 children born per woman	2012	UNICEF
Contraceptive prevalence rate (%)	49.7	2008-12	UNICEF
Delivery care (%), Skilled attendant at birth	36	2008-12	UNICEF
Delivery care (%), Institutional delivery*	35.3	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	58.3	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	50.1	2008-12	UNICEF
Maternal Mortality Rate (MMR)	280 per 1,00,000 live births	2008-12	UNICEF
Infant Mortality Rate (IMR)	34 per 1,000 live births	2012	UNICEF
Health Budget (as % of GDP)	6.0	2013	World bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

2.7.2 SRHR Situation in the country

Family Planning

The Family Planning Program in Nepal was initiated in 1959 by the non-governmental sector, the Family Planning Association of Nepal (FPAN). Government-supported family planning service delivery began in 1968. Over the years, the programme has expanded its coverage and the services have been provided through different channels and agencies.

Family planning (FP) is a priority programme of the Ministry of Health and Population (MoHP) and a component of the reproductive health (RH) package and essential health care services of the Nepal Health Sector Program II (NHSP II) (2010-2015). FP services are available through government, social marketing, and private health facilities and are available free of cost in public health facilities. Temporary FP methods are provided on a regular basis through health posts, sub health posts, primary health care, outreach clinics, and periphery level health workers and volunteers. Methods such as IUCD and implants are available at selected hospitals, primary health care centres, and health posts where trained human resource is available. Depending on the district, sterilisation services are provided at static sites or through scheduled "seasonal" or mobile outreach services.

In 1983, the National Commission on Population (NCP), which was formed in 1979, outlined the National Population Strategy whose goal was to reduce the fertility rate in the country. National Health Policy 1991 reorganised the health service and the Family Health Division was formed to provide public sector FP services. The Second Long-Term Health Plan (SLTHP) for FY 2054-74 (1997-2017) by the Ministry of Health (MoH) of His Majesty's Government of Nepal is the guiding document for moving toward the adoption of an Essential Health Care Package which includes family planning. The Family Planning Programme under NHSP II (2010-2015) aims to:

- Reduce TFR to 2.5
- Increase CPR to 67%
- Reduce unmet need for FP to 18%
- Increase VSC, IUCD and implant to 70000, 77000 and 80000 respectively

Following are some of the barriers according to a 2013 report on Voices from the Community: Study on Access to Health Services by the NHSSP:

- The almost universal preference for sons in Nepal limits the uptake of FP and results in reluctance to use any method until at least one son is born. Men without sons are reported to be discriminated against, by being excluded from social events and public gatherings, meetings, and financial loans from community members.
- Lack of same-sex health personnel is a major deterrent to women and men accessing FP methods. They feel shy to discuss personal issues with staff of the opposite sex, and women feel especially shy to undergo physical examinations by male health staff.
- Gender beliefs and norms affect FP. Most women need permission from their husbands and elders to use FP and visit health facilities for supplies and services. Women's heavy domestic and work burdens, especially in rural areas, leave them short of time to avail services, especially when opening times and availability of health staff are often unpredictable.
- The focus of FP efforts has been largely through community based interventions in MNCH, with minimal attention to services in health facilities. This has resulted in a real service gap for those wishing to access services at facilities, with even those that do provide FP services, often not offering the full range of methods.[181]

Reproductive Health Services

The maternal mortality ratio (MMR) in Nepal decreased substantially between 1996 and 2011, from 539 to 281 deaths per 100,000 births indicating improvements in maternal health services in the country. As per the NDHS 2011, 50% of women make four or more antenatal care visits during their pregnancy. As per NDHS 2011, infant and under-five mortality rates are 46 and 54 deaths per 1,000 live births, respectively. At these mortality levels, one in every 22 Nepalese children dies before reaching age 1, and one in every 19 does not survive till his or her fifth birthday.

The National Reproductive Health Strategy, 1998 includes an integrated package of health services, including safe motherhood. The National Safe Motherhood Policy (1998) and Plan (2002-2017) emphasises strengthening maternity care, at all levels of health care delivery system; enhancing technical skills of the health care providers at all levels; and strengthening referral services for emergency obstetric care. The National Safe Motherhood and New-born Health Long Term Plan (NSMNH-LTP) 2006-2017 lays increased emphasis on neonatal health, recognition of the importance of skilled birth attendance in reducing maternal and neonatal mortalities, health sector reform initiatives, recognition of the significant

[181] The Nepal Health Sector Support Programme (NHSSP). "Capacity Assessment for Health Systems Strengthening". 2010

levels of mother to child transmission of HIV/AIDS and increased emphasis on equity issues in safe motherhood services. Under (MoH) and Population, the FP division implements various programmes including National Safe Motherhood Programme which aims to reduce maternal and neonatal mortalities by addressing factors related to various morbidities, death and disability caused by complications of pregnancy and childbirth. This programme aims at the following:

- Reduction in the MMR to 134 per 100,000 by 2017
- Reduction in the neonatal mortality ratio to 15 per 1,000 by 2017
- Increase in the percentage of deliveries assisted by an SBA to 60% by 2017
- Increase in the percentage of deliveries taking place in a health facility to 40% by 2017

The aforesaid interventions have contributed significantly to improve MCH, some challenges still remain:

- The socio-cultural practices around childbirth such as maternal seclusion after delivery and the preference to treat within the community along with limited capacity to recognise danger signs have been identified as some of the challenges faced by the community[182]
- Lack of awareness or no perceived need for postnatal care by women and their families
- Long distance to the health facility and lack of transportation, especially in the hilly terrain, is a barrier
- Shortage of service providers at hospitals and peripheral levels and women's low position in the society are viewed as major challenges

Prevention and Appropriate Treatment of Infertility

The issue of infertility is relatively new to Nepal. In 2013, the Population division at the MoHP conducted a series of consultations with experts for an in-depth study on the issue which was followed by formulation of the 'Protocol for Infertility Management in Nepal' to determine the underlying causes of infertility and to deal with the issue by using conventional methods. The policy is currently under formation and will address the use and methods of artificial reproductive technologies. This policy will also provide a legal, technological and ethical basis to tackle infertility issues. Prevention and management of sub fertility is one of the components of the Integrated Package of Reproductive Health Services under the National Reproductive Health Strategy 1996[183]. The National Medical Standards for Reproductive Health, Family Health Division 2003 include a chapter on prevention, assessment, management and treatment of infertility. There are private clinics such as the Infertility Centre in Nepal that provide services to address the issue.

Reproductive Tract Infections (RTI)

In Nepal, STI services are provided through the general health services. Health staff is trained in the syndromic approach to STI case management, and if necessary referrals are made to centres where specialist services are available. STI services are also provided by private sector and NGO clinics in some places. The National Reproductive Health Strategy 1996 includes prevention and management of RTIs as one of the priority areas in its Integrated Reproductive Health Package. Apart from this, there is no separate strategy or intervention to address RTI related issues. The National Medical Standards for Reproductive Health, Family Health Division 2003 include a component on prevention, control and management of RTI.

Abortion

The *Muluki Ain* 1959, the basic legal code for the Kingdom of Nepal, prohibited abortion and characterised abortion as an offence against life, making no exception even when pregnancy threatened a woman's life. In March 2002 responding to public health and human rights imperatives, the Nepali Parliament passed the landmark legislation to reverse its archaic abortion law. This was supported by advocacy efforts highlighting very high maternal mortality in the country, much

[182] Mesko, Natasha, David Osrin, Suresh Tamang, Bhim P. Shrestha, Dharma S. Manandhar, Madan Manandhar, Hilary Standing, and Anthony ML Costello. "Care for perinatal illness in rural Nepal: a descriptive study with cross-sectional and qualitative components." BMC International health and human rights 3, no. 1 (2003): 3.
[183] Unable to obtain this document online

attributed to unsafe abortion. The change in legal status and highly organised implementation efforts allowed nearly 500,000 women to obtain safe, legal abortion care by 2011[184].

According to the National Safe Abortion Policy 2006 only listed (trained) doctors or health workers can provide safe abortion services at listed (approved) health facilities, under the following conditions:

- Within the first 12 weeks of pregnancy for any woman on her request. The permission of husband or guardian is not required for women above 16 years of age;
- Within the first 18 weeks of pregnancy in cases of rape and incest;
- At any time if the pregnancy poses danger to the life or physical or mental health of the pregnant woman or the foetus is seriously deformed and it is recommended by a doctor.

The Safe Pregnancy Termination Procedural Order was approved in December 2003. This order calls for use of manual vacuum aspiration (MVA) and introduction of medical abortion (MA) for first-trimester abortion. Mifepristone and misoprostol for MA have been approved by the Department of Drug Administration and are available on prescription from accredited health care providers and clinics. Off-label or over-the-counter sale of MA tablets by pharmacies is not permitted.

NSMNH-LTP (2006 - 2017) talks about enhancing equitable provision of quality Safe Motherhood New-born Health services, including comprehensive abortion care. Medical safe abortion was introduced under the RH programme under the Essential Health Care Services Package for NHSP-2 (2010-2015). The NHSP-2 also talks about expansion of safe abortion services to poor and disadvantaged populations in remote locations who currently lack effective access.

Some issues to be addressed are as follows:

- Despite legal restrictions, unregistered brands of MA pills are easily available at pharmacy retail shops. The open border with India has facilitated illegal entry of several unregistered brands of MA tablets as well as ineffective *ayurvedic* and other indigenous medicines that are purported to be abortifacient. Clandestine procurement and sales of such drugs by pharmacy retailers for menstrual regulation and abortion is common in Nepal[185].
- Nepal faces barriers to extend safe abortion care to remote rural areas, with mountain terrain and inadequate transportation facilities. It is important to support efforts to improve access in these areas, including the training and licensing of lower level health workers to administer medication abortion[186].
- Knowledge among Nepalese women about the correct medications to use for a safe abortion is low even in districts where medical abortion services have been introduced by the government[187].

Following are some of the programmatic barriers according to Samandari et al. 2012:

- As with many health services, obtaining accurate, complete monitoring data on abortion services has also been challenging in Nepal. Often, the provider responsible for completing the logbook is over-burdened and unable or unwilling to enter complete patient data. Moreover, private facilities have no reporting obligations, making their monitoring data unavailable to the government.
- The number of training centres is insufficient to meet the high demand for trained providers, and many providers, particularly those at public facilities in underserved areas, have difficulty getting work release to attend trainings. Hospitals and clinics operating as training centres are also burdened by the dual demands of training and regular service provision. Furthermore, high staff turnover, particularly in remote facilities, creates significant service gaps in care for the most vulnerable women. The dearth of trained providers and authorised clinics in some areas can cause grievous delays for women, preventing some in later stages of pregnancy from obtaining services within the legal timeframe.
- Policymakers and programme managers face challenges related to the practice of sex-selective abortion, which the law prohibits but which remains an issue of great concern socially and for health-care providers.

[184] Henderson JT, Puri M, Blum M, Harper CC, Rana A, et al. (2013) Effects of Abortion Legalization in Nepal, 2001–2010.

[185] Tamang, Anand, Mahesh Puri, Kalyan Lama, and Prabhakar Shrestha. "Pharmacy workers in Nepal can provide the correct information about using mifepristone and misoprostol to women seeking medication to induce abortion." *Reproductive Health Matters*, 2014.

[186] Henderson JT, Puri M, Blum M, Harper CC, Rana A, et al. (2013) Effects of Abortion Legalization in Nepal, 2001–2010.

[187] Tamang, Anand, Mahesh Puri, Kalyan Lama, and Prabhakar Shrestha. "Pharmacy workers in Nepal can provide the correct information about using mifepristone and misoprostol to women seeking medication to induce abortion." *Reproductive Health Matters*, 2014.

AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS

HIV in Nepal is characterised as a concentrated epidemic. More than 80% of HIV infections in the country are transmitted through heterosexual transmission (NCASC, 2011)[188]. The prevalence rate for adults aged 15 to 49 stands at 0.2%.[189]

The National AIDS Policy 1995 gives high priority to the prevention of HIV/AIDS in the country. This was revised to form the new National Policy on HIV and STI 2011 which highlights the roles and linkages of National AIDS Council, HIV/AIDS and STI Control Board (HSCB) and the NCASC. The NCASC was formed under the MoHP for the implementation of the AIDS prevention programme. A National Policy on HIV/AIDS in the Workplace (2007) is also in place. Based on the National Policy, a Strategic Plan for HIV and AIDS in Nepal (1997-2001) was developed and adopted which tried to operationalise the national policy and to define key activities for each policy objective.
The National HIV/AIDS Strategy 2002 – 2006 and 2006-2011 was instrumental in accelerating the responses by expanding the partnerships and dialogue at all levels and offered a strong foundation on which a scaled up response mechanism could be developed. The recent National HIV/AIDS Strategy 2011-2016 has laid a concrete road map in planning, programming and reviewing of the national response to the epidemic with an estimated budget of USD 167,483,892.

On top of policies and strategies, Nepal has developed a three year investment plan (Nepal HIV Investment Plan 2014-2016) to further intensify and scale up its quality targeted prevention interventions that have been proven successful for containing the spread of HIV among key populations.

Apart from the health sector, the National Planning Commission has developed sector-specific guidelines for key ministries for addressing HIV from their sectors. Ministry of Education has been incorporating the HIV into school level curriculum since 2002. Ministry of Labour and Employment has included a session on HIV in the pre-departure training for formal labour migrants travelling abroad. Ministry of Women, Children and Social Welfare (MoWCSW) has incorporated HIV related contents in its various training manuals. In addition to that, it has also included HIV related treatment and care in the guidelines for National Minimum Standard of Care and Protection for Women affected by Human Trafficking.

Despite the efforts to address the incidence of HIV/AIDS:

- Poor information, fear of discrimination and stigmatisation from the health personnel as well as the community are the key factors that discourage people from undergoing diagnostic and treatment procedures[190].

Following are some of the key programmatic barriers according to a 2014 UNAIDS Country Progress Report on HIV/AIDS:

- A lack of clarity in the national governance and coordination framework for HIV/AIDS in Nepal has led to the NCASC being overburdened, which has adversely impacted its capacity for coordination, oversight and accountability. With both the National AIDS Council and the HSCB currently inactive, the NCASC's current responsibilities go beyond its core mandate of coordination, quality control, policy guidance and leadership in the health sector response to HIV, undermining its ability to perform these roles effectively.
- There has been a robust expansion of ART services in the country. However, laboratory facilities that complement ART services have not been scaled up simultaneously. Important ART monitoring tests (CD4 testing, liver function tests (LFT) and renal function tests (Creatinine) are carried out only at teaching hospitals and zonal hospitals, putting them out of the reach of many patients from remote districts due to cost, time and distance.
- Unfilled posts and frequent turnover have limited the capacity for scaling up and providing quality HIV services at both national and sub-national levels, with services reportedly unavailable in many public health facilities due to the absence of trained staff.

Adolescent Sexual and Reproductive Health services – Youth Friendly Services

[188] NCASC, National Estimates of HIV Infections in Nepal, 2011. September, 2011
[189] UNAIDS 2013 http://www.unaids.org/en/regionscountries/countries/nepal
[190] Wasti, S.P., P Simkhada, and Van Teijlingen ER. "Antiretroviral treatment programmes in Nepal: Problems and barriers." *Kathmandu University Medical Journal*, 2009.

As per the NDHS 2011, one-third of girls aged 15-19 were already married. About 60% of them were pregnant or had at least one child, and one in ten had two living children.

The government has several strategies in place to address ASRH. The National Reproductive Health Strategy, 1995 identified adolescent reproductive health as a critical component of the integrated reproductive health package. In May 1996, Nepal participated in the annual meeting of WHO/South East Asia Region where, a Regional Strategy for Adolescent Health and Development was developed. The Adolescent Health and Development Strategy 2000 emphasises the need for a safe and supportive environment through advocacy and a legal framework. It recognises the importance of NGOs and the private sector in supplementing and complementing government efforts to provide accessible and appropriate services to adolescents. ASRH is a sub-component of The Health Communication Strategy for Family Planning, Maternal and Child Health (2005-2009). The National Adolescent Sexual and Reproductive Health Strategy 2011-2015 is also in place.

The Adolescent Sexual Reproductive Health (ASRH) Programme was introduced by the Family Health Division, Department of Health Services, MoH in 2010. It aims to reduce Adolescent Fertility Rate by improving existing clinical services in the fields of safe abortion, FP, MCH care, and HIV and STI prevention and treatment. It also aims to increase access to appropriate and gender-sensitive information by adolescents, parents, educators and service providers including those in disadvantaged or marginalised groups such as disabled, migrants, homeless, and to build the skills of adolescents, service providers and educators to promote and participate in providing expanded opportunities for improved adolescent health and development.

In spite of these developments, adolescents' low uptake of contraception is a persistent and serious problem in Nepal. A few major barriers faced by the country with regards to ASRH are mentioned below:

- Cultural and social barriers faced by unmarried adolescent girls to access contraception and safe abortion services and access to AFS for marginalised adolescent girls and boys[191]
- As early childbearing in Nepal still occurs primarily within marriage, there is a need to understand and address the special needs and preferences of married adolescents by strengthening outreach services and quality of care at the sub-health level, and adopting innovative approaches focused on reaching high-risk groups
- There is a need to generate demand and address supply constraints to increase effective contraceptive use

Comprehensive Sexuality Education

There are many policies and programmes that have been formulated and designed to effectively educate and inform youngsters of their sexuality. The National Adolescent Health and Development Strategy (2000) focuses on developing and providing a standard information package on adolescent health and development to adolescents, service providers, parents, educators, decision-makers and the community at large. Some of the topics covered under this package include information, education and counselling on human sexuality regarding puberty, marriage, the reproductive process; contraception; safe motherhood and prevention and management of unsafe abortions as well as complications of abortions.

A report on sexuality education in Nepal highlights some of the gaps in the SRH curriculum implemented in the schools. It expresses concerns about the lack of detailing of the SRH curriculum along with age inappropriateness of the programme. Teachers often face the challenge of teaching things that are out of curriculum so as to update the students. The report also indicates that the curriculum only covers aspects of reproductive health and not sexual health[192].

Early and Forced Marriage

Child marriage is widely prevalent in Nepal, and is a major cause of gender based violence (GBV) and abuse of young girls. 41% of Nepalese women aged 20-24 years were found to be married before they turned 18.[193] Child marriage is perceived as a violation of children's rights and is considered illegal in Nepal. The Civil Code of 1963 (11th amendment) fixes the legal

[191] Ministry of Health and Population. Government of Nepal. "Nepal Health Sector Programme-2 Implementation Plan -2010-2015"
[192] Youth Activists Leadership Council (YALC). "Issue brief on sexuality education in Nepal". 2012.
[193] Nepal's Demographic and Health Survey 2011

age of marriage at 18 years for both girls and boys with parental consent and 20 years without parental consent. In 2014, the MoWCSW has expressed its support for the worldwide campaign to end child marriage during the 'Girl Summit on Female Genital Mutilation (FGM) and Early, Forced and Child Marriage' in London.

According to media sources as well as a UNICEF news blog, Nepal is in the process of developing a cross-sectoral National Strategy to End Child Marriage which will be the basis of a National Plan of Action to End Child Marriage with each activity aligned with the Government's annual budget and programme.
Following are the key policy and programme barriers facing the country with respect to early marriages:

- Weak implementation and poor enforcement coupled with lack of awareness has undermined the national policy for preventing child marriage. There is a need to undertake capacity building, awareness generation and advocacy at all levels to ensure that the policy is effective[194].
- Life skills, vocational training programmes and support groups for young brides and mothers can help mitigate the results of child marriage[195].

Prevention and Surveillance of Violence against Women (Gender Based Violence)

A total of 371 cases of GBV were reported in the National Women Commission of Nepal in FY 2012-13. Similarly, a total of 96 GBV cases were registered in the Gender and Empowerment Coordination Unit (GECU) under the office of the Prime Minister and Council of Ministers by February 2013. According to the NDHS 2011, three quarters of women who had experienced physical or sexual violence at some point in their lives had not sought any help and two thirds had never mentioned the violence to anyone. The problem of not seeking care was particularly acute among women who had experienced sexual violence, with only 7% reporting the assault.

The Government of Nepal has attached significant importance to addressing GBV issues through legal and institutional frameworks. By ratifying various international human rights instruments, it has pledged to guarantee equality to men, women and sexual and gender minorities in all spheres of their lives. The Government of Nepal's Three Year Interim Plan (2007-2010), Three Year Plan (FY2010/11 -2012/13) and An Approach Paper to The Thirteenth Plan (FY 2013/14 - 2015/16) have identified the end of gender based violence as a key objective. The Gender Equality Act (2006) establishes sexual violence as a crime punishable by varying years of imprisonment, depending on the age of the victim. The National Women Commission Act, 2063 (2006) was passed to keep vigilance on GBV and investigate and recommend cases to law enforcement agencies. The Interim Constitution of Nepal (2007) prohibits physical, mental or any other form of Violence against Women (VAW) and declares that such acts shall be punishable by law. It also incorporates a separate article recognising that women's rights, including reproductive rights, are fundamental. In 2008, the Government of Nepal adopted a 13 point national policy to combat trafficking and all discriminatory and exploitative practices directed towards women and uplift their socio- economic status. The Domestic Violence and Punishment Act 2066 (2009) and Regulations (2010) were passed to mitigate domestic violence by providing a response system in case of rights violation.

The Government of Nepal marked 2010 as the 'Year against Gender Based Violence' and endorsed the National Plan of Action 2010 which focuses on prosecution, protection and prevention, and highlights the need for a special commission to investigate cases of VAW. One-stop Crisis Management Centres (OCMC) have been set up across the country by the MoHP to help female victims of GBV. The government's Gender Based Violence Unit established in 2010 has secured the signed commitment of 11 different ministries to combat GBV. In 2012, the NWC established a Gender Based Violence Information Management System (GBVIMS) to track and monitor GBV cases. National Plan of Action for Controlling Gender Based Violence and Promoting Gender Empowerment, 2012 was incepted by the Office of the Prime Minister and Council of Ministers. Protocols on the management of GBV, including sexual abuse, have been developed and are now operational. Training has been provided to health service providers on the same.

Mentioned below are current challenges that hinder the efforts aimed at suppressing GBV.

[194] Engaging Men and Boys, Communities and Parents to End Violence against Women, Child Marriages and Harmful Practices in Nepal. UNFPA, 2014.
[195] Asia Child Marriage Initiative: Summary of Research in Bangladesh, India and Nepal. Plan Asia Regional Office, 2013.

- The commitment of the government to end GBV has been significantly weakened due to the extended period of political instability that has adversely impacted its public accountability. Strategies and action plans largely remain dormant and unutilised in the face of resource constraints indicating a low-level of priority accorded to this issue by decision makers.[196]
- The lack of awareness among general people especially the survivors of violence and their family are the biggest constraints. Some of the available supporting services are not easily reachable which restrict the survivors' access to justice.[197]
- Inadequate human resources and infrastructure which inhibits victims to seek support through the formal system. Further, inadequate number of safe houses makes victims vulnerable to recurrence of violence.[198]

Sexual Orientation and Gender Identity (SOGI) Rights

Homosexuality was decriminalised in 2007 after Nepal's parliament voted to abolish the monarchy. Subsequently, in June 2009 a government committee was formed to study laws on same-sex marriages in countries that have allowed such unions. As a regressive step in 2011, this committee sought to criminalise homosexuality by prescribing criminal prosecution for "unnatural sex without consent" and defining marriage as "a union between a man and a woman." According to media articles in 2014, this committee is recommending same-sex marriage to be guaranteed in Nepal's new constitution — an unprecedented move that would give gay and lesbian couples the right to adopt, buy joint property, open joint bank accounts and inherit from one another.

In 2007, the Government amended the Nepal Citizenship Regulation, 2006 and put in place guidelines for citizenship certificate distribution of the third gender. Consequently in 2011, Nepal's Central Bureau of Statistics recognised the third gender in the census, becoming the first country in the world to do so. In June 2012, the Supreme Court of Nepal ordered the Government to issue passports with a provision to mark the third gender. According to numerous press articles in August 2014, the Law Ministry under Narahari Acharya will soon present a bill in the country's parliament to legalise homosexuality and allow same sex marriages. Nepal's National Youth Policy 2010 seeks to protect youth belonging to minorities and marginalised groups which includes women, men and third gender. There is limited information available regarding the designing of programmes to protect the LGBT community and address their issues.

As per the 2013 report by Blue Diamond Society (BDS) and Heartland Alliance for Human Needs & Human Rights - Global Initiative for Sexuality and Human Rights, following are some of the key policy barriers:

- Citizens continue to face discrimination based on their SOGI due to deficits in the corresponding laws. While the Nepalese Civil Code does not explicitly prohibit homosexual behaviour it does criminalise "unnatural sex" without defining what exactly constitutes it. The ambiguity in this definition could result in the misuse of the law leading to further discrimination
- Due to the stigma attached to homosexuality, many LGBT people face discrimination in state funded health facilities and are unable to access health care centres to avail services
- Cultural and social constraints prevent people from obtaining legal aid in fear of the taboo attached to homosexuality

Human trafficking

The issue of human trafficking is one of the major areas of concern for the Government of Nepal. According to Global Slavery Index Report 2013 data, 6250 to 6750 persons were trafficked in Nepal.[199] To combat issues of trafficking the Government has put in place various policies and programmes. Article 29 of the Interim Constitution of Nepal 2007 prohibits trafficking in human beings. It also mentions the right against exploitation as one of the fundamental rights. The Human Trafficking and

[196] ESP and UK Aid, Combatting Gender Based Violence, 2013.
[197] Himalayan Human Rights Monitors/PPCC. "Sexual Violence Assessment in Seven Districts in Nepal." 2012.
[198] Shrestha. "Combatting Gender Based Violence." 2013
[199] Trafficking In Persons Especially On Women And Children In Nepal, National Report, 2012-13

Transportation (Control) Act, 2007 (HTTCA) and Regulation 2008 both seek to prosecute traffickers as well as guard the human rights of the trafficking survivors. The National Human Rights Commission (NHRC) established the Office of the Special Rapporteur on Trafficking (OSRT), especially in Women and Children in 2002 to address the issue of human trafficking.

Some of the most relevant strategy plans, guidelines, operation procedures and standards by the GoN related to trafficking include:

- The National Plan of Action Against Trafficking in Persons, especially Trafficking in Women and Children (NPA) (2011-2016)
- National Minimum Standards for Victim Care and Protection (NMS) 2011
- Standard Operating Procedures (SOP) for Rehabilitation Centres 2012 by the MoWCSW
- National Committee for Controlling Human Trafficking (NCCHT)
- Guidelines for Prosecution and Court Proceeding of the Offences of Human Trafficking and Transportation 2011

Some of the barriers identified according to the 2014 report by the Forum for Women, Law and Development (FWLD) titled 'Human Trafficking and Transportation (Control) Act, 2007: Its Implementation':

- Nepal is yet to ratify the UN Convention on Transnational Organised Crime, 2000– Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, 2000 (Palermo Protocol)
- There is a need for an improvement in law enforcement by way of information exchange through international regional and bilateral cooperation and training of judiciary and law enforcement officials
- The lengthy process of court trials dissuades victims from reporting the crime, as they feel that it will simply extend their suffering and stigmatisation. Victims would often rather use informal mediation mechanisms to settle cases of human trafficking, as they feel that informal mediation is far more discreet and swift.

Sex work

Nepal has certain communities such as the *Badis* and the *Deukis* who traditionally practise prostitution. Usually girls born to the mothers of these cultures follow in the same line of work. As per a 2012 World Bank Report, there are between 24,649 to 28,359 female sex workers in Nepal. The Human Trafficking Activities Eradication Bill 1999 criminalises anyone engaging in prostitution. The National Policy, Action Plan and Institutional Mechanisms to Combat Against Trafficking in Women and Children for Commercial Sexual Exploitation 2000 talks about trafficking for commercial sexual purposes.

Even though prostitution is not considered illegal in Nepal, prostitutes or sex workers face a lot of harassment in the hands of authorities, especially the Nepal Police. In the absence of social protection to sex workers, laws are often misused by the police leading to further discrimination. The stigma attached to sex work results in sex workers being deprived of their rights, owing to their profession. Cultural, social and economic constraints inhibit sex workers in negotiating condom usage with clients or from seeking medical or legal aid[200]. There are no legal provisions which define or punish those who procure or provide a child for prostitution.[201].

Migrants (Provision of Health Services)

There is limited information available regarding the status of migration and migrants in Nepal. However, certain laws and policies have been formulated to ensure the well-being of migrants in Nepal. Directives of Nepali Domestic Workers 2010, applicable to domestic workers sent to Saudi Arabia, Qatar, Kuwait and the UAE, includes provisions for the basic monthly salary, insurance, safe accommodation, regular contact with the family and the Nepali embassy. There is limited information available regarding the programmes formulated by the Government while working with the migrant population.

[200] World Bank 2012
[201] Human Trafficking and Transportation (Control) Act, 2007: Its Implementation. Forum for Women, Law and Development (FWLD), 2014.

Nepal is yet to ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. More efforts are required to safeguard the health needs of the migrant population.

Conjugal rights (Marriage related rights)

The issue of marital rape is not discussed openly in Nepal. This leads to a lack of awareness regarding the issue and unavailability of comprehensive and reliable statistics. However, the government has recognised and legally condemned marital rape. Amendment to the Gender Equality Act 2006 criminalises marital rape, following a 2002 Supreme Court case which ruled the marital exemption on rape laws both unconstitutional and against the International Covenant on Civil and Political Rights and the Convention on the Elimination of All Forms of Discrimination against Women.

Despite criminalising marital rape, such practices are rampant across the country. This may be due to the deep rooted male-dominated culture in Nepal. According to various press articles, many women in Nepal are not even aware that involuntary intercourse between spouses is considered rape and that the government has outlawed marital rape. Moreover, they refuse to report their husbands because of loyalty and social stigma. For the few who do report, it is difficult and very time consuming for women to report and pursue a case. Even if found guilty, jail time for the perpetrator ranges from only three to six months, putting the victim in danger soon after[202].

Other harmful practices (Honour Killing)

No information available

2.7.3 Highlights of the issues relevant from Advocacy perspective

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	▶ Coordination of the ASRH Programme with schools to effectively impart information about ASRH issues ▶ Promotion of ASRH services as part of routine health services ▶ Address the SRH needs of female married adolescents	▶ Awareness generation about the availability of adolescent-friendly services at health facilities
HIV and AIDS	▶ Promotion of laboratory facilities that complement ART services ▶ Clearly defined roles and responsibilities of various departments/committees working in the area of HIV/AIDS to ensure better coordination	• Sensitisation of health workers while dealing with PLHIV in order to reduce stigma and discrimination faced by them
Abortion	▶ Increasing the number of training centres and trained personnel providing abortion services ▶ Better enforcement of existing laws to curtail availability of unregistered brands of MA pills	• Need for conducting impact evaluation in order to measure the long-term effect of provision of abortion services on reducing related morbidity and mortality • Awareness generation about abortion laws and provision of safe abortion services

[202] Global Press Journal, January 2012

Access to services and information	▶ Need for programmes addressing the health needs of people with diverse SOGI ▶ Enforcement of existing laws favouring people with diverse SOGI ▶	• Raising awareness about sexual violence and legal provisions • Elimination of stigma and discrimination faced by homosexuals
Others	▶ Ratification of the 2000 Palermo Protocol ▶ Sensitisation of judiciary and law enforcement officials regarding human trafficking ▶ Enforcement of laws preventing child marriage ▶ Stronger enforcement of the marital rape law	▶ Campaign to reduce harassment of sex workers by the police ▶ Provision of legal support to victims of trafficking

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies for Advocacy

- Coverage of relevant issues in regional dailies, electronic media and social media should be understood to design a strategy for advocacy. Using the media for advocacy and public dialogues organized by CSOs to address sensitive issues can help to overcome socio-cultural barriers.
- Since Nepal has made a number of international commitments on various SRH issues, it is important to materialize the high level commitments into action. Engagement with the policymakers and parliamentarians in this regard can help to put forth the relevant issues to maintain momentum and discussion about a particular topic.
- Reinforcement of key messages is also important to sustain interest among various stakeholders. Regular dialogue and discussion about an important topic helps to keep the momentum around that particular area of concern, and leads to greater impact.

2.7.4 Civil Society Organisations

S.No.	Name	Focus Thematic Areas
1	EngenderHealth	Family planning and sexual and reproductive health services
2	AIDS Alliance Nepal	HIV/AIDS
3	FAITH - Friends Affected & Infected Together in Hand	HIV/AIDS
4	Centre for Reproductive Rights	Reproductive freedom and rights
5	Saathi	Women and child empowerment
6	WOREC Nepal	Violence against women, protection and promotion of women rights, economic, social and cultural rights of women
7	Samjhauta Nepal	Women empowerment
8	Child and Women Empowerment Society Nepal	Women and child rights, current programs include a programme on STI
9	HealthNet Nepal	Providing healthcare services
10	Women NGO Federation	Women empowerment and rights
11	Youth Action Nepal	Human rights, peace, SRHR
12	Association of Youth Organizations Nepal	Women health rights, Education, Employment
13	STEP Nepal	Women's reproductive health, reduce HIV infection rate
14	Family Planning Association of Nepal	SRHR advocacy, service provision and access

International Conventions

S.No.	Name of the convention	Year of Signing/Attending
1.	Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others	Acceded in 2002
2.	International Conference on Human Rights, Tehran	Attended in 1968
3.	International Covenant on Economic, Social and Cultural Rights	Acceded in 1991
4.	Convention on the Elimination of All Forms of Discrimination against Women	Signed in 1991, ratified in 1991
5.	Convention on the Rights of the Child	Signed 1990, ratified in 1990
6.	International Conference on Population and Development (ICPD), Cairo	Attended in 1994
7.	UN Fourth World Conference on Women, Beijing	Attended in 1995
8.	ICPD +5	Attended in 1999
9.	World Summit	Attended in 2005
10.	General Assembly declaration of LGBT rights	Attended in 2008
11.	Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery	Acceded in 1963
12.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Signed in 2000, ratified in 2006
13.	SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution	Attended in 2002
14.	ILO Convention 1999 (No. 182), Elimination of Worst Forms of Child Labour	Ratified in 2002
15.	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, 1999	Signed in 2001, ratified in 2007

2.8 Pakistan

Situational Analysis

As far as the change in policies is concerned, the Pakistani Parliament in April 2010 passed the 18th Amendment to the Constitution, which considerably increases provincial autonomy, as well as devolves federal authority and responsibility. A large number of the vertical programmes run by the Federal Ministry of Health have been devolved entirely to the Provinces. These include the Lady Health Workers' Programme, Extended Programme on Immunization, Maternal Newborn and Child Health (MNCH) Programme, among others.

Sexual and Reproductive Health (SRH) Indicators

Indicators	Value	Year	Source
Total Fertility Rate	3.3 children born per woman	2012	UNICEF
Contraceptive prevalence rate (%)	27	2008-12	UNICEF
Delivery care (%), Skilled attendant at birth	43	2008-12	UNICEF
Delivery care (%), Institutional delivery	41	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	60.9	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	28.4	2008-12	UNICEF
Maternal Mortality Rate (MMR)	250 per 1,00,000 live births	2008-12	UNICEF
Infant Mortality Rate (IMR)	69 per 1,000 live births	2012	UNICEF
Health Budget (as % of GDP)	2.8	2013	World bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

a) Family Planning

Pakistan has witnessed much political strife in the last few decades. Along with this the religious and cultural constraints limit the empowerment of women, thereby making the implementation of programmes difficult. Pakistan was among the forerunner countries in Asia in beginning a family planning (FP) programme more than five decades ago, with the support from international donors. Despite these efforts, the rate of fertility has declined slowly in Pakistan than in other Asian countries.[203] According to the most recent Pakistan Demographic and Health Survey (PDHS) 2012-

[203] Hardee, K. And Leahy, E. Population, Fertility and Family planning in Pakistan: A program in stagnation. Population Action International. October 2008. Vol. 3, Issue 3.

13, 35% of married women in Pakistan use a contraceptive method, which is a five percentage point increase from 2006- 07.[204]

In 1997, the Pakistani government revised and updated the first National Health Policy of 1990, and included the specific objective of "expending the delivery of reproductive Health (RH) services including family planning both in urban and rural areas of Pakistan". The Population Policy (2002) aims to reduce population growth rate to 1.3 percent per annum by the year 2020; and to reduce fertility through enhanced voluntary adoption of contraception to the replacement level of 2.1 births per woman by 2020. The National Maternal and Child Health Policy and Strategic Framework (2005) put a great deal of emphasis on raising awareness about FP and increasing number of skilled human resource. In 2009, the Ministry of Population Welfare (MoPW) sought to revise the Population Policy. However, under the 18th Amendment to the Constitution, the Ministry was devolved and its responsibilities were shifted to the Provincial Population Welfare and Health Departments. The Ministry which was responsible for providing family planning services for over four decades ceased to exist after 1st December 2010. The MoPW had been importing and procuring contraceptives for more than three decades and there exists a full-fledged Directorate of Procurement Material and Equipment for this. A central warehouse in Karachi distributes contraceptives throughout the country, mainly through government channels.

The National Program for Family Planning and Primary Healthcare was launched in 1994, and is commonly known as "Lady Health Workers' (LFW) Programme". It is one of the largest community based programmes in the world and aims to expand the availability of FP services in urban slums and rural areas of Pakistan. The government until 2007 remained the primary supplier for almost half of all contraceptive users, at 48%, while the share of the private sector increased to 41%, which indicates that more and more users were paying for contraception. Since 2007, private sector is increasingly becoming the source of methods for users.

Some of the key problem areas listed in the 2012 report by UNFPA and ICOMP titled 'Family Planning in Asia and the Pacific' are as follows:

- Pakistan imports the bulk of its contraceptive supplies and there looms a question of uncertainty now, especially in light of the 18th amendment to its Constitution. The powers have been given to the provincial governments, but adequate built storage facilities for contraceptives do not exist at the provincial and district levels.
- The LHWs were found to be providing inadequate FP services because they were overloaded with other tasks, such as administering polio vaccine, among others.
- The reason given by many women for not intending to use contraception in the future was fear of side effects and health concerns. In urban areas, health-related issues and not religious prohibition was cited as the reason for not intending to use a method in the future.
- The LHWs face problems in payment of salaries, job insecurity, weak supplies and equipment provision, weak referral systems and poor supervision and linkages with peripheral health facilities.[205]

b) Reproductive Health Services

In spite of specific goals on maternal and child mortalities in the Millennium Development Goals and the investment and policy shift, Pakistan has still one of the highest maternal mortality ratios among developing countries. Fortunately, there has been a considerable improvement in the maternal health indicators between the 2006-07 PDHS and the 2012-13 PDHS. There was an increase observed in

[204] National Institute of Population Studies, Measure DHS, and ICF. Pakistan Demographic and Health Survey, 2012-13.
[205] Wazir, M.S., Shaikh, B.T., and Ahmad, A. National program for family planning and primary

the figures on antenatal care from a skilled provider (from 61% to 73%), births assisted by a skilled provider (from 39% to 52%) and births that were delivered in a health facility (from 34% to 48%).[206]

Pakistan's 2002 Population Policy talks about promotion of women's health; integration of reproductive health services with family planning; broader participation of the private sector; and inclusion of mainstream reproductive and sexual health issues into family planning services. The 2009 National Health Policy states that Emergency Obstetric and Neonatal Care, Integrated Management of Neonatal and Childhood Illnesses and FP services will be priority areas for health facilities. The Reproductive Healthcare and the Rights Bill 2009 are awaiting approval. The Bill aims to provide quality RH through short and long term efforts, such as the institutionalization of obstetric care and improvement of the reproductive health system, particularly in the primary health care sector.

The LHW Programme was launched in 1994 and contributes directly to MDGs related to reducing child mortality and improving maternal health (Goals 4, 5). The Maternal, Newborn and Child Health (MNCH) Programme launched in 2005, coordinates the efforts of various federal and provincial bodies in close collaboration with donor and private sector programmes with the aim of improving MNCH indicators in Pakistan.

Following are some of the barriers sighted by the Research and Advocacy Fund on MNCH:

- The lack of provision of sufficient basic health services, well-trained staff, adequate medical supplies and equipment have been reported as direct causes of maternal mortality. Further, the health system in Pakistan suffers from a lack of investment by the national government; Pakistan's investment in the social sector is amongst the lowest in the world, with less than 2% of total government expenditure going to health. Furthermore, the system suffers from poor control in terms of inadequate information, weak linkages and integration between institutions, poor management capacity and poor staff/human resource management.[207]
- The 18th Amendment poses a considerable challenge, with the devolution of the Ministry of Health (MoH) to the provinces. The Provinces which so far were not involved directly with policy formation and supervision of the federally run vertical programmes (including the Maternal and Child Health (MCH)), will now be responsible for setting the policies, targets, and budgets for health.[208]
- Presently, deliveries in most of Pakistan's rural areas are carried out by Traditional Birth Attendants. They are not part of any official programme, yet these unskilled women are essential part of the communities they serve. They are openly accepted by their communities, but usually employ unhygienic practices and are often unable to refer complicated cases in a timely manner, thus increasing the risk of maternal mortality.
- In Pakistan, access to MNCH services varies significantly between different socio-economic groups, due to poverty, ethnic, cultural and religious factors. There is a lack of attention to the social, cultural and political factors which often affect women's access to health services (such as lack of education, employment opportunities, decision making in the family and even low mobility of women).
- In spite of the government commitment towards improving the RH and women's health services, the overall health of the population has suffered a delay due to frequent political changes, inflation and lower allocation for social sector concerns.[209]

[206] National Institute of Population Studies, Measure DHS, and ICF. Pakistan Demographic and Health Survey, 2012-13.
[207] Research and Advocacy Fund. Maternal and Newborn Health: The Policy Context in Pakistan.
[208] Research and Advocacy Fund. Maternal and Newborn Health: The Policy Context in Pakistan.
[209] Abrejo, F.G, Shaikh, B.T. and Saleem, S. ICPD to MDGs: Missing Links and Common Grounds. Reproductive Health (journal) 2008. Accessed on 12th December 2014 at http://www.reproductive-health-journal.com/content/5/1/4

c) Prevention and Appropriate Treatment of Infertility

The reported prevalence of infertility in Pakistan is 4% for primary and 18% secondary infertility. Infertility is not only considered a medical but also a social problem in Pakistani society as cultural customs and religious factors equate infertility with failure on a personal, interpersonal, or social level.[210]

According to a cross-sectional study on knowledge, perceptions and myths regarding infertility in Pakistan[211] correct knowledge of infertility was found to be limited. People could hardly identify correctly when infertility was pathological and less than half the people were aware about the fertile period in women's life cycle. People were found to be misinformed that use of Intra Uterine Contraceptive Device (IUCD) and Oral Contraceptive Pills (OCPs) could cause infertility. Among people with lower level of education, the beliefs in evil forces and supernatural powers as a cause of infertility are widespread. Seeking alternative treatment for infertility is a popular choice, however In-Vitro Fertilization (IVF) is an unfamiliar and an unacceptable option.

d) Reproductive Tract Infections (RTI)

Reproductive Tract Infections (RTIs) is a public health concern in Pakistan, however, information about the prevalence of RTIs among women and their health-seeking behaviour and access is scarcely available.[212]

A study[213] on RTIs among married women in Karachi revealed that the most common reason why women do not seek care for the symptoms was the assumption that their symptom was normal. Other reasons for low health-seeking behaviour were the distance of the health facility from home, hesitation in discussing the problem with a male service provider, awaiting the LHWs' visit and the husband's absence for accompanying to visit a health facility. Even among those who had sought treatment, the first choice was home remedies or traditional medicines suggested by friends or relatives.

e) Abortion

Unsafe abortions continue to be a significant contributor to high levels of maternal mortality in Pakistan, even though they are underreported. According to the 2006-2007 PDHS, 6% of maternal deaths resulted from the complications of unsafe abortion (sepsis or haemorrhage). A study by Population Council on Post-abortion care in Pakistan (2013) stated that "the proportion of women who obtain abortions performed by doctors has increased. A large proportion of women in urban areas still resort to Trained Birth Attendants/Dais/lay practitioners and Lady Health Visitors/Nurses/Midwives, all providers associated with relatively high probabilities of complications."[214]

In 1990, the Pakistan government revised the Penal Code of 1860 with respect to abortion. Under the revision, before formation of the organs of the foetus, abortions are permitted to save the woman's life or in order to provide "necessary treatment." After organs are formed, abortions are permitted only to save the woman's life. The 2009 Karachi Declaration on scaling up Maternal, Neonatal and Child

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[210] Ali, S. et al. Knowledge, perceptions and myths regarding infertility among selected adult population in Pakistan: a cross-sectional study. BMC Public Health. 2011. Accessed on 14th December 2014 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3206477/

[211] Ali, S. et al. Knowledge, perceptions and myths regarding infertility among selected adult population in Pakistan: a cross-sectional study. BMC Public Health. 2011. Accessed on 14th Nov.2014 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3206477/

[212] Sami N, Ali T S, Khan E. Reproductive Tract Infections among married women in peri-urban areas of Karachi, Pakistan: A population based study. Natl J Community Med 2013; 4(2).

[213] Sami N, Ali T S, Khan E. Reproductive Tract Infections among married women in peri-urban areas of Karachi, Pakistan: A population based study. Natl J Community Med 2013; 4(2).

[214] Population Council. Post-Abortion Care in Pakistan: A national study. 2013.

Health-Family Planning (MNCH-FP) Best Practices in Pakistan talks about inclusion of post-abortion care in policies, guidelines, protocols and standards for health facilities at the national level. The RH Service Package 1999 provides broad guidelines outlining eight key components of necessary RH care services, which includes pre- and post-abortion care. The National Committee for Maternal Health (NCMH) established in January 1994 as a technical arm of the MoH has been actively conducting capacity building trainings and advocacy on post-abortion care.

Following are the key barriers according to a 2013 Population Council national study on Post-Abortion Care (PAC) in Pakistan:

- In Pakistan, receiving direct information from women about abortion and post- abortion complications is difficult because of the stigma, taboo and reluctance attached to the process.
- Lack of access to healthcare facilities due to a number of reasons, such as lack of awareness of facilities providing services, identification of complications, transport and the inability to pay for travel and the procedure, or take time off from work.
- High levels of unwanted pregnancy lead women to seek covert abortions performed by unskilled providers using unsafe methods, which can often result in medical complications and even death.
- Most public health facilities offering PAC are equipped with functional Dilation and Evacuation (D&C) sets, but very few facilities below the level of teaching hospital are equipped with functioning manual vacuum aspiration (MVA) or electrical vacuum aspiration (EVA) kits.
- Doctors in both private and public health facilities which provide PAC are of the opinion that the personnel/staff is largely inadequate. The absence of gynaecologists and anaesthetists in many health facilities in the public sector is a prominent challenge.

f) AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS

In 1987, the first case of HIV in Pakistan was diagnosed; by the end of 2009, Pakistan had an estimated 98,000 people living with HIV. Until recently, Pakistan was classified as a low prevalence but high risk country. However, in recent times, the risk of an HIV epidemic has become more pronounced. It is highest primarily among high-risk populations, with injecting drug users (IDUs) exhibiting the highest HIV prevalence (27.2%) in 2011, followed by *Hijra* or transgender and male sex workers (MSWs) at 5.2% and 1.6%, respectively. Female sex workers (FSWs) exhibit a prevalence of 0.6%.[215] Other high risk groups are truckers, prisoners and migrants.

The HIV & AIDS Prevention and Treatment Act, 2007 aims to prevent the spread of HIV among the general population, particularly in most-at-risk and vulnerable populations, and to provide for the care, support and treatment of persons living with HIV and AIDS (PLHIV). A draft National AIDS Policy 2007 (recommending the formation of a National AIDS Council) has been prepared by the National AIDS Control Program (NACP). Antiretroviral therapy (ART) will be provided free of charge under the Policy. The HIV/AIDS Safety and Control Act 2010 (Islamabad Bill) seeks to offer protection to PLHIV in Islamabad and to make HIV testing mandatory for high risk groups, like sex workers, migrants and couples before marriage.

Pakistan's Federal Ministry of Health initiated NACP in 1987. The Government with the support of World Bank launched the "Enhanced HIV-AIDS Control Program" (EHACP) for the period from 2003-2008. The NACP and its provincial counterparts are implementing the programme throughout the country. The principal components of the EHACP are the interventions for target groups, HIV prevention for general public, prevention of HIV transmission through blood and blood products, capacity building and programme management. The NACP conducts advocacy and research, coordinates to ensure participation and partnership between the public sector and civil society on

[215] SAARCLAW, IDLO and UNDP. Legal Reference Brief: Pakistan. 2011.

HIV/AIDS issue, provides technical support to various sectors, monitors and evaluates programme implementation.

The National and Provincial AIDS Control Programs (PACPs) under the leadership of the MoH and with support of the Government of Pakistan have established 15 HIV Treatment and Care centres nationwide. These centres provide comprehensive HIV care services including free ART, free advanced HIV diagnostics, and management of HIV related infections and counselling services to HIV positive people. Recently, the NACP and the PACPs have entered into multiple engagements with private sector firms and large NGOs through public-private partnership (PPP) arrangements, as the latter have the advantage of accessing marginalised sub-populations.

The National HIV and AIDS Strategic Framework (2007-2012) (NSF 2) aims to improve the quality of life for people living with HIV and AIDS through the provision of quality treatment, care and support (including meeting their medical, social, and sometimes material needs), and ensuring a secure environment for all people infected and affected by HIV and AIDS.

UNDP's report[216] on 'The National HIV/AIDS Strategic Framework: An Overview' stated the following as programmatic barriers:

- Social and cultural constraints inhibit frank expression, thus making HIV/AIDS messages on print and electronic media vague. Further, there is resistance from certain segments of society, and a few political and religious leaders, to explicit safer sex messages.
- High risk groups (commercial sex workers, IDUs, men who have sex with men and migrant workers) are difficult to approach for HIV/AIDS prevention interventions due to their illegal status, marginal social status and/or limited education/awareness.
- Low levels of general public awareness about the signs and symptoms of STIs, which leads to delayed, inadequate and often harmful health care seeking behaviour.
- Fear and stigma related to HIV/AIDS continues, leading to discriminatory practices and segregation of PLHIV, as well as lack of formation of PLHIV networks or support groups

g) Adolescent Sexual and Reproductive Health services – Youth Friendly Services

Youth (between 15 to 24 years of age) account for a large proportion of the population in Pakistan. Adolescents face many challenges with respect to education and health. They are exposed to significant health risks as a result of inadequate access to information and exclusion from health care services.

The Population Policy of Pakistan, 2002 recognises the need to create a mind set for responsible parenthood amongst the youth and tackle issues faced by adolescents through population and family life education. Pakistan's National Youth Policy 2008 mentions raising awareness among youth about marriage related laws and RH as a part of its plan of action.

Key barriers faced by the country in this sphere are as follows:

- Policies as well as legal provisions do not adequately meet the reproductive health needs of adolescents. Very few government led programmes address the issues of young people's sexual health and rights.[217]
- In spite of including youth as part of the National Population Policy, the intervention programmes are still silent on issues regarding sexuality education for youth and availability of youth-friendly health services.[218]

[216] UNDP. The National HIV/AIDS Strategic Framework: An Overview. Accessed on 17th December 2014 at http://undp.un.org.pk/unaids/documents/National%20HIV-AIDS%20Strategic%20Framework%20(2001-06).pdf
[217] World Population Foundation. Revised Country Paper Strategy: Pakistan (2009-2012)
[218] World Population Foundation. Revised Country Paper Strategy: Pakistan (2009-2012).

- Adolescent girls (including those who are married) face significant social restrictions in accessing health care, which may have implications for their gynaecological well-being, as well as on their ability to control their own fertility and abortion in a safe manner.[219]

h) Comprehensive Sexuality Education

In Pakistani society open discussion about sexuality is generally considered a taboo. The National Health Policy of Pakistan, 1997 states that health education will be among the Health Ministry's priority programmes. While the discussion mentions that all aspects of the reproductive system and its functions will be taught, sexuality doesn't feature in the document. A significant area of focus for the government's education initiatives has been the prevention of HIV/AIDS, which has been integrated in the national curriculum. Various NGOS such as the Hayat-Lifeline Campaign (2013), the Rutgers-World Population Foundation and Aahung (2009) have developed curricula on SRHR aimed to impart formal education to youngsters on SRHR. They cover critical SRHR topics such as physical development, harassment and violence, marital rights and birth spacing. Several MoUs were signed between Hayat-Lifeline and different government departments and some of the curricula have been adopted by the Pakistani government.

Some of the key problem areas are as follows:

- The systematic development of clear guidelines for the integration of a comprehensive curriculum is lacking. Moreover, integration plans are required to be made independently in each province and cannot be mandated by the federal government.[220]
- Due to fear from right wing fundamentalists and the ill-equipped education system, government bodies have accepted the importance of the curriculum, but have been reluctant to prioritise its implementation.[221]

i) Early and Forced Marriage

Similar to other South Asian countries, early marriage is common in Pakistan. Although prohibited by law, the practice of buying and selling brides continues to take place. Economic constraints often lead families to sell their young daughters into marriage as younger girls tend to receive higher bride prices.[222] Due to parental beliefs that investment in a girl's education tends to become useless once she marries, girls are more likely to be pulled out of school than boys as soon as they are considered ready for marriage. Subsequently, girls lack the skills to enter the labour market, which limits their own and their families' financial progress.

- Child marriage (2008-2012) before the age of 15 years: 7%
- Child marriage (2008-2012) before the age of 18 years: 24%[223]

The Child Marriage Restraint Act of 1929 seeks to combat child marriages in Pakistan. The Act sets the legal age of marriage at 18 for men and 16 for women and prescribes jail terms and fines for defying the rule. In addition, under the Muslim Family Law Ordinance, a girl should have attained the age of 16 and a boy, of 18, and received consent of their parents before marriage can take place. Child Marriage Restraint (Amendment) Bill, 2014 was introduced to make the act of solemnising a child marriage a cognizable offense and to provide stiffer punishments for contracting child marriages. The bill also suggested raising the age defining a child to 18 years for females. The Prevention of

[219] Population Council and UNFPA. Adolescents and reproductive health in Pakistan: A literature review, 2000. (Research Report no. 11)
[220] Ali, S.A., Hadi, S., Ijaz, A. and Baig, Q. How a group of non-government organizations built support and pushed ahead with implementing Comprehensive Sexuality Education, in a climate of growing conservatism: The case of Pakistan. Accessed on 10th December 2014 at http://www.who.int/woman_child_accountability/ierg/reports/24a_Pakistan_longversion.pdf
[221] Ibid.
[222] Women living under Muslim laws network. Child, Early and Forced Marriage: A Multi- Country Study. 2013.
[223] UNICEF statistics, available at: http://www.unicef.org/infobycountry/pakistan_pakistan_statistics.html

Anti-Women Practices (Criminal Law Amendment) Act 2011 prohibits and prescribes punishment for practices such as depriving women of inheritance, forcing them into marriage to settle personal or family disputes, bartering them, or forcing them to "marry the Qur'an".

Despite these interventions, there are barriers to elimination of child marriage and areas requiring attention:

- Pakistan is not a signatory to the International Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages (1964).[224]
- Despite the law prohibiting child marriage, the penalties are too low to have any deterrent effect. Further, in case such a marriage does take place, the law does not invalidate it.[225]
- After the 18th amendment, subjects of marriage and divorce now fall exclusively within the legislative domains of the provincial assemblies. There are serious concerns about provinces' legislation giving due consideration to the minimum rights guaranteed under the CRC and the possibility of unequal provisions in its implementation across various provinces.[226]
- Adolescent girls, especially between the ages of 15 to 19 years are particularly vulnerable to early marriage. Consequently, they are vulnerable to early and frequent pregnancies, have insufficient access to contraception and knowledge about birth spacing, inadequate prenatal care, and related maternal morbidities.[227]
- Other barriers include weak legislation, community's lack of awareness about the negative consequences of child marriages, extreme poverty, internal trafficking and lack of political will.[228]

j) Prevention and Surveillance of Violence against Women (Gender Based Violence)

In Pakistan, gender based violence (GBV) stems from a patriarchal social structure which considers women to be subservient to men. A 2014 survey conducted by Aware Girls revealed that 20.65% of the particiants felt violence against women is not an important issue in Pakistan. A similar attitude is reflected in programing, decision making and peace building process of the country, where women are side-lined. The survey also revealed that 35.87% of the respondents felt it is acceptable for husbands to beat their wives, 10.87% consider beating wives to be the right of men while 25% responded that men can occasionally beat their wives[229].

In the past two decades, there have been significant developments in the country related to law and policies for condemning violence against women. The Protection of Women (Criminal Laws Amendment) Act, 2006 was passed to promote the welfare of women in the country by abolishing some of the most harmful provisions of the Hudood Ordinances. The Domestic Violence (Prevention and Protection) Act (DVPPA) 2009 enacted by the Parliament in 2012 aims to identify, address and treat the incidents of violence occurring in the home. It calls for setting up committees to supervise the provisions of legal protection and guarantee medical care for victims of violence. The Protection Against Harassment of Women at Workplace Act 2010 criminalises the sexual harassment of women at work place.The Prevention of Anti-Women Practices Act 2011 prohibits forced marriages, marriages with Quran, depriving a female from inheritance and giving away female in *vani* or *swara*[230].

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[224] Women living under Muslim laws network. Child, Early and Forced Marriage: A Multi- Country Study. 2013
[225] UNICEF. National Report Pakistan: Situation Analysis of Children and Women in Pakistan. 2012.
[226] Institute for Social Justice. Child marriages in Pakistan. Accessed on 18th December 2014 at http://www.isj.org.pk/child-marriages-in-pakistan/
[227] Ali, S.A., Hadi, S., Ijaz, A. and Baig, Q. How a group of non-government organizations built support and pushed ahead with implementing Comprehensive Sexuality Education, in a climate of growing conservatism: The case of Pakistan. Accessed on 10th December 2014 at http://www.who.int/woman_child_accountability/ierg/reports/24a_Pakistan_longversion.pdf
[228] Institute for Social Justice. Child marriages in Pakistan. Accessed on 18th December 2014 at http://www.isj.org.pk/child-marriages-in-pakistan/
[229] Aware Girls and Young Feminists Movement. "Survey on the Perceptions and Attitudes of People Towards Domestic Abuse in Pakistan." 2014.
[230] The practice of marrying off young girls in exchange for paying a debt.

In 2006, the Gender Crime Cell was established in the National Police Bureau with three main functions: data collection on cases of GBV, policy advice to government on particular cases and investigating cases on the request of the Ministry of Interior. *Dar ul Amans* (DuAs) are shelters for women against whom there is an FIR or a legal case. They are under the control of the Social Welfare Departments and the provincial governments. Women in need of protection are placed through the local courts in the shelter.

While there are laws and codes in place to protect the rights of women and prevent any form of violence, there are areas that require further consideration and attention:

- It has often been observed that even after law reforms, the acts addressed by those laws continue to be committed as a matter of habit, and laws on the statute books fail to eradicate the persisting social problems. Since domestic violence against women has deep cultural and historical roots, legal response in isolation arguably is bound to fail[231].
- There is also a scarcity of technical expertise for developing effective procedures and mechanisms for implementation of the substantive laws at federal, provincial and local/district government levels[232].
- Lack of a mechanism for protection for women who are either victims of or at the risk of domestic abuse. Women live under strict surveillance and restricted mobility in the limited shelter homes. Women who face domestic abuse usually do not have family support to fight their case in the court and since they are economically dependent on their families, they are left helpless and unable to fight their case[233].

k) Sexual Orientation and Gender Identity (SOGI) Rights

Homosexuality is viewed as illegal under Pakistani law. Section 377 of the country's Penal Code does not explicitly mention homosexuality but 'carnal intercourse against the order of nature' is punishable. The Supreme Court in 2009 in a landmark judgment (through an Order) recognised *Hijras* as citizens of Pakistan, and held that they were entitled to equal protection of rights, including right to life and dignity.

However, with limited number of specific laws the rights and protection to be offered to people with diverse SOGI is dependent upon the interpretation of the courts of law[234]. Due to the social stigma attached to homosexuality, the gay community in Pakistan remains underground and same sex relationships are kept secret. They are often threatened and harassed by citizens or the police. Raids conducted by the police in gay "cruising areas" are common. It has been observed that it is often difficult for a member of the Lesbian, Gay, Bisexual and Transgender (LGBT) community to access housing, a good job or healthcare without concealing their sexuality or taking extra precautions to remain discreet. [235]

[231] Qureshi, Shazia. "Legislative Initiative in the Area of Domestic Violence in Pakistan: Gender Approach to the core provisions of the Domestic Violence (Prevention and Protection) Act 2009." *Pakistan Vision*, 2012.
[232] Khan, Rabia. "Situational Analysis and Mapping of Women's Human Rights in Pakistan." Submitted to CIDA Pakistan Program, 2009.
[233] Aware Girls and Young Feminists Movement. "Survey on the Perceptions and Attitudes of People Towards Domestic Abuse in Pakistan." 2014.
[234] SAARCLAW, IDLO and UNDP. Legal Reference Brief: Pakistan. 2011
[235] Home Office, UK Govt. Country Information and Guidance: Pakistan- Sexual Orientation and Gender Identity. Accessed on 17th December 2014 at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331641/Pakistan_CIG.SOGI.2014.07.16.v1.0.pdf

l) Human trafficking

Pakistan is a destination for men, women and children from Afghanistan, Iran and to some extent, Bangladesh, who are subjected to forced labour and prostitution. Particularly vulnerable are Afghan refugees, religious and ethnic minorities. Due to its clandestine nature, human trafficking largely remains an under reported crime. Therefore availing reliable statistics on the same poses a challenge.

There are several policies and programmes that have been formulated and designed by the Government to combat human trafficking. The Prevention and Control of Human Trafficking Ordinance (PCHTO) enacted in 2002 and Rules appurtenant thereto have also been notified in 2005 which specifically address, inter-alia, the protection of victims of human trafficking. The National Action Plan for combating Human Trafficking implemented in 2004 aims to address the problem of trafficking in a comprehensive manner. Under this plan the Federal Investigation Agency, Government of Pakistan has set up specialised anti-trafficking Units (ATUs). Under the Immigration Wing, the FIA also operates so-called 'Anti-Human Trafficking Circles' in all major cities across Pakistan which deal with all forms of undocumented immigration, migrant smuggling, as well as trafficking in persons.

Despite the prevalence of laws and policies there have been reported several barriers:

- Trafficked women are further victimised by the legal system and the police who treat them as criminals. The women are booked under the controversial Hudood Ordinance and are charged with Zina
- One of the major challenges is the lack of trained human resources at the FIA and the lack of expertise at data collection, compilation, scientific analysis and its interpretation. A 2011, a UNODC report on Pakistan's Law Enforcement Response to the Smuggling of Migrants and Trafficking in Persons indicates that staff joining the Anti-Human Trafficking Circles or FIA Immigration Control Point from within the FIA, are not inducted or formally trained by the authorities.

m) Sex work

Sex work in Pakistan has gradually evolved from a brothel based culture to a more varied sector in which men, women and transgender people sell sex in a variety of settings. Extrapolation of surveillance data in 2005 suggests that there are around 1,36,300 female sex workers, 62,636 male sex workers and 42,877 transgender sex workers in Pakistan[236]

Section 371A and Section 371B of the Penal Code creates offences for buying or selling persons for the purposes of sex work is an offense. Male-to-male sex is criminalized by Section 377 of the Pakistan Penal Code 1860. Section 377 of the Pakistan Penal Code 1860 criminalises male to male sex. The Offence of Zina (Enforcement of Hudood) Ordinance, 1979 seeks to penalise a man and a woman wilfully having sexual intercourse with each other without being married to each other. The HIV and AIDS Prevention and Treatment Act, 2007 includes a provision by which no law enforcement or public official will in any manner prevent or restrict condom usage by the most at risk populations, including sex workers. The Protection of Women Act 2006 has major implications for the female sex trade as it removes the right of police to detain people suspected of having sex outside of marriage, instead requiring a formal accusation in court. The National AIDS Control Programme and each of the Provincial AIDS Control Programmes (PACPs) focus on scaling up targeted prevention programmes for FSWs in major cities. The National Strategy on Female Sex Work in Pakistan 2010 addresses the need for directives to prevent confiscation of condoms and to address police violence and harassment.

[236] AIDS Data Hub (Thematic Capsule). Sex work and HIV- Pakistan. 2010

Following are the barriers according to a 2013 report by UNAIDS, UNDP and UNFPA on Sex Work and the Law in Asia and the Pacific:

- Due to sex work being criminalised and the social stigma attached to it, sex workers often disguise themselves as “kothiwalis” or musicians and often have to share their income with those who offer them protection from the police. Further, they are often exploited, harassed and abused by the police
- Sex workers are often hesitant to avail health service due to the stringent laws and policies against sex work, and limited protective legislation for the rights of sex workers.
- There are no national programs by the government to build the capacity of sex workers on awareness of their rights. The few organizations working in the area exhibit limited understanding of empowerment, and perpetrate some level of stigma and discrimination against sex workers by the programme staff.
- Due to the illegal status of sex work, sex workers are hesitant to come together and form forums. There is also no national group advocating HIV prevention amongst sex workers or violation of their rights[237]

n) Migrants (Provision of Health Services)

Millions of Pakistani men regularly migrate to the Gulf States in search of better employment opportunities each year. As per the Statistics from the Bureau of Emigration and Overseas Employment (BEOE), it has been found that majority of such men working in the Gulf countries are between the ages of 20 and 30 years and are unskilled and uniformed about health issues, including HIV. In a UNDP study[238] of Pakistani migrants it was found that migrants diagnosed with HIV in host countries were arrested, harassed and forcefully deported back to Pakistan without being informed about their HIV status and without being paid their wages. Given their poor living conditions, migrants suffer from various issues such as diarrhoea, hepatitis-A and other diseases.

The National Emigration Policy 2009 for migrants looks into the health needs of the migrant population. It seeks a comprehensive social security scheme for overseas Pakistanis. The policy has been passed by the Interim Government but is awaiting approval by the new Government. The National HIV/AIDS Strategic Framework (2001-2006) considers migrants as a vulnerable group with regard to HIV transmissions within the country. ILO has also been working with the BEOE to create awareness about HIV/AIDS.

Although it is mandatory, the briefing mechanisms, health assessment and health education mechanisms have not been adequately institutionalised for the migrant population[239]. Due to the lack of healthcare and HIV/AIDS preventive services and information the migrant population remains vulnerable. When diagnosed with a serious illness or HIV they often face the risk of deportation[240]. Although it is mandatory for all registered migrant workers going to the Arab states to undergo HIV testing, HIV testing centres in Pakistan do not provide pre and post counselling[241].

o) Conjugal Rights (Marital rape)

In Pakistan, marital rape is not recognised by law and cannot be prosecuted. Additionally, deep rooted cultural norms make the victims extremely vulnerable. Victims of marital rape cannot report it to bring the culprit to justice and continue to be persecuted.

[237] UNAIDS, UNFPA and UNDP. Sex Work and the Law in Asia and the Pacific. 2013
[238] UNDP. HIV vulnerabilities faced by women migrants: From Asia to the Arab States. 2008.
[239] Ministry of Labour and Manpower, Govt. of Pakistan. National Emigration Policy. 2009
[240] Sustainable Policy Development Institute (Jan, M.A.) Pakistan’s National Emigration Policy: A Review. 2010.
[241] UNDP. HIV vulnerabilities faced by women migrants: From Asia to the Arab States. 2008.

Apart from the lack of a law, the fear of husband abuse following reporting of marital rape, alienation from family and in-laws and fear of social stigma can discourage the reporting of marital rape[242]. Even if reported, the law does not help women in prosecuting her husband. Support is generally received from counselling groups. The problems in prosecuting marital rape has more to do with the very nature of the crime, since an absence of consent has to be proved, coupled with the accused being aware of/or at least suspecting that said consent was absent, a difficult burden to discharge when confronted with a situation where intimate relations are to be expected, and all elements of the crime must be proved beyond reasonable doubt[243].

p) Other harmful practices (Honour Killing)

Honour killings are acts of violence, usually murder committed by male members of the family against female members who are perceived to have brought dishonour upon the family. Under Pakistan's penal code, honour killings are treated as murder. However, the law states that the family of the victim is allowed to compromise with the killer, who is usually a relative[244]. Additionally, the Government has failed to ensure that women are aware of their legal and constitutional rights and that these rights take precedence over the cultural norms that deny women equality. Women confined to the private sphere seldom benefit from their fundamental rights. Often honour killings are carried out for the smallest reasons. Such crimes are dealt with extreme leniency by the concerned authorities and murderers often are not convicted. This has contributed to the continued practise of honour killings. Women are isolated and there is little place to hide.

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[242] *SRHmatters.org.* http://www.srhmatters.org/behaviours/rape/ (accessed December 18, 2014).
[243] Marital Rape: An Unacknowledged Crime, Zubair Khan. Muslim Times. N.d. Available at: http://www.themuslimtimes.org/2013/02/countries/pakistan/marital-rape-an-unacknowledged-crime
[244] PAKISTAN: Focus on honour killings. IRIN News. January 2013. Available at: http://www.irinnews.org/report/19247/pakistan-focus-on-honour-killings

3. Strategic Framework for Advocacy

The goal of IPPF is to work towards strong public, political and financial commitment to and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health.

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	• Need for focussed policies addressing the SRH needs of adolescents • Formulate programmes for the provision of youth friendly health services	• Campaign to include sex education for students in schools
HIV and AIDS	• Concerted efforts to target high risk groups for HIV/AIDS prevention interventions • Offering schemes for social protection for people infected and affected by HIV/AIDS	• General public awareness about the signs and symptoms of STIs in order to improve health seeking behaviour • Formation of PLHIV networks or support groups
Abortion	• Procurement of MVA or EVA kits at health facilities providing PAC • Training and recruitment of staff providing PAC	• Awareness generation about facilities providing abortion services and identification of complications • Campaign for standard guidelines to curtail unsafe abortions
Access to services and information	• Development of technical expertise for formulating effective procedures and mechanisms for implementation of the laws regarding GBV at federal, provincial and local/district government levels • Orientation and training of FIA officials in dealing with cases of human trafficking	• Campaign against social stigma faced by LGBT population • Formation of forums/groups advocating for the rights of sex workers
Others	• Ratify the International Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages • Enforcement of legislation regarding early marriage	• Awareness generation regarding negative consequences of child marriage • Campaign to recognize the problem of marital rape

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies

1. Engaging the media in highlighting relevant SRH issues can propel meaningful public discourse which can help in overcoming socio-cultural barriers. The media can play an effective role in raising awareness among the masses as well as advocating with government functionaries for

enforcement of relevant laws and allocation of adequate resources for multi-sectoral health interventions.

2. Since Pakistan's investment in the social sector is amongst the lowest in the world, sensitizing parliamentarians regarding the consequences of poor health facilities, lack of well-trained staff, inadequate medical supplies and equipment can help to mobilize the required investment in the social sector, particularly healthcare.
3. With the 18th amendment to the Constitution of Pakistan in 2010, the Ministry of Population Welfare (MoPW) was devolved and its responsibilities were shifted to the Provincial Population Welfare and Health Departments. There is a need to build the capacity of staff in areas such as policy formation, establishing targets, budget planning, programme design and implementation among others. They also need to be apprised of the relevant legislations and compliance with international commitments.
4. Working with community representatives such as teachers, religious leaders and parents can act as a useful strategy in bringing out social change and positively influencing community opinion regarding culturally sensitive issues.
5. Pakistan can leverage its huge youth demographic by building a strong network of young peer educators, participation in international and national youth conferences and representation at global forums. This can help to highlight issues specially related to SRHR of adolescents.

4. Civil Society Organisations

S.No.	Name	Focus Thematic Areas
1	AMAL Human Development Network	► HIV/AIDS ► Reproductive Health ► Gender
2	Family Planning Association of Pakistan	► Sexual and Reproductive Health ► Social Development
3	Aahung	► Sexual and Reproductive Health ► Child Sexual Abuse ► Gender Based Violence ► Life Skill Based Education
4	Pakistan Voluntary Health and Nutrition Association (PAVHNA)	► Reproductive Health ► Adolescent Reproductive Health
5	Root Work Foundation (RWF)	► Gender and Violence Against Women (Social Mobilisation, Research, Advocacy and Lobbying) ► Primary Education (Mobilisation, School Establishment and Capacity Building) ► Disaster Response (Relief, Rehabilitation and Early Recovery)
6	Rozan	► Gender Awareness and Sensitisation ► Psychosocial Support with Communities affected by Disaster or Conflict ► Adolescents' Sexual and Reproductive Health Concerns
7	Shirkat Gah - Women's Resource Centre	► Reproductive Health ► Livelihood
8	South Asia Partnership Pakistan (SAP-PK)	► Democratic Governance ► Poverty and Sustainable Livelihood ► Human Security and Safe Environment ► Peace and Regional Cooperation ► Gender and Development
9	UKS Research Centre on Women & Media (UKS)	► Media Monitoring and Sensitisation ► Radio Productions
10	Women's Empowerment Group (WEG)	► Women's Economic Empowerment ► Gender Equity and Equality ► Women's Health
11	Population Council (Pakistan)	► Family Advancement for Life and Health ► Client-cantered Salutation, Assessment, Help, and Reassurance
12	Action Aid Pakistan (AAPK)	► Women’s Rights ► Education ► Governance ► Peace, Human Security, HIV Aids
13	Youth Advocacy Network Pakistan	► Human rights ► Civic education ► Sexual reproduction
14	Women's Rights Association Pakistan	► Women Rights

5. International Conventions

S.No.	Name of the convention	Year of Signing/Attending
1.	Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others	Acceded in 1950, Ratified in 1952
2.	International Conference on Human Rights, Tehran	Attended in 1968
3.	International Covenant on Economic, Social and Cultural Rights	Signed in 2004, Ratified in 2008
4.	Convention on the Elimination of All Forms of Discrimination against Women	Acceded in 1996
5.	Convention on the Rights of the Child	Signed in 1990, Ratified in 1990
6.	International Conference on Population and Development (ICPD), Cairo	Attended in 1994
7.	UN Fourth World Conference on Women, Beijing	Attended in 1995
8.	ICPD +5	Attended in 1999
9.	World Summit	Attended in 2005
10.	London Summit on Family Planning	Attended in 2012
11.	Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery	Signed in 1956 , Acceded in 1958
12.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Pakistan signed in 2001, acceded in 2011
13.	ILO Convention 1999 (No. 182), Elimination of Worst Forms of Child Labor	Ratified in 2001
14.	Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others	Acceded in 1950, Ratified in 1952

2.9 Sri Lanka

2.9.1 Situational Analysis

Sri Lanka has achieved remarkable social and health indices, some of which are almost at parity with those of developed countries. By 2006, the maternal mortality rate (MMR) was lowered to 39 per 100,000 live births, and infant mortality was reduced to 19 per 1000 live births. Such positive figures placed Sri Lanka among the top five Asian countries. Life expectancy has increased, particularly for females where the rise of the average life span is now to 78 years. Sri Lanka has achieved these remarkable indicators due to a combination of high political commitment; free health and education policies; evidence-based intervention; strong social welfare measures to address people's basic needs; agricultural credit; food subsidies; free school meals; and free maternal nutrition packages.
On the issue of gender and women, it should be noted that gender equality is a fundamental right, as stipulated in the Constitution of Sri Lanka, and girls and women have equal access to the benefits of state education, as well as to social and health policies. In the Asian region, Sri Lanka's health services are considered among the best. Heavy investments in the healthcare system have resulted in access to quality care. Key indicators for the country are presented in table below.

Sexual and Reproductive Health Indicators

Indicators	Value	Year	Source
Total Fertility Rate (TFR)	2.3 children born per woman	2012	UNICEF
Contraceptive prevalence rate (%)	68.40	2008-12	UNICEF
Delivery care (%), Skilled attendant at birth	98.6	2008-12	UNICEF
Delivery care (%), Institutional delivery	98.2	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least one visit	99.4	2008-12	UNICEF
Antenatal care (%) 2008-2012, At least four visits	92.5	2008-12	UNICEF
Maternal Mortality Rate (MMR)	29 per 1,00,000 live births	2014	World Bank
Infant Mortality Rate (IMR)	8 per 1000 live births	2012	UNICEF
Health Budget (as % of GDP)	1.4	2013	World Bank

In the following sections, key issues related to SRHR in each of the identified 16 areas are discussed.

2.9.2 SRHR Situation in the country

Family Planning

Sri Lanka's fertility levels began to decline in the early 1960s, even before policy decisions were made to introduce family planning at the national level. The decline has been attributed to two significant factors: an increase in age at marriage for women, and second, a decline in marital fertility achieved largely through the use of sterilisation and traditional contraceptive methods[245]. The next four decades witnessed a steady decline in crude birth rates and TFR in the country. However, the most recent data from the Sri Lanka Demographic and Health Survey (SLDHS) 2006-07(Department of Census

[245]International Family Planning Perspectives and Digest. Vol 4, no.3 (1978)

and Statistics, 2009) suggests that fertility began to fluctuate on the higher side rather than declining constantly. TFR for the country as of 2012 stood at 2.3.

According to the SLDHS 2006-07 survey findings, the contraceptive prevalence rate in Sri Lanka is 68%. Over half of currently married women (53%) use a modern method and 16% use traditional methods. Among modern methods, the three most commonly used methods are female sterilisation (16 %), injectables (15%), and pills (8%). Among traditional methods of family planning, the rhythm method[246] was found to be the most popular method with 10% of currently married women using it.[247]

In 1965, family planning was integrated with the government's maternal and child health (MCH) programme, and in 1968 the Family Health Bureau (FHB) was established to co-ordinate family planning (FP) under the Ministry of Health (MoH). In the national five year plan of 1971, FP received due importance and a statement emphasised that 'family planning should be made available to all groups and not be confined to the privileged section of society'. The government's concern with population reduction was clearly expressed when it formulated the Population Policy in 1977. In 1998 a Population and Reproductive Health policy with eight goals was developed, out of which six fall within the direct ambit of the MCH/FP services or the Family Health programme. Moreover, one of the goals of the Maternal and Child Health Policy, 2009 is to enable all couples to have a desired number of children with optimal spacing whilst preventing unintended pregnancies. This is further reinforced in the National Family Health Programme under the MoH.

In Sri Lanka, free family planning services are provided through primary care facilities and hospitals. In rural areas, this infrastructure is complemented by a network of public health nurses and midwives providing MCH and FP services. Oral contraceptives are made available without prescription from pharmacies and from the public health midwives (PHMs), who are the health workers mainly responsible for field level service provision. The PHMs counsel clients on adopting a method and make referrals to appropriate service outlets. Sri Lanka has roughly 8,000 outlets for sale of condoms and oral contraceptives. PHMs also assist in the MCH and FP clinics, and conduct regular follow-up with family planning users in the area.

In spite of having a well-defined population policy and several programmes to address FP there continue to be a number of social barriers. Some of the key problem areas are as follows:

- The data from the DHS 2006-07 has shown that almost one-third of family planning users discontinue using the method within 12 months of beginning it. About 8% stop in order to become pregnant, and another 7% stop using the method due to health concerns or because of side effects. About 3% experienced a method failure. Among the methods, discontinuation rates are highest for pill (43%), withdrawal (40%), and condom (35%), and lowest for IUD (10%).
- Sri Lanka is also faced with a challenge where a group of people have moved away from family planning methods due to religious reasons.

Reproductive Health Services

In Sri Lanka, the Maternal and Neonatal Health (MNH) care is addressed by well-developed infrastructure for service delivery, efficient management information system (MIS), and effective supervision, monitoring and evaluation. The PHMs are the foundation of the Health Unit system, and serve a population of 3,000 to 5,000 within a clearly defined area. PHMs are responsible for the care of all pregnant women in their area, which includes early identification and registration of all pregnant mothers, provision of regular antenatal care, domiciliary and clinic care, identification and intervention for women who are at risk, planning to ensure safe delivery, assistance at home delivery when needed, and post-natal care of mothers and new-born babies.

[246] The rhythm method is a way to prevent pregnancy by taking advantage of the natural cycle of fertility. It requires an understanding of the body's natural ovulation cycle.
[247] Department of Census and Statistics and Ministry of Health Sri Lanka. Sri Lanka Demographic and Health Survey 2006-07.

Reduction in the MMR has been one of the biggest achievements in the health domain, most of which has been possible due to favourable policies. The National Health Policy of 1992 (revised in 1996) identified MCH as a priority concern. In 1998, a Population and Reproductive Health policy with eight goals was developed, of which six goals were directly linked with the issue of maternal and child health. The Maternal and Child Health Policy was developed in 2009 and aims to contribute to the attainment of highest possible levels of health of all women, children and families through provision of comprehensive, sustainable, equitable and quality MCH services in a supportive, culturally acceptable and family friendly setting.

The MCH programme of the MoH is directed at women during pregnancy, delivery and postpartum period, and at the new-born, infants, and children. Maternal care is provided free of charge to all pregnant women during antenatal, intra-natal and postnatal periods through the health care system of Sri Lanka. Antenatal care is provided at MCH clinics in health centres both in the field and in medical institutions. The National Strategic Plan on Maternal and New-born Health (2012-16) outlines the strategic directions for the Maternal and New-born Health programme in areas including Health System Structure and Functions, Human Resources, Service Delivery and Behaviour Change Communication. The FHB is the focal point for MCH in Sri Lanka. The services for MCH, women's health and FP are provided through the carefully streamlined infrastructure of the MoH and Provincial Health Services in Sri Lanka which comprise a wide network of medical institutions and Medical officers of Health (MOH) areas. Family Health Services of the FHB among its many functions mentions advocacy for MCH issues as a priority, along with designing, planning and monitoring MCH programmes.

The aforesaid interventions have contributed significantly to improve MCH, some challenges still remain:

- The current MCH based information system being a paper-based information system has some inherent problems including poor quality of data, gaps in timeliness, poor monitoring of data and feedback. There are also practical difficulties faced by the health workers at the field as they are overburdened by field work and paperwork. [248]
- Though Sri Lanka has made significant achievements in service coverage in the area of MCH/FP, there is a need to improve the quality of service delivery in order to attain further reductions of maternal mortality and morbidity. An external review of Maternal and New born Health in Sri Lanka conducted in 2007 identified the need to streamline the provision of maternal care and check the duplication of services. Further, recommendations of National Maternal Mortality Reviews and District Maternal and Child Health Reviews also pointed out the need for revision to streamline the services and to address the gaps in service provision. [249]

Prevention and Appropriate Treatment of Infertility

National level data on the prevalence of sub-fertility in Sri Lanka is not available; however, small scale studies have estimated that roughly 8% to 10% of couples in Sri Lanka suffer from sub-fertility or infertility. Services for basic investigation and management of sub-fertility are available in major hospitals as a routine service in the gynaecology clinics. The FHB runs a sub-fertility clinic where a large number of couples undergo basic investigations and management[250]. Even though there are no government programmes on infertility, there are many private infertility clinics offering treatment, counselling services, which have gained popularity in recent times. In 1998 Vindana, the first private sector Reproductive Health Centre in Sri Lanka produced the first test tube/IVF baby. While awareness of the prospect of these technologies (such as IVF) has reached a larger population, limited services are being provided by the government and therefore very few people are able to access and afford such treatment. IVF still remains an expensive service which can only be accessed in the private sector[251].

Reproductive Tract Infections (RTIs)

[248] Manoj, M.S. Customising DHIS2 for Maternal and Child Health Information Management in Sri Lanka. Sri Lanka Journal of Bio-Medical Informatics. 2012, Vol. 3
[249] Family Health Bureau (MoH). Maternal Care Package- A guide to Field Healthcare Workers. 2011
[250] UNFPA. ICPD@15 Sri Lanka (1994-2009)
[251] Reproductive Technologies as Global Form: Ethnographies of knowledge , practices and transnational encounters. Campus Verlag GmbH. 2012

Under the Goal II of the Population and Reproductive Health Policy 1998, RTIs were highlighted as a focus area to improve maternal health and ensure safe motherhood. Cultural norms and social stigma commonly prevent women from seeking services even for RTI/STI problems they recognise, or may result in their approaching the wrong service providers.[252]

Abortion

Abortion is legal in Sri Lanka only to save the life of the woman. The alarming increase in unsafe abortions is a major health and social concern in Sri Lanka. Most of the deaths in this regard have been reported to be caused due to ruptured uterus, tetanus or severe systematic infection developed after such abortions. As quoted in a UNFPA report, maternal deaths due to abortions ranked as the fourth leading cause accounting for 12.33 and 10.64 % of all maternal deaths in 2006 and 2007, respectively (FHB, 2010)[253].

In Sri Lanka, only gynaecologists who are certified by a Board can provide abortion services. Legal abortion services with clear medical indication to save the life of the woman are available at government hospitals that have specialised maternity and gynaecology units. These services are free of charge when certified by two obstetricians/ gynaecologists and/or a psychiatrist. A draft policy for Post-Abortion Care is being developed, and in the meanwhile, women presenting with abortion complications are hospitalised and the treatment is free of charge.

Some issues to be addressed are as follows:

- In Sri Lanka, since the 1970s a series of efforts have been made towards legalising abortion, yet abortion laws still remain highly restrictive. Access is further constrained since the procedure has to be certified by two obstetricians/gynaecologists and/or a psychiatrist.[254]
- Due to the restrictive abortion laws and absence of national standards and guidelines, it is challenging to get information regarding providers and methods which are generally used for abortion procedures.[255]
- In addition to the constraints posed by political environment, the issue of abortion also faces immense barriers which are triggered by socio-religious perceptions. The recent new religious group formations have slowed down the advocacy efforts on safe abortion significantly. [256]
- As a rule, only those facilities which fulfil the requirements stipulated by the government can be registered to provide abortion services. This reduces the availability of safe services for many women since approved and registered facilities are often located in urban centres, which means that access to rural women is restricted, as they may need to travel long distances to reach an authorised facility. Access is also limited given the inadequate personnel who can legally provide abortion services.[257]
- The price of unsafe abortions is mainly borne by those who are most vulnerable and least able to access safe services: women who are poor, from rural areas and young women and their families. Women who are from middle-income and lower income households, however, often get the services of unsafe 'back-door abortionists' under unhygienic and unsafe conditions, resulting in high maternal mortality and chronic ill health.[258]

AIDS - Prevention, Care and Treatment of STIs and HIV/AIDS

HIV/AIDS is a communicable yet preventable disease, which can have serious social and economic consequences. Although, the first HIV infected person in Sri Lanka was detected as early as in 1986, due to effective control programmes, the prevalence has been kept at a low level of less than 0.1% in the general adult population. Despite a long-standing civil

[252] World Bank. Better Reproductive Health for Poor Women in South Asia. Report of the South Asia region Analytical and Advisory Activity, 2007. Accessed on 11th November 2014 at https://openknowledge.worldbank.org/bitstream/handle/10986/7667/42027.txt?sequence=2
[253]UNFPA. Population Situation Analysis: Sri Lanka. Accessed on 2nd November 2014 at http://unfpa.org/psa/wp-content/uploads/2012/11/Sri-Lanka-Population-Situation-Analysis.pdf
[254]WHO. Mapping abortion policies, programmes and services in the WHO South-East Asia Region. 2013
[255]Asia Safe Abortion Partnership (ASAP). *Country Profile-Sri Lanka.* Accessed on 1st November 2014 at http://www.asap-asia.org/country-profile-sri-lanka.html
[256]Ibid.
[257]WHO. Mapping abortion policies, programmes and services in the WHO South-East Asia Region. 2013
[258]Asia Safe Abortion Partnership (ASAP). *Country Profile-Sri Lanka.* Accessed on 1st November 2014 at http://www.asap-asia.org/country-profile-sri-lanka.html

war, there is little evidence of transmission within the population and most cases of HIV are found among migrant labourers returning from abroad.[259]

The National STD/AIDS Control Programme (NSACP) 1992, MoH, spearheads the national response to HIV/AIDS in Sri Lanka. NSACP is the focal point for planning and implementation of the National HIV Strategic Plan 2013-2017 (NSP) and AIDS Policy together with all the other stakeholders.[260]The National programme reaches the provinces through 28 STD clinics throughout the island. As part of the NSACP, these STD clinics are involved in advocacy, surveillance and preventive work in the community, in addition to provision of services for patient management. Comprehensive care is offered free of charge to all who seek services at the STD clinics, including diagnostic facilities such as screening for STI with routine pap screening for women. Compulsory pre-service training is conducted for major staff at the NSACP premises. Sri Lanka also has a National Policy on HIV and AIDS in the World of Work[261], 2011 covering all workers in the country. This policy aims to guide the national response to prevention of HIV and AIDS, treatment care and support and mitigate and manage its impact in the workplace, in public, private and informal sectors, while safeguarding and respecting workers' rights.[262]

Since the government health services are provided free of charge to all citizens, in 2004, a policy decision was taken to provide free of charge ART to PLHIV in the Government sector. A key milestone was the launch of the National Strategy for the Elimination of Congenital Syphilis in Sri Lanka in November 2009. The National HIV/AIDS Policy 2011 provides a rights-based framework with which laws and policies are intended to comply.[263]It states that 'the human rights of people living with HIV/AIDS are promoted, protected and respected and measures taken to eliminate discrimination and combat stigma.'

The NSP of the MoH is designed to guide the country's response to HIV/AIDS and STI control and has been formulated with involvement of (relevant governmental, non-governmental, international) stakeholders, drawing on the existing strengths and lessons learned in the past decade. It considers the policy and legal environment, the available scientific evidence, best practices from international arena, and the estimated needs for prevention and treatment and current coverage rates.

Despite the efforts to address the incidence of HIV/AIDS:

- There is a limited framework of laws and policies in relation to HIV/AIDS in Sri Lanka. While laws respecting and protecting the rights of PLHIV and vulnerable communities are required, it is doubtful whether Sri Lanka with its high levels of stigma and discrimination, misconceptions and prejudices is prepared to legislate on such a sensitive subject.[264]
- A large number of STI patients seek treatment in the private sector however such statistics do not get recorded in the health management information systems.[265] Hence, there is a significant difference between the estimated number of people living with HIV and AIDS and the number reported to the NSACP. One of the key problems which NSACP faces is that many STD clinics have inadequate infrastructure, human resources and skilled professionals to manage STDs and HIV/AIDS.[266]
- Despite the fact that the current prevalence rate is contained, Sri Lanka is vulnerable to HIV due to many underlying risk factors. The country has large numbers of key affected populations, including sex workers, men who have sex with men (MSM), transgender persons, migrant workers, military personnel, internally displaced persons, refugees and those who use drugs; as well as a high frequency of unsafe sexual practices, which include low condom use and rising rates of STIs.[267]

[259]Bulletin of the WHO. Control of sexually transmitted infections and prevention of HIV transmission: mending a fractured paradigm. 2009. Accessed on 11th November 2014 at http://www.who.int/bulletin/volumes/87/11/08-059212/en/

[260] National STD/AIDS Control Programme (NSACP) Website. Accessed on 5th November 2014 at http://www.aidscontrol.gov.lk/web/index.php?lang=en

[261] The policy, which draws on international human rights instruments such as ILO labour standard on HIV in the workplace, prohibits discrimination of people based on real or perceived HIV status for purposes of recruitment or at any other stage of employment.

[262] Ministry of Labour and Labour Relations. National Policy on HIV and AIDS in the World of Work in Sri Lanka, June 2010.

[263] UNDP, SAARCLAW and IDLO. Legal Reference Brief: Sri Lanka. Accessed on 6th November 2014 at http://www.aidsdatahub.org/sites/default/files/publication/rbap-hhd-2013-sri-lanka-legal-reference-brief.pdf

[264] Centre for Policy Alternatives. HIV/AIDS in Sri Lanka: A Profile on Policy and Practice, July 2007

[265]UNFPA. ICPD@15 (1994-2009).

[266] Centre for Policy Alternatives: HIV/AIDS in Sri Lanka: A Profile on Policy and Practice, July 2007

[267] UNDP, SAARCLAW and IDLO. Legal Reference Brief: Sri Lanka. Accessed on 6th November 2014 at http://www.aidsdatahub.org/sites/default/files/publication/rbap-hhd-2013-sri-lanka-legal-reference-brief.pdf

- The response on HIV/AIDS has been dominated by initiatives on prevention rather than treatment, care and support. Certain trends in the society such as a lack of awareness of what exactly is HIV/AIDS, methods of contracting, rights of PLWHA and their families, misconceptions, prejudices and doubts need to be addressed.[268]

Adolescent Sexual and Reproductive Health services – Youth Friendly Services

Adolescents (10-19 years of age) constitute about 19.7% of the total population of Sri Lanka, placing nearly 3.9 million adolescents in this age group.[269] The Annual Report on Family Health, Sri Lanka (2010) reported that 6.5% of the total registered pregnancies in the country were teenage pregnancies. Evidence shows that they may have obstetric and neonatal complications such as unsafe abortions, anaemia, premature labour, and low birth weight.[270] Due to lack of knowledge on sexual and reproductive health, improper family planning services and meagre information on contraceptives, adolescents suffer from social and habitual issues detrimental to their health and bear the consequences of such challenges. Unwanted pregnancies, abortions, STD and HIV/AIDS, smoking, alcohol and drug abuse, suicide, violence, nutritional problems and dropping out of school are the most common issues.

The primary healthcare system provides ASRH services in the country. As envisaged in the International Conference on Population Development Plan of Action (1994), the Government of Sri Lanka has focussed on adolescent sexual and reproductive health (ASRH) needs and rights by formulating policies, planning and implementing programmes and encouraging research activities to address the sexual and reproductive health needs of young people. The recently formulated National Policy and Strategy on Health of Young Persons and the National Strategic Plan on Adolescent Health (2013-2017) have a broader focus on adolescent sexual and reproductive health. Goal IV of the Sri Lanka Population and Reproductive Health Policy is to promote responsible adolescent and youth behaviour by ensuring availability of adequate information on family life, sexuality and drug abuse in school curricula, among others. The School and Adolescent Health Unit of the Family Health Bureau acts as the focal point for the National School and Adolescent Health (SAH) Programme. Medical Officers of Health (MOH) engage in teacher training and education programmes for students on reproductive health, nutrition, non-communicable diseases prevention and life skills. The PHM and the Public Health Inspector are responsible for providing care for out-of-school adolescents.

Following are some of the areas having opportunity for further improvement with regards to ASRH:

- Among adolescents, comprehensive knowledge on transmission and prevention of HIV/AIDS is low. The National Survey on Emerging Issues among Adolescents in Sri Lanka (2004) revealed that only 50% of both in-school and out of school adolescents have the correct knowledge. (UNICEF, 2004).[271]
- There is lack of reliable data on ARH issues, such as teenage pregnancies, abortions, contraceptive use, child abuse, and gender-based violence among adolescents which makes it difficult to achieve political commitment for a coherent ARH policy initiative.[272]
- There are many gaps in service provision and implementation of policies through the system need further strengthening. Providing services for adolescents and youth still remain a challenge due to various deficiencies on established systems and therefore service delivery systems need to be strengthened.
- There is a lack of public awareness about sexual health for adolescents, primarily because of cultural taboos. This leads to minimal or no communication between parents and children on the subject. Even teachers and community leaders to do not openly discuss issues among themselves or with adolescents.[273]

Comprehensive Sexuality Education

[268] Centre for Policy Alternatives: HIV/AIDS in Sri Lanka: A Profile on Policy and Practice, July 2007
[269] UNFPA, Adolescent Sexual and Reproductive Health in Sri Lanka: A Situation Analysis. 2012
[270] Family Health Bureau, Ministry of Health, Sri Lanka. National Strategic Plan for Adolescent Health (2013-2017), 2013.
[271] Family Health Bureau, Ministry of Health, Sri Lanka. National Strategic Plan for Adolescent Health (2013-2017), 2013.
[272] USAID. Adolescent and Youth Reproductive Health in Sri Lanka: Status, Issues, Policies and Programs. 2003.
273 USAID. Adolescent and Youth Reproductive Health in Sri Lanka: Status, Issues, Policies and Programs. 2003.

A National Survey on emerging issues among adolescents in Sri Lanka (2004 UNICEF, Colombo) revealed that knowledge on STI/HIV/AIDS is poor among adolescents with only 50% of both in-school and out of school adolescents having the correct knowledge.[274]

The Population and Reproductive Health Policy, 1998 recognises the need to enhance the knowledge of the school-going population on reproductive health issues, and also highlights the development of abilities in young people to take rational decisions about sexuality, gender, prevention of STI/HIV, and drug use. In 2012, the Health Ministry of Sri Lanka compiled a legal and policy document on SRH for youth and adolescents in accordance with its global obligation to protect the youth from sexual diseases through education[275]. The School Health Promotion Programme (SHPP) talks about inclusion of life skills, reproductive health, healthy living and health promotion. As part of the programme, school health clubs are in place which offer an opportunity for young adults (senior class students) to discuss issues related to sexual behaviour and responsible living and to enhance their knowledge of reproductive health issues, such as HIV/AIDS and STI prevention, through lectures and seminars.

Some issues of concern include:

- Bringing attitudinal changes among the vast and varied education system including staff and students is a daunting task. Other than this, other stakeholders such as the officers of the MoH, other governmental and non-governmental institutions and the parents for whom awareness programmes have to be conducted are all very varied groups, and bringing them together to achieve a common goal is a difficulty.[276]
- Adolescents usually turn to their peers or to media sources (newspapers or magazines) while searching for information. These resources fail to provide correct information, and may mislead them.[277]
- Although education on reproductive health has been imparted through various subjects such as health science and life skills, the key aspects of sexuality and sexual health are not addressed and remains a taboo topic on account of cultural sensitivity. Earlier attempts to introduce concepts on this subject have been resisted by a few school principals, teachers, administrators and parents.[278]

Conjugal rights (Marital Rape)

Marital rape is not a crime in Sri Lanka unless a judge has ordered a spousal separation/divorce. A variety of reasons may prevent the victim from reporting and addressing this issue- social stigma, cultural norms, fear, shame, community and family disapproval, fear of losing children, negative perception and possible harassment at the hands of the police.[279] This further worsens the situation. Marital rape is not considered a crime in Sri Lanka unless a judge has ordered a spousal separation/divorce.

The 2005 Prevention of Domestic Violence Act (PDVA) provides some protection in the case of marital rape by allowing victims of domestic violence (including rape and sexual assault) to request a protective order from a Magistrate's Court that would limit contact between the perpetrator and the victim. Recent amendments to the Penal Code in the country do recognise marital rape but only with regard to divorced partners. However, there are no government sponsored shelters for women and child victims of abuse available.[280]

The lack of a proper legal structure to condemn conjugal violence and provide assistance to the victims creates many policy and programmatic barriers. Most women do not disclose intimate partner violence within marriage to anyone unless the violence becomes unbearably severe or if children are threatened.[281]Marital rape cases are considered and dealt with as

274United Nations Children's Fund. National Survey on Emerging Issues among Adolescents in Sri Lanka. UNICEF. 2004
275 Daily Mirror. 2012. Accessed on 24th June 2015. http://www.dailymirror.lk/24504/lanka-prepares-sex-education-policy
276WHO Sri Lanka. School health programme. Accessed on 8th November 2014 at http://whosrilanka.healthrepository.org/bitstream/123456789/254/1/School%20health%20promotion.pdf
277UNFPA. Adolescent Sexual and Reproductive Health of Sri Lanka: A situation analysis. 2012
278Ibid.
279 Fernando, V. Sri Lanka: Rape, Marital rape, Incest, Law issues, Shame. Accessed on 12th November 2014 at http://www.wunrn.com/news/2008/09_08/09_15_08/091508_sri.htm
280 International Centre for Ethnic Studies. Domestic Violence Intervention Services in Sri Lanka (2009-2011). 2012
281Ibid.

domestic violence issues which can be settled between the parties with counselling. In the Sri Lankan context, rape within a marriage is regarded as a domestic or private matter in the legal system.

Early and Forced Marriage

Sri Lanka has witnessed an increase in the average age of marriage over time, which is currently 25 years. This accomplishment has been possible due to the introduction of legal reforms which necessitated that all marriages should be registered and the consent of both marriage partners must be recorded. The positive outcome of these legislative changes have been supported and enhanced by affirmative social policies on health and education. These have helped to steeply reduce the practice of early marriage.Sri Lankan society in general does not encourage child marriage because it considers it an infringement of the education and reproductive health rights of girls.

Sri Lankan courts have on numerous occasions ruled invalid non-consensual marriages forced on girls by parents, which has helped educate the public about the injustice and illegality of child marriage. The Marriage Registration (Amendment) Act, 1995 was a major step in curbing child marriage. It legally set the marriagable age for both boys and girls at 18 years for the majority of the population. However, the Muslim Marriage and Divorce Act governs marriage between Muslim parties. Though it does not specify a minimum age for a valid marriage, but where a marriage involves a girl below age 12, the act requires consent of the *Quazi*. Between 2002-2012, 1.7% girls were married by the age of 15, and 11.8% were married by 18 years of age [UNICEF, 2013].[282] Another factor deterring early marriages is the provision of free education from primary to university level by the government, which encourages families to keep girls in school instead of marrying them off. The National Child Protection Authority (NCPA) of the Child Development and Women's Affairs Ministry, annulled 300 underage marriages in October 2010 when it was noted that some under age marriages continued because of accepted cultural norms in some regions.

Despite the improvement in the situation and government's efforts to eliminate early marriage, there have been some natural and some long standing barriers in Sri Lanka that hamper the progress.

- Decades of civil war and the devastating 2004 tsunami in the country aggravated poverty, thereby pushing desperate families to marry off their young daughters to reduce the economic strife. [283]
- The continuous years of armed conflict have resulted in a phenomenon of early marriage and teenage pregnancy of girls in the conflict areas, and in Internally Displaced People.[284]

Prevention and Surveillance of Violence against Women (Gender Based Violence)

In Sri Lanka, gender based violence ranges from sexual harassment in public spaces to acts of violence within the privacy of the home or even at workplaces. According to the statistics compiled by the Sri Lanka police based on complaints registered during 2003, there were 2155 cases of violence against women, of which 690 cases were of battering, assault and injury[285].

In 2005, the Ministry of Child Development and Women's Affairs was established with the objective of addressing issues relating empowerment of women and women's rights and well-being of all children while upholding their rights. The Sri Lanka Women's Charter was drafted and adopted by the country in March 1993 expressing the country's commitment to eliminate all forms of discrimination against women. A country wide Campaign to End Violence against Women (CEVAW) was launched in 2004 and the outcomes are continuously monitored and evaluated by the National Committee on Women. The PDVA 2005 provides for protection orders to be urgently obtained to safeguard women and children suffering and at risk of domestic violence. The Ministry of Health in partnership with non-government agencies has developed hospital-based centres to provide medical assistance to those requiring attention for injuries suffered before referral to legal and psychosocial support. The National Commission for Women works proactively on addressing issues of gender based violence through research, training workshops and discussions with various stakeholders on issues of gender based violence. The

282UNICEF. Sri Lanka- Statistics (2013). Accessed on 11th November 2014 at http://www.unicef.org/infobycountry/sri_lanka_statistics.html

283 UNFPA, ICRW and Australian AID. Child marriage in Southern Asia: Policy Options for Action.

284UNICEF. Emerging Concerns and Case studies on Child Marriage in Sri Lanka. 2013

285Govt. of Sri Lanka website (Current Affairs). Campaign to end domestic violence against women launched. Sep, 2004. Accessed on 12th November 2014 at http://www.priu.gov.lk/news_update/Current_Affairs/ca200409/20040924campaign_end_domestic_violence.html

Institute of Judges' Services and the Police Department of Sri Lanka have been conducting training and sensitisation programmes for law enforcement officials. The National Action Plan for the Protection and Promotion of Human Rights 2011 further consolidates the policy framework with its strong focus on violence against women.

Mentioned below are current challenges that hinder the efforts aimed at suppressing gender based violence.

- The PDVA does not address the particular needs of women since they are grouped with children and disabled persons.[286]
- Women in conflict zones of Sri Lanka are specifically at risk of sexual violence and other abuse by security forces while they are held in custody. However, most of the crimes in these areas go unreported.[287]
- Police officers show an unresponsive attitude because they fail to take complaints seriously due to gender bias.[288]
- One of the major barriers to the much needed legal and social reform is the societal perception of women. The belief that female household members need to be protected by men and in such ways so as to ensure female conformity is deep-rooted.[289] Norms and identities are enforced not only by men but also by women in the house which results in a continuous cycle of violence against women and girls.[290]
- The Ministry of Women's Affairs has often been combined with other Ministerial portfolios ranging from Health to Housing to Social Services and is presently coupled with child welfare. This raises questions as to the commitment of and recognition by consecutive governments to 'gender equality and the advancement of women'[291].

Migrants (Provision of Health Services

Migration is an important aspect of Sri Lanka and migrant health continues to be important affecting all types of migrants and impacting all stages of migration. To ensure better health and development outcomes for all flows of migrant populations and the families they leave behind the Government of Sri Lanka has been collaborating with the International Organization for Migration (IOM). The Sri Lankan commitment towards the migrant populations can be seen in the various policies that have been passed and implemented such as the Sri Lanka National Migration Health Policy 2012, the National Labour Migrant Policy and the Ten Year Horizon Development Framework 2006-2016 – the Mahinda Chintana.

To ensure the well-being of the migrant population several programmes have also been implemented such as the Migration Health Development programme launched in 2009 involving 12 key government ministries. This programme has helped Sri Lanka to proactively respond to its migration health related challenges. The Government with the support of IOM has also launched a web portal on "Migration, Health and Development".

In spite of Governmental efforts to address the needs of the migrant population several barriers have been identified in the policies implemented and in the implementation of the programmes designed to assist the migrant population such as:

- Insufficient insurance cover for migrant workers who are outbound leading to a lack of proper healthcare and hesitation in reporting sickness due to the fear of repatriation[292].
- The National Policy on Labour Migration is limited to STIs and HIV/AIDS, with no focus on other communicable and non-communicable diseases of migrant and mobile populations[293].
- The State's free health services are only available to citizens of the country. Presently the main stakeholder in providing health services to inbound migrants is the private health network.

Sex work

[286]World Bank Group. Violence against Women and Girls: Lessons from South Asia. 2014.
[287]Campaign to end domestic violence against women launched. Sep, 2004. [Ibid]
[288]Campaign to end domestic violence against women launched. Sep, 2004. [Ibid]
[289]Campaign to end domestic violence against women launched. Sep, 2004. [Ibid.
[290]World Bank Group. Violence against Women and Girls: Lessons from South Asia. 2014.
[291]Women defining Peace. Understanding Gendered Violence against women in Sri Lanka (Background paper). 2009.
[292] Ministry of Health and IOM. Sri Lanka National Migration Health Policy. 2012
[293] Ministry of Health and IOM. Sri Lanka National Migration Health Policy. 2012

It has been estimated that Sri Lanka has about 40,000 sex workers, majority of which operate in Colombo[294]. The 2010 UNAIDS report on the Global Aids Epidemic described sex work as "central to the region's epidemics". Female sex workers have been identified as the highest risk group for HIV infection in the country as recognised by the NSP. The number of male sex workers has also been increasing since the beginning of 2013[295].

Although sex work continues to be illegal, through amendments in 1995 and 2006, the Penal Code of Sri Lanka specifically created offences in regard to sex work/prostitution and trafficking. A few ordinances linked to sex workers and sex work, have been passed by the Government such as The Brothels Ordinance that deals with the running of brothels and punishes anyone involved in the management, acting or assisting of a brothel. Since sex work is illegal there are no formal programmes that have been sponsored by the Government. Further, the stigma attached to sex work often inhibits sex workers from accessing safe and quality healthcare. Since sex work is criminalised, legal provisions drive sex work and sex workers underground to effectively avoid detection by the police[296].

Human trafficking

Human trafficking is a major area of concern for Sri Lanka. Men, women and children are trafficked for various purposes such as labour and commercial sexual exploitation including domestic child sex tourism. Sri Lankan women have also been known to be subjected to forced prostitution in Jordan, Singapore, Maldives and other countries[297].The Trafficking in Persons (TIP) report of the US Department of State (2013) places Sri Lanka at —Tier 2 watch list which is just one level above the worst category, —Tier 3.

The NCPA and Criminal Investigation Department (CID) investigated 44 reported cases of trafficking in 2011, and referred nine of these cases to the Attorney General's office for advice. Further, in 2012 and 2013, the government investigated 44 and 20 cases of trafficking, respectively[298].

Various sections of the Sri Lankan Penal Code prohibit various forms of trafficking, including for sexual exploitation. The Convention Preventing and Combating Trafficking in Women and Children for Prostitution Act, 2005 has been passed but is yet to come into force. The NCPA, Sri Lanka is the nodal organisation for child protection services. IOM, Sri Lanka has supported the Ministry of Child Development and Women's Affairs to establish the first Government shelter for victims of human trafficking.

In spite of the formulation of policies to combat trafficking, numerous barriers have been identified in the enforcement of the same such as:

- Lack of a comprehensive definition of trafficking makes it difficult to punish offenders[299].
- Lack of a gender sensitive system translates into the lack of gender sensitive laws[300].
- The negative attitude of the Government and the police towards victims is another big challenge.[301]
- The TIP report 2009 reports that the NCPA has several cases pending against child traffickers but no trials have been completed and conviction seems to be a remote possibility[302].

Sexual Orientation and Gender Identity (SOGI) Rights

Various articles of the Penal Code of Sri Lanka prohibit same-sex activities and relations. Such laws result in discrimination, harassment, violence and the unequal treatment of the Lesbian, Gay, Bisexual, Transgender (LGBT) community. The legal

294UNFPA, Adolescent Reproductive and Sexual Health in Sri Lanka: A situation analysis. 2012
295 Ministry of Health, Sri Lanka. Annual Report of National STD/AIDS Control Programme, 2013
296 University of Southern California. Realigning government action with public health evidence: the legal and policy environment affecting sex work and HIV in Asia. *Culture, Health & Sexuality: An International Journal for Research, intervention and care*, 2014.
297 United States Department of State, *2013 Trafficking in Persons Report - Sri Lanka*. Accessed on 11th November 2014 at http://www.refworld.org/docid/51c2f38b16.html
298 United States Department of State, *2013 Trafficking in Persons Report - Sri Lanka*. Accessed on 11th November 2014 at http://www.refworld.org/docid/51c2f38b16.html
299UNODC. Responses to Human Trafficking in Bangladesh, India, Nepal and Sri Lanka: Legal and Policy Review. 2011
300 Ibid
301US Department of State. Trafficking in Persons (TIP) Report, 2014. Accessed on 11th November 2014 at http://www.state.gov/documents/organization/192597.pdf
302Bureau of Democracy, Human Rights, and Labor. Human Rights Report: Sri Lanka, 2008. Accessed on 11th November 2014 at http://www.state.gov/j/drl/rls/hrrpt/2008/sca/119140.html

provisions deny sexual minorities the rights they are entitled to and legitimise the social stigma often attached to homosexuality[303].Furthermore, there are no government programmes identified to address the needs of the LGBT community.

Following are some of the barriers which inhibit the LGBT community in Sri Lanka:

- The law (Sections 365 and 365A of the Penal Code) is repressive, prohibitive and often used to threaten the LGBT communities especially the MSMs[304]. The Penal Code outlaws "gross indecency", with no specificity on what it means.
- The Constitutional right of non-discrimination is in contrast with the provisions of the Sri Lankan Penal Code which criminalise same-sex sexual relations, thereby discriminating against persons on the basis of their SOG)[305].
- Most media coverage on LGBT issues is either negative or sensationalised.
- The LGBT community often face harassment in the hands of the authorities[306]
- The criminalisation of homosexuality and the social stigma and discrimination attached to it often results in unsafe sexual behaviour[307].

Other harmful practices (Honour Killing)

No Information available

303 Equal Ground. Human Rights Violations Against LGBT People in Sri Lanka: A shadow report. 2013. Accessed on 4th November 2014 at http://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/LKA/INT_CCPR_ICO_LKA_15986_E.pdf
304 Ibid
305 UNDP. HIV and Men who have Sex with Men: Country Snapshots - Sri Lanka, 2012
306 UNDP and IDLO. "Report to the Regional National Human Rights Institutions Project on Inclusion, Right to health and Sexual Orientation and Gender Identity." 2013
307 UNDP, SAARCLAW and IDLO. Legal Reference Brief Sri Lanka: Protective Laws related to HIV, Men who have Sex with Men and Transgender people, 2011

2.9.3 Highlights of the issues relevant from Advocacy perspective

The goal of IPPF is to work towards strong public, political and financial commitment and support for sexual and reproductive health and rights. The following issues were identified while mapping of policies and programmes related to Sexual and Reproductive Health

Priority areas of IPPF	Issues for Advocacy with the Government	Issues for Advocacy with Civil Society
Adolescents/young people	• Inclusion of CSE in school curricula	• Sensitisation of stakeholders including officers of the MoH, other governmental and non-governmental institutions and the parents regarding ASRH issues • Need for reliable data on ARH issues, such as teenage pregnancies, abortions, contraceptive use, child abuse, and gender-based violence among adolescents.
HIV and AIDS	• Advocacy to make the National HIV Strategic Plan Sri Lanka more decentralised, for effective functioning • Recognising AIDS as a development issue rather than just a health issue • Need for a comprehensive health management information systems which captures data from the private sector as well	• Advocacy to reduce stigma and discrimination against PLHIV, thus promoting access to VCT and free treatment • Advocacy to increase awareness, methods of contracting, rights of PLHIV and their families, misconceptions, prejudices and doubts regarding HIV/AIDS
Abortion	• Advocate for national standards and guidelines • Provision of guidance and training to health professionals in the use of misoprostol	• Advocate for more liberal abortion laws as currently the procedure has to be certified by two obstetricians/gynaecologists and/or a psychiatrist
Access to services and information	• More inclusive health policy on migrants	• Information and awareness generation on health issues to migrant population • Campaign against social stigma for people with diverse SOGI
Others	• Sensitisation of government employees towards trafficking issues • Better enforcement of trafficking laws	• Advocate for recognition of marital rape as a crime • Prevention of violence against women in conflict zones where most crimes go unreported

The rationale for identifying these issues is discussed in the previous sections of this document.

Strategies for Advocacy

- Baseline surveys particularly in the field of reproductive health can be important since the knowledge, attitude and skills tend to differ among target groups. Such research studies can help to provide inputs to the ongoing advocacy efforts – policy advocacy, people centred advocacy, media advocacy. Regional co-operation across countries will also lend voice to ongoing advocacy.
- Educating and counselling parents about the importance of Adolescent Reproductive Health (ARH), involving them as members of advisory committees that review programme content on adolescent SRH issues and gaining their support in this regard can help to promote adolescent healthcare services in Sri Lanka.
- A more in-depth analysis of media coverage of issues related to SRH is required; media advocacy can act as an effective advocacy tool due to its widespread outreach. Coverage of relevant issues in regional dailies, electronic media and social media should be understood to design a strategy for advocacy.
- Building a strong network of young peer educators, participation in international and national youth conferences and representation at global forums can help to raise issues specially related to SRHR of adolescents.

2.9.4 Civil Society Organisations

S.N.	Name	Focus Thematic Areas
1.	Suriya Women's Development Centre (SWDC)	▶ Gender and women's rights
2.	Centre for Women Research (CENWOR)	▶ Reproductive health. ▶ Violence against women including rape, domestic violence etc. ▶ Women's rights
3.	Women Development Centre(WDC)	▶ Gender based violence ▶ Skill development ▶ Women's rights
4.	Family Planning Association of Sri Lanka	▶ Family Planning ▶ HIV-AIDS
5.	Women in need (WIN)	▶ Domestic violence, including sexual violence
6.	Women's voice in Sri Lanka	▶ Women's rights in a post conflict situation
7.	Muslim Women's research and action forum	▶ Upholding equity and justice for all women ▶ Gender-based violence
8.	International civil society action network(ICAN) (The Association of War Affected Women)	▶ Gender rights in conflict situation
9.	US Agency for International Development, Sri Lanka	▶ Democracy, Human Rights and Governance ▶ Humanitarian Assistance ▶ Economic Development
10.	Sri Lanka Association for Family Health and Voluntary Surgical Contraception	▶ Voluntary surgical contraception ▶ HIV-AIDS
11.	AIDS Foundation	▶ HIV/AIDS
12.	Companions on a Journey	▶ AIDS Prevention ▶ Reproductive Health ▶ LGBT support and advocacy
13.	Equal Ground	▶ LGBTIQ advocacy ▶ Sensitising programmes on sexuality, awareness raising on gender and human rights ▶ Prevention and educational programmes on HIV/AIDS

International Conventions

S.No	Name of the convention	Year of Signing
1.	Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others	Acceded in 1958
2.	Convention on Consent to Marriage, Minimum Age for Marriage and Registration of Marriages	Signed in 1962
3.	World Population Conference - Bucharest	Attended in 1974
4.	International Covenant on Economic, Social and Cultural Rights	Acceded in 1980
5.	Convention on the Elimination of All Forms of Discrimination against Women	Signed in 1980, ratified in 1981

6.	International Conference on Population, Mexico City	Attended in 1984
7.	Convention on the Rights of the Child	Signed in 1990, ratified in 1991
8.	International Conference on Population and Development (ICPD), Cairo	Attended in 1994
9.	UN Fourth World Conference on Women, Beijing	Attended in 1995
10.	ICPD +5	Attended in 1999
11.	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	Acceded in 1996
12.	Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (Supplementing the United nations convention against transnational organised crime)	Singed in 2000
13.	World Summit	Attended in 2005
14.	Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery	Signed in 1957, acceded in 1958
15.	Optional Protocol to the Convention on the CRC on the Sale of Children, Child Prostitution and Child Pornography, 2000	Signed in 2002, acceded in 2006
16.	SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution	Attended in 2002
17.	ILO Convention 1999 (No. 182), Elimination of Worst Forms of Child Labour	Ratified in 2001
18.	Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, 1999	Acceded in 2002

3. Chapter 3: Proposed strategy, results and recommendations

We understand that the South Asia region has socio-cultural and religious similarities which in many cases influence a county's laws and policies. While the country chapters talk about country specific issues and strategies, this section provides a synopsis of the key issues common to the region and outlines strategies to address the same.

Key Issues

The political mapping exercise revealed that there is a need to increase access to affordable and quality reproductive health services including an integrated package of family planning services through outreach initiatives, particularly to the vulnerable population such as migrants, PLHIV, people with diverse SOGI, sex workers, IDUs, and the like. Further, formulation and enforcement of laws protecting the rights and preventing discrimination of these populations are required. Even in case of early and forced marriage, while most of the countries have laws prohibiting the same, stronger enforcement and sensitization of officials in this regard is required. Sensitization of law enforcement officials dealing with human trafficking and gender based violence is also needed as these are issues where the victims are usually vulnerable and in most cases lack the social and financial support.

As far abortion is concerned, even though most countries have favourable policies pertaining to protecting the health of the woman, more efforts are required in terms of formulating and enforcing stringent laws to curtail illegal and unsafe abortions which are responsible for significant number of maternal deaths in this region, especially since abortion is an issue associated which social stigma in most of the countries in this region.

Strategies and Recommendations

6. **Include other stakeholders in advocacy initiatives** such as religious leaders, private practitioners and migrants. For instance, considering the socio-cultural environment in the region involvement of religious leaders can help to overcome cultural sensitivities, personal beliefs/attitudes of teachers and parents regarding sexuality education. Therefore, involving these categories of people in advocacy efforts as stakeholders would help in better understanding of ways to address the various barriers.
7. **Leverage the youth demographic** – South Asia region has a significant population below the age of 25 years. The health issues of adolescents particularly related to SRHR can be highlighted by building a strong network of young peer educators, building their capacity, providing them with platforms to participate in international and national youth conferences and representation at global forums.
8. **Greater engagement with policy makers** - With the dynamic political landscape in the region, it is important to engage with the Parliamentarians so that relevant issues are put forth the decision makers to enable maintaining the momentum of existing good work and advocacy for what needs to be done. It is also important to ensure that financial allocation for the programmes is not compromised.
9. **Greater emphasis on evidence based advocacy,** such as epidemiological studies on health seeking behaviour, prevalence patterns, motivators and barriers to health services, can provide inputs to the ongoing advocacy efforts – policy advocacy, people centred advocacy and media advocacy. Regional co-operation across countries will also lend voice to ongoing advocacy. It is important to ensure that there is adequate participation of men in all the initiatives.
10. **Advocacy for effective implementation of policies and programmes** – As seen in the discussion in the country chapters a number of progressive policies and programmes have been initiated in the last decade. While it is important to continue to contribute to these policies, it is vital that the existing policies and programmes are implemented effectively. In many areas it is seen that implementation on the ground is not effective due to a number of issues related to supply chain, capacity of human resource and lack of accountability. A close watch on the implementation of programmes and constructive suggestions for their improvement may help in effective implementation of programmes.
11. **Reinforcement of key messages** is also important to sustain interest among various stakeholders such as members of the civil society, policymakers and implementing/ enforcement officials. Regular dialogue and discussion about an important topic helps to keep the momentum around that particular area of concern, and leads to greater impact.

12. **Educating and counselling parents** about the importance of Adolescent Reproductive and Sexual Health (ARSH), involving them as members of advisory committees that review programme content on adolescent SRH issues and gaining their support in this regard can help to promote adolescent healthcare services in the region.

4. Annexure 1: Terms of Reference

Calling for Expression of Interest from
Consultants / Firms to undertake mapping of the Political Environment and CSOs Networks relevant to Sexual and Reproductive Health and Rights (SRHR) in the nine South Asian Countries

Proposed schedule

Table 1

1.	Tender Inviting Authority	International Planned Parenthood Federation South Asia Regional Office (IPPF SARO)
2.	Job Requirement	'Appointment of Consultant/ firm to undertake mapping of the Political Environment and CSOs Networks relevant to Sexual and Reproductive Health and Rights (SRHR) in the nine South Asian Countries'
3.	Publication of the EoI	February 07, 2014
4.	Contact person for clarification	Ms. Anju Mathur (amathur@ippfsar.org) IPPF SARO, 66 Sunder Nagar, New Delhi - 110003
5.	Last date for receiving queries / clarifications	Feburary 13, 2014 till 5:00 PM
6.	Last date for submission of Bids	Up to 5:00 PM on **February 23, 2014** at the following address: • Office of the Regional Director, IPPF SARO,IPPF House, 66 Sundar Nagar, New Delhi 110003, India. • The proposals sent in ***Two Envelope* system** (as mentioned in clause 13) will only be accepted for bidding process. **Note:** Application sent by email will not be considered for the bidding process

1. Due Diligence

The Bidder is expected to examine all instructions, forms, terms and specifications in the bidding document. The bid should be precise, complete and in the prescribed format as per the requirement of the bid document. Failure to furnish all information required by the bidding document or submission of a bid not responsive to the bidding document in every respect will be at the Bidder's risk and may result in rejection of the bid.

2. Cost of Bidding

The Bidder shall bear all costs associated with the preparation and submission of its bid and IPPFSARO, will in no case be held responsible or liable for these costs, regardless of the conduct or outcome of the bidding process.

3. Clarification of Bidding Documents

A prospective bidder requiring any clarification on the bidding document may notify IPPFSARO in writing or by e-mail. The following personnel may be contacted for this purpose:-

Name of the officer	Contact Particulars
Ms. Anju Mathur	IPPF House, 66 Sundar Nagar, New Delhi 110003 (amathur@ippfsar.org)

The bidder shall submit any queries related to the Bid document in the following format not later than 5:00 PM on **February 13, 2012.**

S. No	Page No	Reference Clause	Queries	Recommendations/Explanation of the Bidder << Name of the Bidder>>

4. Amendment of Bidding Documents

At any time before the deadline for submission of bids, IPPFSARO may, for any reason, whether on its own initiative or in response to the clarification requested by a prospective Bidder, modify the bidding document by amendment.

All such amendments shall also be uploaded on the website of IPPFSARO (www.ippfsar.org) and shall be binding on the bidders.

If required in order to allow prospective bidders reasonable time to take the amendment into account in preparing their bids, IPPFSARO reserves the right to extend the deadline for the submission of bids

5. Validity Period

Bids shall remain valid for 90 days from the date of submission of the bid as specified in this EoI. IPPFSARO holds the right to reject a bid valid for a period shorter than 90 days as non-responsive, without any correspondence.

TENDER DETAILS

Note to the reader:

These Terms of Reference(ToR) do not contain comprehensive documentation of the initiative to be reviewed. It will however contain adequate information needed for the prospective consultant to develop a technical and financial response. Detailed documentation on the project will become available to the selected consultant.

1. Introduction to IPPF and the Change Goals:

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. It is a worldwide movement of national organizations working with and for communities and individuals. 2012 marked the first year implementing IPPF's three Change Goals – Unite, Deliver and Perform[308]. The Change Goals focus and prioritize IPPF's work to deliver its Strategic Framework 2005–2015[309], and guide it to maximize impact for those people who have the greatest unmet needs for sexual and reproductive health. IPPF

[308] Please read more about IPPF's work under the three Change Goals by following this link: http://ippf.org/sites/default/files/ole_apr2012-13_web.pdf

[309] http://www.ippf.org/resource/IPPF-Strategic-Framework-2005-2015

works through a federation of 152 Member Associations (MAs) working in 172 countries and through 6 regional offices and central office headquartered in London.

2. Project Rationale

In recent past the focus of the national governments in South Asia has been towards globalization and developing market economies. In these rigorous processes, there had been a lopsided and inconsistent focus on issues such as SRHR. Moreover, the concept of SRHR has expanded from access to Family Planning to approaching Sexuality from Right's perspective where an individual has a right to have choices related sexual and reproductive health.

In many countries in South Asia, access to comprehensive SRH services is inadequate leading to high unmet need for family planning, high maternal mortality, lack of response to gender based violence, high fertility, unintended pregnancy, unsafe abortion, high child mortality and lack of access to services for HIV/AIDS. Universal access to reproductive health is a key to achieving the Millennium Development Goal (MDGs) 5. Particularly the MDG 5b, 'universal access to reproductive health' is the most off track of all the other goals though importance of reproductive health to development has widely been acknowledged.

With this in view IPPF South Asia office in partnership with Member Associations in South Asia and Asian Forum of Parliamentarians on Population and Development (AFPPD) will implement a European Commission (EC) supported advocacy project in Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan and Sri Lanka.

3. Project Brief

Specifically focus of this project action will be to mobilize political support and strengthen civil society networks to influence favourable political changes in the perspective of sexual reproductive health rights in each of these countries in South Asia.

The key components that this project action focuses on are:

1. Build advocacy capacity of CSOs
2. Increase voice and profile of SRHR
3. National and Regional advocacy
4. Develop Parliamentarian Champions

The outcome of this initiative is expected to result in the following developments in nine countries in South Asia.

- Increased commitment of parliamentarians and policy makers in 9 South Asian countries to sexual and reproductive health and rights (SRHR) -core group of 'champions' developed
- Enhanced capacity of networks of civil society organisations in South Asia to influence political change in favour of SRHR nationally and regionally
- Improved legislation and funding in favour of SRHR in at least 5 South Asian countries as well as regional legislative improvement.
- Increased uptake of SRH services by all people, particularly the most marginalised and vulnerable in 9 South Asian countries

Largely, through this project initiative IPPF aims to build a momentum for the needed political and financial prioritization of SRHR issues in each of these countries in South Asia.

6. Specific Objective of this assignment:

The purpose of this assignment is to assess the status of policies relating to SRHR in each of the nine countries of South Asia and prioritize issues of importance for advocacy and to identify civil society organizations who can partner with IPPF in the effort to improve SRHR profile of these countries. The

outcome document of this assignment will be a referral base for IPPF to further its Advocacy Strategy Plan for South Asian Countries.

The specific objectives are:

1. To REVIEW and develop an updated situational analysis of SRHR in the nine countries in the South Asia region
2. To IDENTIFY potential CSOs working on relevant SRHR issues in these nine countries (minimum 10 for each country) and
3. To DEVELOP a strategic framework for national and regional level advocacy to be undertaken in the next three to five years by IPPF and its Member Associations.

7. Scope and focus:

This assignment requires an exercise focusing on the following areas:

a) **Conceptual overview:** Develop a conceptual overview for the political maps based on internationally recognized definitions of the broad gamut of sexual reproductive health rights and as defined clearly by IPPF.
b) **International commitment:** Develop an overview of relevant treaties that each of these countries have ratified to.
c) **Review of national policy and programme pertaining to SRHR:** Analyze the existing gaps and areas of improvement in the field of SRHR which require advocacy efforts that will ensure "SRHR for all".
d) **Prevalence rate of issues relating to SRH:** Develop an in-depth analysis of the status of SRHR in view of international targets like MDGs, ICPD(International Conference on Population and Development) Plan of Action(PoA) and commitments made at the national level through policies and laws.
e) **Socio cultural and political context:** Articulate an overview on the role of religious leaders, media and civil society organizations in each of these countries.
f) **Review of existing campaigns:** Develop a brief on relevant campaigns related to any SRHR issues that are active in the national and regional level.
g) **Recommendations:** Offer clear set of country specific and possible strategies to be adopted as recommendations for effective and result oriented advocacy and networking with other civil society organizations and government institutes for the next three to five years.

8. Methodology

a. General orientations

This mapping exercise will use qualitative and quantitative data for analysis and to develop the report. Data collection will be done through desk review and validation through semi-structured interviews with key informants and groups. These may include Ministry of Health, academia, UN Agencies, international and local NGOs and donor entities. The consultant/agency will be expected to provide a clear explanation of how all information was validated and recommendations constructed.

Note: A more detailed methodology will need to be proposed by the consultant.

b. Information sources

i. Desk research:

- Policies programmes and status report only from National Government sources such as Demographic and Health Surveys (DHS), National Family Health Survey(NFHS).
- UN treaties, UN data, and data of other leading international agencies like WHO and World Bank.

ii. Interview with Key informant (virtual):

- Government stakeholders of the respective countries.
- UN & Other Donor representatives involved in the programme
- Leading CSO representatives
- Advocacy focal persons of IPPF and Member Associations

9. Role of IPPF SARO

IPPF SARO will assist the Consultant by providing all necessary basic documents (existing relevant report of the respective countries and other IPPF documents related SRH concepts) and by facilitating access to key stakeholders and specific information or expertise needed to complete the document including meetings. The team at SARO will also review and comment on design and content of the document.

10. Deliverables and Timeframe

The assignment should be implemented within a maximum of 6 weeks between **March- May 2014:**

a) **Draft Document:** Upon completion of desk review and field work (if any), the consultant will submit a draft document in English to the team at IPPF SARO. The report should be submitted in the agreed format (Table 2). The draft will be distributed to the SARO team for comments. Comments will be communicated back to the consultant within 10 days of receipt of the draft report. The consultant will document all comments in a tabular format (including who sent them, location in the draft report, whether they were accepted or not, and, if not, why).

b) **Final Document:** The final document shall be submitted within 10 days of receipt of comments from IPPF SARO team, after considering and incorporating the feedback so received.

The report should be a minimum of 45 pages, excluding annexes, presented in a way that makes the information accessible and comprehensible with evidence-based findings, conclusions, lessons and action-based recommendations, use a consistent and conventional system for footnotes and references in the text, and should be structured in the following manner:

Table 2

Acronyms
Executive Summary

1. Brief Background

2. Country Specific Chapters (9) with following heads:

- *Brief country demography*
- *SRHR Situation in the country & key advocacy issues in the current political scenario (including policies and laws which impedes / affect SRHR in the country; refer to point 5. Scope and Focus for more details)*
- *Highlights of the issues relevant from Advocacy perspective*
- *List of CSOs & CSO Networks who are in the forefront in voicing issues of SRHR in these countries.*
- *Record of the MA level networks and partnerships for Advocacy along with the list of future target partners/networks.*

3. Recommendations
4. Proposed Strategy and Results Framework (3 year potential project)

Annexes:
• Terms of reference
• List of persons interviewed
• List of documents assessed

c. Presentation: The consultant will prepare a PowerPoint presentation outlining the process of mapping and analysis , main findings and recommendations, and present to IPPF SAR at an arranged time.

11. Requirements and qualifications

The proposed team should consist of 4-5 consultants with good knowledge and previous consultancy experience in the area of Sexual and Reproductive Health and Rights. The team requirements must include:

Team Leader:

- Experience in conducting and leading advocacy specific political mapping
- In-depth knowledge of sexual and reproductive health rights and minimum of 7 years work experience in Health / gender equality/Human Rights

Team members:

- In-depth knowledge of sexual and reproductive health and rights (expert in Health / gender equality/Human Rights is added value).
- Demonstrated capacity for advocacy related strategic thinking and ability to work collaboratively with multiple stakeholders (experience of support to UN agencies, Government and civil society)
- Good knowledge in capacity development
- Very good knowledge of the political and social situation in South Asia, including public health situation.
- Fluency in English (oral and written)

12. Criteria for evaluating proposals

The proposals will be evaluated sequentially with proportion of technical and financially evaluation as 70:30. The technical proposals will be evaluated on the basis of the following three criteria:

- Proven and relevant track-record in the countries to be covered: Experience of policy and programme research in area of SRH, HIV, youth and safe motherhood including abortion. Preference will be given to agency/ consultant having knowledge of advocacy under SRH/HIV/Health and experience of developing regional learning documents specific to Advocacy Projects.
- Rigor of overall approach and methodology including the work plan and quality-assurance-quality-control procedures
- Details on and exposition of logistics including scheduling, staffing, communication, and overall management

The detail technical evaluation criteria is provided in annex 1 to this EoI.

IPPF SARO will only review financial proposals from agencies/consultant whose technical proposals meet minimum 70% score.

Sl. No.	Description	Details
1	**Stage-I :** • Technical Bid. • Technical Bid Presentation.	This stage is scored out of 100.
	Minimum absolute technical score to qualify for financial evaluation is 70	
2	**Stage-II:** • Financial Bid	Financial bids of only the bidders having the minimum absolute technical score of 70 will be opened
3	**Stage-III** • Joint Technical-Financial Evaluation	Proposals will be ranked according to their combined technical (Tn) and financial (Fn) scores using the weights (T = 0.70 the weight given to the Technical Proposal; P = 0.30 the weight given to the Financial Proposal; T + P = 1).

13. Deadline for submission of proposal

Responses to this Request for **Proposals should be received only by courier with subject; "Regional SRHR Political Mapping"** no later than **February 23, 2014**. Proposals delivered and/or received

after this deadline will not be considered and will be marked as disqualified. The proposal should be enclosed in a **two envelope system** as below:

- *Sealed Envelope A: containing hard and soft copy of the Technical bid. The envelope should clearly provide the contents of the envelop and should be super scribed as "Technical Bid: Hard and Soft Copy".*
- *Sealed Envelope B: containing only hard copy of Financial bid. The envelop should clearly provide the contents of the envelop and should be super scribed as "Financial Bid- Do not open with Technical Bid".*
- *All the above mentioned sealed envelopes (i.e. Envelope A and B) should be enclosed in another envelope 'C' stating the contents of the envelope. The envelope should also indicate the name and address of the Bidder to enable the bid to be returned unopened in case it is declared "late".*

Technical and financial proposals should be prepared as per the given proposal format(Section1 and 2).

Clarifications on the EoI, if required, may be sought by e-mail only – at **amathur@ippfsar.org**

14. Copyright of the report

IPPF SARO reserves the copyright of the report and the agency/ consultant cannot publish the full or part or the report without taking prior written approval from IPPF SARO. Also IPPF SARO reserves the right to review / study the work in progress at any time during the assignment period. Review by IPPF SARO will be performed in such a manner, which will not interfere with the procedure and time schedule.

15. Payment Terms

Schedule of Payments

The amount shall be payable to the successful Bidder/consultant as per the following terms.

S.No.	Deliverable	Amount (%)
1.	**Submission & Approval of Inception Report**	20% of the contract amount
2.	**Submission & Approval of first draft**	30% of the contract amount
3.	**Submission and approval of final draft**	50% of the contract amount

Cont…

SECTION 1: FORMAT FOR TECHNICAL PROPOSAL

1. Covering letter

2. Consultant/consultancy firm details

a) About the Firm/Company

b) Signing Authority

3. Relevant Past Experience

Please provide descriptions of up to 10 relevant projects carried out in the last five years that best illustrate qualifications and capability of your agency/ consultant to conduct the proposed evaluation.

4. Key personnel and staffing

- The bidder should provide the detailed structure of the team proposed for the assignment.
- The bidder should ensure that the CV details should best illustrate the ability of the resource to undertake the assignment ToR.
- For all the above resources the bidder should use the CV Format as given below(Not more than 3 pages):

Proposed position:				
1. Name of Firm/Consultant:				
2. Name of Staff:				
3. Date of Birth:		**Nationality:**		
4. Education:	**Year**	**Institution**	**Degree**	
5. Certifications if any	<<provide details and documentary proof for the same>>			
6. Countries of Work Experience:				
7. Languages:	**Language**	**Speaking**	**Reading**	**Writing**
8. Employment Record:	Total Years of Experience:			
	Year	**Employer**	**Position**	

Proposed position:	
9. Work Undertaken that Best Illustrates Capability to Handle the Tasks Assigned:	**Name of assignment / project:** **Year:** **Location:** **Client:** **Main project features:** **Positions held:** **Activities performed:**

5. Approach & Methodology Proposed for the Project

This section should include your response to the given tasks identified under the scope of work section of this TOR. Details of the methodology for each task must be provided along with description of any additional research that may be needed to complete the task. A detailed methodology for ensuring Quality Assurance and Quality Control (QAQC) measures for conducting the data collection, and analysis should be provided. It would be helpful to describe your plan in terms of your experiences on all these issues. The bidder should cover the following minimum details:

- Understanding of the project and its objectives.
- Overall approach and its responsiveness to the objective of the assignment.
- Methodology to be adopted, with suggested tools, if any.
- Risk Management.
  (The details should not exceed more than 40 pages)

6. Comments and Suggestions

Please clearly identify input required from IPPF SARO on the proposed scope of work and on the data, or other inputs.

7. Timeline and Deliverables

The firm/ consultant needs to submit a timeline for each deliverable within the broad time frame for this project.

SECTION 2: FORMAT FOR FINANCIAL PROPOSAL

As part of its quote, each bidder shall provide a lump sum quote inclusive of taxes. The bidder also needs to provide the breakup of the lump sum quote by cost per type of resource to be deployed, cost of other out of pocket expenses, if any, in the format below. In case the breakup is not given separately as per the formats provided, the bidder would run the risk of being disqualified. The Financial Bids should strictly conform to the formats to enable evaluation of bids.

A special care must be taken to ensure that the bids do not have any hidden costs or conditional costs, as this shall make the proposal liable for rejection.

Proposed Format

S.No.	Category	Total cost in INR
1.	Financial Quote for the project	

S.No.	Category				Total cost in INR
	Resource Perons	**Rate**	**Unit (no of days)**	**Amount**	
	Team Leader				
	Tehcnical Expert				
	Other team members (add more rows, as required)				
	Other Costs (add more rows, as required)				
Taxes thereof @ %					
Total Quote (inclusive of taxes) in INR					

ANNEXURE

Scoring grid for evaluation of Technical Bid

Sl.No.	Evaluation Criteria	Maximum Score
A	**Relevant Past Experience**	**15**
A. 1.	*Experience of working in South Asian countries.*	3
A. 2.	*Relevance of the prior experience with the current assignment*	12
B	**Key Personnel (Proposed Team for this project)**	**25**
	The capability of the proposed Team along with the deployment status: • Team leader /Project Manager (14 marks) • Other team members (25 marks) Some of the parameters to be evaluated would include: • *Total years of experience* • *Past relevant experience* • *Educational qualifications* • *Skill sets proposed* • *The deployment status i.e. the adequate deployment of the team member and their time committed.* The details on these resources should be provided as per the format provided in Annexure 1 along with copies of certification if any	
C	**APPROACH & METHODOLOGY PROPOSED FOR THE PROJECT**	**40**
	Proposed approach and methodology based on the understanding of scope of the project. *Some of the parameters to be evaluated would include:* • *Understanding of the project and its objectives.* • *Overall approach and its responsiveness to the objective of the assignment.* • *Methodology to be adopted.* • *Risk Management.*	
D	**PROJECT IMPLEMENTATION PLAN**	**20**
	• Project plan Some of the parameters to be evaluated would include: • *The detailing of the project plan and coverage of the deliverables as specified in the ToR.* • *Parallel execution of the activities in order to comply with the specified timelines.* • *The deployment of resources for the entire project period*	
TOTAL SCORE		**100**

5. Annexure 2: List of persons consulted

S.No.	Name	Designation	Organization
1.	Dr. Navin Thapa,	Director-Advocacy and Resource Mobilization,	Family Planning Association of Nepal
2.	Ms. Madu Dissanayake	Director-Advocacy	Family Planning Association of Sri Lanka
3.	Dr. Shahram Zarrabian	Chief Executive Officer	Family Health Association of Iran

6. Annexure 3: List of documents reviewed

Title	Policy Document/ Research Article/ Program Document/ Evaluation Document	Year of Publication	Author/ Organization	Citation (Chicago)	Web link
Afghanistan National Strategic Framework for HIV/AIDS	Policy Document	2006	Ministry of Public Health, DG preventive Medicine and PHC, National HIV and AIDS and STI Control Programme	MOPH. (2009). Afghanistan National Strategic Framework. Kabul: DG preventive Medicine and PHC.	www.hsph.harvard.edu/population/aids/afghanistan.aids.06.pdf
National Reproductive Health Policy (2012-2016)	Policy Document	2012	Reproductive Health Task Force	Reproductive Health Task Force. (2012). National Reproductive Health Strategy 2012-2016. Kabul: MoPH.	http://www.nationalplanningcycles.org/sites/default/files/country_docs/Afghanistan/reproductive_health_policyenglish15120131426710553325325.pdf
Afghanistan profile of the sexual and reproductive health services available at primary care level	Program Document	NA	Said Mohd Karim Alawi	Alawi, S. M. (2011). Afghanistan profile of the sexual and reproductive health services available at primary care level. Kabul: MoPH.	www.gfmer.ch/SRH-Course.../A2-010-Alawi-Said-Mohd-Karim.pdf
Young people and the law in Asia pacific	Research Article	2013	Godwin J	Godwin, J. (2013). Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people s access to sexual and reproductive health and HIV services.	http://www.popline.org/node/577897
Reproductive Health in Post-conflict Afghanistan	Case study/Presentation	NA	Iain Aitken	Aitken, I. (2009). Reproductive Health in post conflict Afghanistan. Management Sciences for Health and School of Public Health, Granada.	http://www.unfpa.org/sowmy/resources/docs/library/R053_Aitken_2009_Afghanistan_ReprodHealthAfghanistanCaseStudy_Sep2009.pdf
NATIONAL STANDARDS for reproductive health services-Antenatal Care	Policy document	2003	Multiple authors under Reproductive Health Task Force	Reproductive Health Task Force . (2003). National Standards For Reproductive Health Services Antenatal Care Services. Women's and Reproductive Health Directorate.	http://moph.gov.af/Content/Media/Documents/Anti-Natal-Care29122010164552313.pdf

Title	Policy Document/ Research Article/ Program Document/ Evaluation Document	Year of Publication	Author/ Organization	Citation (Chicago)	Web link
Country progress report-Communicable Disease Directorate	Evaluation Document	2012	Director General of Preventive Medicine and Primary Health Care	Communicable Disease Directorate (CDC). (2012). Country Progress Report. Director General of Preventive Medicine and Primary Health Care.	http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_AF_Narrative_Report[1].pdf
Challenges and Successes in Family Planning in Afghanistan	Research Paper	2007	Miho Sato	Sato, M. (2007). Challenges and Successes in Family Planning in Afghanistan. MSH	http://www.msh.org/resources/challenges-and-successes-in-family-planning-in-afghanistan
Implementation report EVAW	Evaluation Document	2014	MoWA	MoWA. (2014). First report on implementation of EVAW law in Afghanistan. Kabul: MoWA.	http://unama.unmissions.org/Portals/UNAMA/Documents/UNAMA%20REPORT%20on%20EVAW%20LAW_8%20December%202013.pdf
National Family Planning/ Birth Spacing Strategy	Policy Document	2006	Reproductive Health Task Force	Family Planning Working Group, Reproductive Health Task Force. (2006). National Family Planning/Birth Spacing Strategy. Kabul: MoPH.	http://moph.gov.af/Content/Media/Documents/Family-Planning-Strategy-7-March29122010164213335.pdf
Provider Attitudes to Abortion and Abortion Services	Summary report	NA	IPPF SARO	IPPF SARO. (2012). Provider Attitudes to Abortion and Abortion Services.	http://www.chsj.org/uploads/1/0/2/1/10215849/ippfabortionstudyrepdiff.pdf
National HIV Testing and Counselling Guideline	Policy Document	2008	National AIDS Control Program		
National policy on internally displaced persons	Policy Document	2013	Ministry of Refugees and Repatriation		http://morr.gov.af/Content/files/National%20IDP%20Policy%20-%20FINAL%20-%20English(1).pdf
National HIV and AIDS Policy	Policy Document	2012	National AIDS Control Program		http://moph.gov.af/Content/Media/Documents/NationalHIVAIDSPolicy(English)Jan2012226520129381022655332532 5.pdf
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Improving the reproductive health of married and unmarried youth in India	Report on ARH Program in India		Rohini Pande Sc.D		http://www.icrw.org/files/publications/Improving-the-Reproductive-Health-of-Married-and-Unmarried-Youth-in-India.pdf
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Empowerment and Sense of Adequacy in Infertile Couples: A Fundamental Need in Treatment Process of Infertility - A Qualitative Study	Research Article	2014	Ali Zargham-Boroujeni and Fatemeh Jafarzadeh-Kenarsari, , Isfahan University of Medical Sciences, Iran	Zargham-Boroujeni, A., Jafarzadeh-Kenarsari, F., Ghahiri, A., & Habibi, M. (2014). Empowerment and sense of adequacy in infertile couples; a fundamental need in treatment process of infertility: A qualitative study. The Qualitative Report, 19(11), 1-14	http://www.nova.edu/ssss/QR/QR19/zargham-boroujeni11.pdf
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The Global Family Planning Revolution	Book	2007	The World Bank	Robinson, W. C., & Ross, J. A. (Eds.). (2007). The global family planning revolution: three decades of population policies and programs. World Bank Publications.	http://siteresources.worldbank.org/INTPRH/Resources/GlobalFamilyPlanningRevolution.pdf
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Poor Thermal Care Practices among home births in Nepal : Further analysis of Nepal Demographic and Health Survey 2011	Research Article	2014	Vishnu Khanal, Tania Gavidia, Mandira Adhikari, Shiva Raj Mishra, Rajendra Karkee (plos.org)	Vishnu Khanal, T. G. (2014, February 28). Retrieved from plosone.org: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0089950	http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0089950
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Pregnancy reducing maternal death	Article	2003	Professor Dulitha Fernando	British Medical Bulletin (Pregnancy-reducing maternal deaths and disability in Sri Lanka: national strategies) http://bmb.oxfordjournals.org/content/67/1/85.full	http://bmb.oxfordjournals.org/content/67/1/85.full
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Reproductive health and family planning programme in Sri Lanka	Research article	2008	Dr. A.T.P.L. Abeykoon Senior Fellow Institute for Health Policy		www.icomp.org.my/new/uploads/fpconsultation/ATPL%20abeykoon.pdf
Infertility in Sri Lanka	Blog	2011	Kumar	Infertility in Sri Lanka (Infertility in Sri Lanka) http://www.infertilitysrilanka.blogspot.in	www.infertilitysrilanka.blogspot.in

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National HIV/AIDS Policy: Sri Lanka	National Policy		National STD/AIDS control programme		http://www.aidscontrol.gov.lk/web/images/web_uploads/Policy_or_Law/National%20HIV-AIDS%20Policy%20Sri%20Lanka%20Book.pdf
National STD/AIDS Control programme, Department of Health Services	surveillance data	2009	Department of Health Services	http://un.lk/wp-content/uploads/2012/09/1147.pdf	http://un.lk/wp-content/uploads/2012/09/1147.pdf
Adolescent sexual and reproductive health in Sri Lanka	situational analysis	Jul-05	Dr. Sujatha Samarakoon	http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2013/ASRH%20situational%20anaylis.pdf	www.http://asiapacific.unfpa.org/webdav/site/asiapacific/shared/Publications/2013/ASRH%20situational%20anaylis.pdf
Sri Lanka's Success Story in Population Management: A Lesson for Other Programmes	Report	June/July 2011	Dr. A.T.P.L. Abeykoon		http://www.ihp.lk/publications/docs/Successstory.pdf
Review of Research Evidence on Gender Based Violence (GBV) in Sri Lanka	Evaluation Document	2011	Professor Jennifer Perera	http://whosrilanka.healthrepository.org/bitstream/123456789/434/1/GBV.pdf	http://whosrilanka.healthrepository.org/bitstream/123456789/434/1/GBV.pdf
National Strategic Plan Adolescent Health (2013-2017)	Policy	2013	Family Health Bureau		www.familyhealth.gov.lk/.../index.php?...453%3Anational-strategic-plan
National Health Development Strategy 2013-2017	Policy	2013	Family Health Bureau		http://www.health.gov.lk/en/publication/NHDP2013-2017-page1-100.pdf
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