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Promoting Sexual and Reproductive Health Rights (SRHR) to the Adolescents in Bangladesh: Policy Prospects and Challenges

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Abstract— Sexual and reproductive health and rights (SRHR) are a concept of human rights applied to the sexuality and reproduction of human beings. Most Bangladeshis, especially adolescents in rural areas, are still unaware of these rights for countless reasons. A significant barrier towards such awareness is created. There has been some research in recent times covering various aspects of SRHR in Bangladesh. Nevertheless, the element that makes this research unique is that it is aiming to analyze in a doctrinal or qualitative manner if the existing laws and policies are enough to ensure that adolescents have access to knowledge and information on SRHR, or whether any major or minor reforms to existing legal framework are necessary. The research would like to prove the necessity of enacting legally enforceable national policies to ensure that adolescents in Bangladesh have access to SRHR education, which is very important in protecting their sexual and reproductive health and well-being.

Keywords— SRHR (Sexual and Reproductive Health and Rights), Adolescents, National Policy, Bangladesh, Education

Introduction

Sexual and reproductive health and rights (SRHR) represent a framework of human rights that pertains to the sexuality and reproduction of individuals. Nevertheless, in Bangladesh, a significant number of individuals still do not acknowledge the idea of SRHR as an essential human right. A significant number of individuals in Bangladesh, particularly adolescents in rural regions, remain uninformed about these rights due to various factors. A notable obstacle to achieving such awareness is established by social institutions like mosques and temples, which are regarded with religious reverence; both Muslims and Hindus frequently perceive this topic as taboo. The adolescents lack awareness or have not been informed about the critical details concerning these facts, which pose significant risks to their physical, mental, and social well-being. Sexual and reproductive health and rights are essential for the realization and exercise of the right to health. This right is fundamentally linked to the right to life, recognized globally as part of the universal, inalienable, indivisible, inviolable, and unavoidable human rights, and is also enforceable as a fundamental right within national constitutions. Recent studies have explored various aspects of SRHR in Bangladesh.

Nonetheless, the distinctive aspects of this study lie in the Researchers' focus on a specific demographic of adolescents, particularly in certain rural regions of Bangladesh, to investigate the reasons behind their lack of awareness regarding SRHR. The study will involve the administration of questionnaires and interviews, complemented by field visits to various rural areas. This will include engaging with adolescents, their family members, and community members of all ages. The Researchers aim to visit various schools and colleges in those

areas to distribute questionnaires and conduct interviews with both male and female adolescents as part of their qualitative study. Additionally, they plan to carry out interviews with specialists in this area to gather their insights and perspectives on the adequacy of current laws and policies in providing adolescents with access to knowledge and information regarding SRHR, and to determine if any significant or minor reforms to the existing legal framework are required. Utilizing the data gathered through these qualitative research methods, they aim to demonstrate the critical need for implementing legally enforceable national policies that guarantee adolescents in Bangladesh access to SRHR education, essential for safeguarding their sexual and reproductive health and overall well-being.

The young men and women of today represent the future of this nation. Consequently, it is essential for all adolescents in Bangladesh to possess the necessary understanding of SRHR, and the Government must facilitate this through suitable policies. The current situation demands urgent attention, and this study seeks to contribute positively to society.

Literature Review

In 2004, Haseen and Deb set off to determine the effectiveness of school-based interventions in Bangladesh among adolescent students [1]. They also identified the complexity of adolescent reproductive health interventions and the need to be flexible [2]. However, their works have not recognized SRHR as a right and how that right shall be ensured in the form of education properly through national policy. Khan and Raby emphasize the perspectives of teachers and parents; they talked about children and adolescents, especially boys. Their research discusses how nine Bangladeshi young men aged 19–24 learned about sex and sexuality during their adolescence, how they interpreted what they learned, silence from parents, lack of school-based sex education, unreliable peer navigators, pornography as an opposing force, and the relevance of embodied learning [3]. The research did not show a proper effective measure to use as problem solving, let alone national policy. Hellwig, in his research, also sought opportunities to perform additional trials to determine whether the Girl Talk App improves sexual health knowledge, increases contraception usage, and decreases sexually transmitted infections and unplanned pregnancy [4]. Through our research, we tend to do the same things in Bangladesh through national policy to ensure SRHR education for adolescents.

Rashid, in his research supported by BRAC, focuses on the attitudes of Bangladeshi parents. He talks about the Adolescent Reproductive Health Education (ARHE) programme for adolescent men and women in rural areas, and religious views on sex education in Bangladesh's school curriculum [5]. This research showed both positive and negative parents' views on including SRHR as a subject in the curriculum. But this research lacks the recommendation of practical measures that should be taken through National policy to counter the obstacles to make it successful. Reeuwijk and Nahar have analyzed common approaches like awareness-raising through the Community-based model, Peer model, School-based model, Community Mobilization, and service delivery. The researchers also studied physiological changes in married and unmarried adolescents during adolescence [6]. However, Reeuwijk and Nahar lack coordination between stakeholders and collaboration with the Government and that's a major problem of their research as awareness raising approaches need to be initiated by the Government to be more effective.

Articles 19 and 32 of the Constitution of the People's Republic of Bangladesh impliedly indicate SRHR education as right. Home Economics books and Physical Education books of classes 6-10 in Bangladesh cover some aspects of this subject matter: menstruation and cleanliness, physical and psychological change in adolescents. However, there is no proper guideline instructing adolescents to follow an appropriate way of maintaining sexual health and reproductive hygiene. With the appropriate interpretation of the afore-mentioned Articles of the Constitution and the addition of some new topics in the above-referred books, SRHR knowledge can be promoted. Moreover, through a national policy, we can we can achieve the aims of our research, that is to promote SRHR knowledge in a cost-effective way through national policy to the adolescents in Bangladesh. Bangladesh Population Policy of 2012 aims to raise awareness among adolescents on family planning and reproductive health. The National Health Policy of 2011 similarly has objectives and strategies that are comprehensive and include addressing adolescent health by focusing on ensuring good quality health care for all Bangladesh citizens. Also, the Bangladesh National Children Policy of 2013, Education Policy of 2010, the Child Labour Elimination Policy of 2010, and the Nutrition Policy of

2015. All contribute to addressing adolescent health issues.

Several laws exist which directly or indirectly contribute to addressing the overall health and wellbeing of adolescents. These include the Children Act 2013, Women and Children Repression Prevention Act 2000 (amended in 2003), the Human Trafficking Prevention and Deterrence Act 2012, the Child Marriage Restraint Act 1929 (amended in 2017), the Child Marriage Restraint Act (1984 Amendment Ordinance), the Penal Code 1860 (Sections 312– 314), and the Cruelty of Women Act (Deterrent Punishment Act of 1983). These laws have the potential to be effective as national policies promoting SRHR education in Bangladesh. Through this research, we hope to determine whether there is a need for any new code to implement existing national policies or to make new ones promoting SRHR education to the adolescents in Bangladesh, or whether the existing laws are enough or need some slight modifications.

Almost All research that researchers have carried out in this field is either focused on parents' behaviors regarding SRHR as a subject of education or existing policies through which Government and NGOs may deal with the situation. Also, none of the research studies have been significant enough to lead to effective solutions or measures through which SRHR can be made a subject of education in Bangladesh through the proper new policies made by the Government. Furthermore, the majority of the research works have focused only on either men or mostly women.

Methodology

This research utilizes a doctrinal approach to assess the importance of Sexual and Reproductive Health and Rights (SRHR) education for adolescents in Bangladesh. The study also evaluates the role of national policies in facilitating adolescents' access to SRHR education in a qualitative manner by examining existing national laws and policies concerning SRHR education in Bangladesh and its reach towards the adolescents of the country to find out the lacking in them (if any).

The study hypothesizes that the effective implementation of existing national laws and policies, with potential amendments or the introduction of new, cost-effective policies, will reduce the challenges in promoting SRHR education among adolescents in Bangladesh.

What is SRHR?

The human rights concept regarding sexuality and reproduction is known as sexual and reproductive health and rights is one of the most crucial human rights concepts existing, also known as SRHR. This concept has four parts: sexual health, sexual rights, reproductive health, and reproductive rights. However, distinctions between the four fields of SRHR are not always made. For example, sexual health and reproductive health are sometimes used interchangeably, as are sexual rights and reproductive rights (Ahmed & McGovern, 2023). Enshrined in the 1948 Universal Declaration of Human Rights (UDHR) and other international human rights consensus agreements, declarations, and conventions, sexual and reproductive health (SRH) is a crucial component of the universal right to the highest possible attainable standards of both physical and mental health [7]. SRH needs must be met for all individuals, irrespective of their age, sex, gender identity, and/or sexual orientation. Human rights standards require states to protect, respect and fulfill sexual and reproductive health rights. The conditions also require that everyone has the opportunity to participate in individual care decisions such as when and whether to have children as well as the development of health care policy in protection of the rights of others to sexual and reproductive health through ensuring home, violence-free relationships, and in seeking education, information, and care for one’s children [8].

Sexual Health

Men and women should be able to express and enjoy their sexuality free from the risk of sexually transmitted diseases, coercion, unwanted pregnancy, violence, and discrimination [9]. As per the definition of Sexual Health provided by the World Health Organization (WHO) emphasized that Sexual health concerning sexuality is a state of social, mental and physical well-being. It requires a respectful and positive approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence [10].

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Sexual Rights

Sexual rights are norms that emerge when existing human rights are applied to sexuality. These rights include equality, anatomy, dignity, integrity, equality, and privacy; principles recognized in many international instruments as particularly relevant to sexuality. The struggle for sexual rights, on the contrary, includes and focuses on emotional, sexual expression, and sexual pleasure, unlike the other three aspects of SRHR.

Reproductive Health

Within the World Health Organization's (WHO) framework, health is defined as a state of complete social, mental, and physical well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene. It addresses the reproductive processes, functions, and system at all stages of life [11]. Therefore, it implies that people should have a safe satisfying, and responsible sex life and have the reproductive capability and freedom to decide if, how, and when.

Reproductive Rights

Reproductive rights are considered legal rights and freedoms relating to reproductive health and reproduction. According to the World Health Organization's definition, reproductive rights rest on recognizing the fundamental right of individuals and all couples to decide freely and responsibly the number, spacing, and timing of their children and have the means and information to do so, and the right of attaining the highest standard of reproductive and sexual
health including the right to make decisions concerning reproduction free of discrimination, coercion, and violence [12].

SRHR IN BANGLADESH AND THE IMPORTANCE OF PROMOTING KNOWLEDGE ON SRHR

SRHR in Bangladesh

While Bangladesh has made progress in delivering maternity, neonatal, and child health (MNCH) and family planning (FP) support services, there are still significant gaps and unmet needs. High maternal mortality and morbidity remain essential concerns in the country, with an estimated 5,200 mothers dying each year from pregnancy-related causes [13]. Family planning, competent birth attendants at births, prenatal, postpartum, and emergency obstetric care are all life-saving services that impact fertility, maternal mortality, and morbidity rates. According to the Bangladesh Bureau of Statistics (BBS) 2015, Bangladesh's teenage population (between the ages of 10 and 19) accounts for more than one-fifth of the country's overall population of 36 million people. Although many initiatives (policies, strategies, and programs) are in place to protect adolescents' rights, current trends in sexual and reproductive health (SRH) of adolescents point to the need for a rights-based approach to protect adolescent and youth sexual and reproductive health and rights (SRHR) [14]. Because of their lack of understanding of puberty, sexuality, and fundamental human biological changes, adolescents have significant obstacles in satisfying their sexual and reproductive health (SRH) requirements. Early pregnancy, sexually transmitted diseases (STIs), sexual violence, weak negotiation skills, forced marriage, and high fertility rates are caused by these underlying issues [15]. One of the primary reasons for this problem is that most people in Bangladesh, both males and females, particularly in rural areas, lack sufficient knowledge about SRHR. The adolescent period is the best time to learn about SRHR. During this time, both males and females are students. Student life is a time for studying and obtaining knowledge about various topics that are significant in one's life. Sexuality is a basic human need that must be correctly learned about living a more sexually healthy and hygienic life. Adolescence is a time when young people are going through the different stages of puberty and experiencing physical changes, and all of these developments to the body are very new and often confusing, and the changes also impact a child's emotional and psychological well-being. It is very important at this stage, therefore, to know why these changes are taking place, and to have answers to questions that will arise naturally, to clarify misconceptions and misinformation about bodies and sex and sexuality and reproduction and things like gender identity, so children can develop a healthy sense of self-respect, and have a positive image their changing bodies, and understand things like bodily autonomy – and access to comprehensive SRHR education / CSE is therefore the best way for adolescents to get appropriate and accurate information regarding

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the above in addition to adolescence being the time of life when young people are students and are more receptive to knowledge.

However, Bangladeshi adolescent students, particularly in rural areas, are not well informed about SRHR, and as a result, the rate of sexually transmitted diseases, early marriage, child mortality, and early pregnancies is high.

To better meet the health needs of adolescents, the government is working to advance the health sector and has made significant commitments to SRH in its 2016- 2020 five-year plan. Several issues, however, remain concerning, 'in terms of addressing the SRH of adolescents [16].

- The government has established an adolescent-friendly health corner (AFHC), but its operating hours (9 a.m. – 2 p.m.) are inconvenient for students, as most attend school during those hours.
- The National Strategy for Adolescent Health 2017-2030 (NSAH) makes no mention of lesbian, gay, bisexual, and transgender (LGBT) and non-binary adolescents in its suggested measures, implementation strategies, or, more specifically, in the section on vulnerable adolescents and adolescents under challenging circumstances.
- The strategy lacks a tailored, age-appropriate SRH program for younger adolescents (ages 10 to 14). Policies and programs must address early adolescents. This is the age at which gender and sexual norms, values, and attitudes begin to develop, and many adolescents begin sexual activity during or shortly after this period.
- Among other concerns, there is a dearth of an explicit focus on STIs, mainly HIV services for adolescents. According to ASRH reports, only 12% of ever-married Bangladeshi adolescents have a thorough understanding of HIV/AIDS. Other sexually transmitted diseases are far less well-known than HIV. Additionally, most programs prioritize reproductive health (e.g., family planning, maternal care, and so on) but overlook sexual health [16].

However, Bangladesh fails in this area most significantly because it has yet to identify and promote SRHR as a fundamental human right. Adolescents in Bangladesh have little access to information on SRHR. Additionally, sex and sexuality are considered taboo by parents, especially in rural parts of the country. They are ashamed and reluctant to learn about SRHR for themselves, or to educate their children. As long as this age-old traditional limitation on knowledge of sex and sexuality remains in place, Bangladesh may face health problems in addition to failing to keep up with global contemporary understandings of sex and gender. Not only that, religious organizations in Bangladesh also act as significant impediments to promoting SRHR among adolescents, and in Bangladesh, treating sex and sexuality as taboo has created an emerging risk to public health. Additionally, SRHR as a human right must be established, which is not currently the case in Bangladesh. The interconnection of human rights is reflected in every element of SRH and the rights, policies, and funding required for ensuring universal access to SRH. Adolescents in Bangladesh lack access to complete SRHR information and services due to poverty, inadequate healthcare and transportation, and a lack of awareness, particularly in rural regions. Infrastructure, ineffective administration, insufficient training of healthcare professionals, and a lack of dependable supplies and supply chains are only some of the obstacles [17]. The absence of strategies and initiatives to promote SRHR knowledge among adolescents in Bangladesh should be viewed as the primary issue that needs to be addressed with utmost urgency. Without appropriate information, the adolescent period, with all of its challenges associated with puberty, can become more complicated for young people to navigate. To overcome these barriers, preventive health measures such as regular health worker visits and state-sponsored online resources dedicated to this age group may be beneficial [16].

Importance of Promoting Knowledge on SRHR to Adolescents

Sexuality education is one way of recognizing and promoting human rights skills, values, and knowledge necessary for the realization of bodily autonomy and personal liberty, making informed sexual and reproductive choices, ensuring gender equality, and sexual and reproductive well-being, including the prevention of HIV and other sexually transmitted diseases, among other things. As per evidence, comprehensive, scientifically accurate, culturally and age-appropriate, gender-sensitive, and life skills-based sexuality education can provide young people with the skills, efficacy, and knowledge to make informed decisions about their sexuality and lifestyle [18].

The right to information, education, and comprehensive sexuality education are enshrined as sexual rights in the 16 sexual freedoms of the WAS Declaration [18]. Everyone's right to education has been internationally acknowledged

by various treaties, conventions, declarations, and other international human rights instruments. Education is the birthright of all human beings. However, the concept of education is sometimes narrowed down to a limited number of subjects, issues, or courses. Such a restricted view cannot be the prime conceptual purpose of education. Education means learning everything essential to life. Sex and everything relating to sexuality are amongst the most fundamental parts of a human's daily life. People should have access to age-appropriate and accurate information that allows them develop a basic understanding of the physical and psychological aspects of sex and sexual and reproductive well-being, including safe and healthy sexual practices and choices, and other crucial issues related to sexuality and reproduction, while they are still young. The adolescent period is such a time in a person's life when one way of recognizing and promoting knowledge on multiple subjects. In a changing world, comprehensive sexuality education or CSE is an essential part of a decent education that helps to prepare young people for a happy, healthy, and fulfilling life [19]. It improves sexual and reproductive health outcomes, promotes safe and gender- equitable learning environments, and improves education access and achievement. Governments of developed countries have acknowledged the rights of adolescents to have sexuality education, and have done for quite some time now. The adolescent period is the best time to learn and study sexuality. In this time, people change not only physically but also emotionally and psychologically. They need to know about the changes to their bodies, hormones, mentality, the use of safe and informed sexual and reproductive practices, the right to bodily autonomy, and the rights to consent and choice and control over personal decision- making, and have sufficient awareness of any health risks or sexual and reproductive diseases, which can be ensured through the proper promotion of knowledge on SRHR.

Family life education (FLE), relationships and sex education, SRH education and life skills education, devoted sexuality education, population education, and program sexuality education can all be offered through various programming modalities as mediums of promoting knowledge on SRHR to adolescents, according to UNESCO. Four overarching principles guide UNFPA's work on sexuality education: achieving social equity by paying particular attention to vulnerable groups; protecting young people's rights, particularly their rights to health, education, and civic participation; maintaining cultural sensitivity by advocating for sexuality and reproductive health in cruel and engaging ways; and affirming a gender perspective that, while not perfect, is a step in the right direction [20]. SRH education should be made a required learning component, according to UN treaty monitoring organizations. The CEDAW Committee on the Elimination of Discrimination Against Women (CEDAW) urges all Member States to implement compulsory sex education in all educational institutions [21]. A good education should support young people in developing the information, skills, and ethical values they need to make informed and healthy choices about relationships, sex, and reproduction, in addition to the usual academic focus. The importance of receiving a high- quality education cannot be overstated. In a world marked by complexity and uncertainty, it is essential.

CRITICAL ANALYSIS OF EXISTING POLICIES REGARDING SRHR

National Health Policy 2011

The main goal of any national health policy is to create an egalitarian condition that ensures that the country's citizens have a functional health status. However, most countries around the world refer to health policy as "medical care policy [22]. Although Bangladesh has made significant progress over the years in ensuring access to healthcare, the country still faces several crucial challenges that require immediate attention. One of the most significant issues impacting Bangladesh's healthcare system is a lack of necessary financial resources [23]. For the fiscal year 2019–2020, the current healthcare budget allocation is 1.02 percent of Bangladesh's GDP, whereas the value is 2.5% in India and 2.33% in Myanmar [24]. In Bangladesh's National Health Policy 2011, there is no clear strategy to enhance GDP contribution and per capita total health expenditure in the health sector [25]. The health information system (HIS) is one of the most critical components of any health system [26]. A health information system (HIS) refers to a system designed to manage healthcare data. This includes systems that collect, store, manage and transmit a patient's electronic medical record (EMR), a hospital's operational management or a system supporting healthcare policy decisions. Health information systems also include those systems that handle data related to the activities of providers and health organizations. As an integrated effort, these may be leveraged to improve patient outcomes, inform research, and influence policy-making and decision-making. Because health information systems commonly access, process, or maintain large volumes of sensitive data, security is a primary concern. Bangladesh's HIS is still in its infancy. There is no clear plan in place to improve the HIS.

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Sexual and Reproductive Health and Rights in National Curriculum

Bangladesh has a patriarchal and conservative society with traditional values and religious beliefs that make it challenging to create a welcoming environment for SRH education.

Having outlined major discourses and their positive role on the national curriculum in promoting SRHR, some key hindrances to providing sexuality education will be overviewed. These include lack of access to information, curriculum content issues, acknowledgment of diversity, pedagogical approach, the role of teachers in sexuality education, and the role of parents and communities and their possible opposition to sexuality education. The right of young people to complete and accurate information and education on SRHR is enshrined in the Convention on the Rights of the Child and the commitments made at the ICPD. Complete information covers various sexual and reproductive health themes, ranging from gender relations and equality to responsible sexual activity and STI and HIV prevention [27]. Despite this, the lack of SRH education and knowledge continues to be a problem. The poorest girls and women have the fewest opportunities for knowledge and services. Stigmatization may result from such practices and cultural understandings, preventing the exercise of sexual and reproductive health and rights [28]. The transmission of disinformation, or non-scientifically based information, is also a significant concern.

Another issue of concern is parental or communal resistance. Teachers often feel confined and find it difficult to challenge current norms and beliefs when they are forced to teach things that contradict societal values, standards, and religious notions. Instead, they try to stay away from conflict. Societal circumstances can be hostile to sex education in general or amenable to forms that are solely intended to impose prevailing norms [29]. Although SRHR instruction is included in the curriculum, our teachers fail to communicate the material. The chapters on reproduction and reproductive health are stapled in most textbooks, however most schools require pupils to cover these chapters at home. Sexuality education programs are frequently dominated by health or moral discourses, frequently chastised for being clinical, overly technical, impersonal, prevention-oriented, doom-laden, and limited in scope [30]. Such content shows little resemblance to young people's lived experiences in varied socio-cultural contexts. Gender disparities in the way different genders are treated by society are at the heart of many SRHR challenges. Nonetheless, many sexualities education programs neglect to include gender analysis regarding challenges faced by different genders, which isolates sexuality education from the socioeconomic and cultural context in which sex occurs.

Simply teaching adolescents about sexuality does not guarantee that the harmful health consequences sought by sex education programs will be avoided. Similarly, when sex education is presented as a set of moral prohibitions against premarital sex, it silences adolescents from having deeper conversations about sexuality and their thoughts and experiences [31]. Many sex education programs lack role plays or tools to help students learn how to negotiate, express themselves, and say no. The prevalent morals and values of a culture, which invariably impact how sexuality education is administered in schools, are a last source of worry. Frequently, such cultural norms and ideals stifle or directly prohibit discussion of some aspects of sexual diversity [32].

National Population Policy 2012

The government has done many positive things and made many good plans under the National Population Policy 2012. It is unclear, however, how the various Govt. and Non-govt. organizations will collaborate with them. The issue of coordination between several organs is not addressed in the policy. In order to accomplish these goals, the government has become increasingly reliant on its affiliates and non-governmental organizations (NGOs), which may obstruct the policy's execution.

The population of Bangladesh is 18.6 percent adolescents aged 15 to 24 and 29.4 percent young people aged 10 to 24 years old, according to the Bangladesh Bureau of Statistics (BBS). Because most young people attend school before becoming sexually active, schools are well- positioned as an intervention site [33]. However, they are frequently ignored when it comes to resolving the issue. Bangladesh's rapid population expansion drew national and international attention during its first five-year plan (1973-1978), as its overall population had quadrupled in the previous century. The high mortality rate, poverty, rural economic base, increased prevalence of child marriage, lack of education, son preference, and male dominance all play a role in the low socio-economic status and destitution in Bangladesh. The Ministry of Finance is responsible for allocating funds to the Directorate General of Family Planning to implement the family planning program under this policy, although no precise allocation has been set

for other ministries. The efficient utilization of a large workforce did not prioritize policy, which might stymie economic development. Religious institutions are not included in the policy. It can be considered one of the policy's most serious flaws. In our country, religion plays a significant role. Without this, the policy's execution could be regarded as impossible.

Family Planning 2020

Towards recent decades, FP has lost credibility, with numerous signs pointing in the other direction. Child marriage is on the rise, and teen pregnancy is still a concern. Unmet needs are more common among adolescents than among adults, exacerbating the situation. Compared to what is required to meet the city's ever-growing population, urban regions, mainly slums, are neglected. There has been a lack of closer collaboration between DGFP and DGHS in implementing FP programs. In most areas, a shortage of human resources prevents FP services from continuing regularly.

Furthermore, according to 'Costed Implementation Plan for National Family Planning Program in Bangladesh (2020-2022)', vacancies are more common in hard-to-reach areas, severely restricting services to the most vulnerable. LARC&PM services are now available in only 26% of facilities, and more than a third of district hospitals lack them. Because clinical providers are critical to the delivery of LARC&PMs, the human resource crisis in this sector could significantly impact the success of LARC&PMs. In addition, because the FP sector is designed to be women-centric, gender conventions and the socio-cultural backdrop make it challenging to engage male clients.

Menstrual Health Strategy 2001:

In 1979, the Bangladeshi government introduced the Menstrual Regulation Policy [34]. They were designed to guarantee adequate health safety through menstrual regulation. Despite this fact, many women are unaware of its advantages. Three out of every ten public and private sector organizations that may potentially provide MR services lacked essential MR equipment, qualified personnel, or both in 2014.

Furthermore, despite having trained employees and equipment to perform MR techniques, many facilities failed. Even while 63 percent of commercial facilities claimed to have both the equipment and trained people, only around one-third of them supplied MR. In 2014, public and private facilities denied MR services to an estimated 105,000 women. Approximately a quarter (27%) of all women seeking MR at these types of facilities fall into this category. The majority of institutions indicated they turned away women seeking MR because they had been without a period for longer than the allowed number of weeks or for medical reasons. Some providers, on the other hand, cited societal or cultural reasons that ran counter to official policy: women were turned down by 27% of respondents because they were childless, 6% because they were unmarried, 7% because they thought the woman was too young, and 8% because the woman's husband had not given his consent [35].

National Nutrition Policy 2015

Agricultural policy and research in low-income nations have centered on raising staple food production to fulfill the requirements of a growing population [36]. Much less emphasis has been paid to manufacturing the wide range of foods required to provide a balanced diet rich in vitamins and minerals. This is a significant worry because micronutrient deficiencies, such as vitamin A and zinc, have been linked to poor child health and death. These issues also exist in Bangladesh's nutrition policy. Bangladesh's government has placed a greater emphasis on food availability than on food variety. As a result, diverse food characteristics of different sorts of food are impossible to obtain. Many people are also unaware that there is a nutrition policy in place. As a result, they are oblivious to the different nutrients. This policy does not apply to a vast portion of the population.

National Women's Development Policy 2011:

Among the poor in rural Bangladesh, systems of patrilineal descent, patrilocal residence, and purdah (the practice of secluding and protecting women from upholding social standards of modesty and morality) interact to isolate and subordinate women. Women are economically and socially reliant on men. Cultural standards are built on uneven assumptions about what is proper for each sex and what males and females require and are entitled to. Girls' education is frequently dismissed, and they learn to accept deprivation compared to male family members at a young

age. Many women are confined to the homestead and the local surrounding area due to purdah, and their interactions with the outside world are minimal. These social norms curtail women's market transactions and constrain their potential to generate incomes, reinforcing their economic dependence.
These challenges were not addressed in the National Women's Development Policy 2011. The government did not devote the needed number of staff and scope of work when implementing this strategy. Consequently, there was no equality between men and women in society as a result.. The presence of women in primary education was confirmed, but it could not be protected subsequently. Child marriage is a pervasive social problem that affects people at all levels of society. As a result, there is no way to expedite women's growth.
This legislation disregards several health protections, particularly women's reproductive health, which is one of the major roadblocks to a healthy nation. In many ways, a nation's future health and knowledge protection are dependent on all of these women's protections. Even though the Women's Development Policy raises many essential topics, many elements are left out that impede the building of a civilized nation.

National Cervical Cancer Strategy:
Cervical cancer is the fourth most frequent malignancy among women worldwide, with roughly 70% of cases involving infection with HPV genotypes 16 and 18. According to the International Agency for Research on Cancer, over 50 million Bangladeshi women are at risk of cervical cancer, with 17 686 new cases and 10 362 deaths occurring each year. Cervical cancer, on the other hand, can be successfully treated if detected at an early stage [37]. In Bangladesh, there is little awareness of the benefits of early detection and prompt treatment in eliminating cervical cancer. First and foremost, the cervical cancer patients are unconcerned about the situation, which has the consequence of causing harm. Bangladesh's healthcare system suffers as a result of this. Despite having a National Cervical Cancer Strategy, the government has failed to control the disease.

Maternal Health Strategy 2009:
Maternal morbidity, like maternal death, is considered a public health emergency in Bangladesh. In Bangladesh, reliable data on health concerns during pregnancy is sparse, making estimates of morbidity problematic. According to the little data available from the Demographic and Health Survey (DHS), girls and women had a higher frequency of disease and malnutrition than men. According to new information, the frequency of sexually transmitted illnesses is significant, and the spread of HIV/AIDS is a significant issue. Iron deficiency anemia is frequent among Bangladeshi girls, particularly in rural areas, and it affects 50 to 90 percent of pregnant women in the country. According to the DHS, from 2000, 13.8 percent of women experienced complications during their previous pregnancy. The most prevalent side effects were abdominal discomfort (25.31 percent), leg or body swelling (23.33 percent), anemia (19.94 percent), urinary problems (16.76 percent), eclampsia (1.99 percent), and hemorrhage (3.51 percent). According to a national survey of reproductive-age women who had at least one pregnancy, the prevalence of antepartum morbidity that is "life- threatening" is 5.7 percent (2.7 percent for bleeding and 3.0 percent for fits/convulsion), and the prevalence of high-risk antepartum morbidity is 22.7 percent for edema, 3.6 percent for hypertension, 16.9 percent for fever lasting more than three days, and 15.7 percent for a fever lasting more than three days [38]. One of the primary underlying reasons for Bangladesh's poor maternal outcomes is the low percentage of women who receive adequate medical treatment for deliveries and complications. Only 7.9% of predicted deliveries occur in hospitals, and only 5.0 percent of expected difficulties necessitate hospital treatment. These maternal delivery issues are the result of mistakes in the Maternal Health Strategy. This is due to the government's lack of foresight and capacity to put in place effective policies.

Neonatal Health Strategy 2009:
The government has taken various measures to reduce maternal and child mortality and protect the health of newborns. To this end, the National Neonatal Health Strategy and Guidelines for Bangladesh were adopted in 2009. However, there has been a lack of transparency and accountability. The government has taken various initiatives in this commendable regard. Due to a lack of adequate law and law enforcement, problems are being produced. Another factor is that the poorest people do not benefit from these prospects. Often, opportunistic individuals or groups attempt to benefit the general public through public officials and government employees.

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National AIDS/STD Program:

The percentage of people in the five Key Population categories (FSW, PWID, MSM, MSW, and Hijra) who were fully aware of HIV/AIDS ranged from 15% to 28%. A high level of ignorance about HIV viral transmission contributed to the rate infection as well as rate of death. The lowest rates of getting core services were seen in all categories of KPs, with Hijra having the most significant rate of 54 percent and female PWID having the lowest rate of 29 percent. The program's low number of KPs receiving BCC services significantly reduced the number of KPs receiving core services.

Lack of comprehensive knowledge about HIV/AIDS, particularly about its transmission and preventive measures, has been an essential factor for preventing HIV/AIDS. CBCC programs were miserably inadequate due to a lack of skilled counselors and communicators, communication tools, and empathy among certain essential care professionals.

National Adolescent Reproductive Health Strategy, 2006 & National Strategy for Adolescent Health 2017-2030:

NAHRS played an essential role in introducing the specific SRH needs of adolescents into the existing sexual and reproductive rights discourse. While NARHS was formulated relatively quickly, implementation was marred by delays. Indeed, due to internal wrangling, poor coordination, and a lack of financing, the action plan for executing the NARHS was only completed in 2013, three years before the strategy was set to expire. Until the new strategy reflected adolescents' evolving needs, the gap in service provision for vulnerable groups in NAHRS, including adolescents with disabilities, those living in urban slums, and those in hard- to-reach locations, was a significant concern. The gap in service provision for vulnerable adolescents in NAHRS, including adolescents with disabilities, those living in urban slums, and those in hard-to-reach locations, was a significant concern. Prior to the introduction of the new strategy (NAHS), adolescents' evolving needs were not addressed comprehensively in previous policy documents. The strategy attempts to take a holistic approach to addressing the needs of vulnerable adolescent groups through its Strategic Directions (SDs) and Cross Cutting Issues (CCI).

Over time, the relative power balance between main policy actors driving the NAHS (state agencies, donors, and civil society organizations) has altered. While CSO coalitions were more influential during the 2006 policy's strategy formulation phase (reflecting more open policy space at the time), national organizations and rights-based international NGOs have lost influence. The Ministry of Health, the DGFP, and the DGHS all play essential roles in keeping the strategy alive and developing an implementation plan. Lack of collaboration between the DGFP and the DGHS and between the Ministries of Health and Education on reproductive health education content is a significant worry that could stymie implementation.

Even though the policy addresses a wide range of teenage requirements, implementation is likely to be complicated. This limitation can be attributed to: (a) lack of coordination between ministries and departments; (b) funding gaps, reflecting shifting donor priorities; (c) staff capacity and challenges in meeting diverse needs; and (d) conservatism inside the state or fear of a backlash. Given conservative societal norms, inadequate service delivery, lack of training and sensitization of service providers, and poor planning and coordination within state institutions, teenage access to these services has long been a concern, and these issues persist. The strategy's framework also has a conservative approach to bodily integrity and sexual and reproductive health rights. Sexuality is a political struggle stuck between “repression and danger on the one hand and exploration, pleasure and agency on the other” (Muhanguzi). The government has prioritized sexual health and right related matters from an instrumental perspective or as a way of achieving other political objectives. This highly politicized perspective needs to be complemented with a rights-based approach. This would establish the nexus between sexual health and human rights, and emphasize the individual interests and needs of individuals of any sexual orientation or gender to achieve the best possible sexual health. This may reflect social conservatism in national policy circles and the political reality in which conservative forces have gained traction.

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SUGGESTIONS

National Health Policy 2011:

The government should increase healthcare spending and prioritize preventative programs like on-time SRHR education, removal of social barriers, etc., to maximize health promotion budgets. The NHP aims to improve young people's SRH status and national development potential. The Policy will examine the social, economic, cultural, and demographic context of adolescent sexual and reproductive health and rights to integrate these concerns into the primary public health and development system. The policy implementation framework must cover management, ASRH services, sector and stakeholder roles and responsibilities, research and evidence-based treatments. It will help focus on youth sexual and reproductive health. The following principles guide the Policy's implementation:

a. Respect for human rights and fundamental freedoms, including the right to life, dignity, gender equality, sex, age, disability, health status, location, or social, cultural, and cultural practice religious belief.
b. Responsiveness to the different requirements of adolescents in the field of sexual and reproductive health.
c. To provide holistic and integrated ASRH information and services utilizing multinational or multi-sectoral approaches that are efficient and successful in achieving information and services for adolescents.
d. Recognition of the crucial roles of teenage SRH promotion by parents, guardians, and communities.
e. Youth participation in planning, delivering, monitoring, and evaluating ASRH programs to implement the programs, support partner organizations efficiently, and establish open communication channels to achieve mutual objectives.
f. Use of evidence-based programming and interventions.

National Adolescent Reproductive Health Strategy, 2006 & National Strategy for Adolescent Health 2017-2030:

Early marriage and pregnancy reduce the government's 'demographic dividend,' which it wants to take advantage of. It's estimated that 36 million Bangladeshis are adolescents. This massive cohort has excellent social and economic potential for the nation. Investing in adolescent health has been shown to benefit the immediate, adult, and future generations. Thus, policymakers wanted to capitalize on the country's demographic transition, which produced a one-time "demographic dividend." Keeping fertility rates low was another context as the country worked toward MDG on maternal health, and issues like early marriage and pregnancy gained attention. Due to these factors, the government prioritized adolescent health and changed the strategy. Given these circumstances and Bangladesh's progress toward the MDGs, higher policy circles should focus on adolescent health. The government and donors must work together to implement a comprehensive adolescent health strategy. The need for solid coordination will foster collaboration and allow donors to shape the new strategy, albeit with limited influence on contentious issues. The recent rise of religious groups and their impact on politics suggests staunch opposition. The current strategy's problems have been prioritized from an institutional perspective, so a rights-based approach is needed to prioritize adolescents' interests and needs. In conservative contexts, instrumental framing of adolescents' needs in programming may avoid controversy.

Family Planning 2020:

DGHS institutions should improve FP service availability to reduce unmet needs and increase coverage. Alternative solutions like hiring paid volunteer retirees and outsourcing to non-governmental organizations will require legislative amendments and inter-ministerial coordination, which could hinder practical cooperation. Policy changes are needed to provide marriage counseling, train traditional providers and pharmacy shop owners, and increase FP content in the medical curriculum. FP service providers' promotional structure, which makes it hard to motivate employees, should be changed to improve service. DGFP and DGHS facilities must be ready quickly to complete all required actions. DGHS institutions need coordination to improve PPFP services and service coverage.

Sexual and Reproductive Health and Rights in the National Curriculum:

Comprehensive sexuality education can help children and teens critically evaluate the accuracy, reliability, and relevance of SRHR information in their immediate environment and engage in peer discussions about SRHR concepts. This knowledge can help them identify SRH issues and seek advice and support. Educators and

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policymakers must be flexible and use multiple methods to reach more people. Examples include out-of-school peer education, street theatre, youth groups, sports clubs, parent-teacher associations, and community-based and faith-based organizations. Menstruation and menstrual hygiene should be discussed in primary school because many girls start their period at 8 or 9. This will prevent young girls from being traumatized when they begin menstruating without knowing why. Discuss the nocturnal emission with the boys.

To transform sex education, teachers may need to educate parents due to parental and community resistance. Sexuality education programs must discuss emotions, feelings, and relationships with significant others, even though relationships and broader contexts are essential. To meet youth needs, sexuality education programs must cover "disease to desire" discourses. Such programs should address knowledge gaps and develop critical thinking, assertiveness, communication, negotiation, and peer pressure awareness and resistance.

Any sex curriculum must consider teens' sexuality and experiences. Several surveys show that young people want to participate in what is said. These methods improve information-to-real-world behavior translation. The failure to recognize sexual diversity emphasizes the need to train educators to teach sexuality issues. Such training requires a basic understanding of sexuality and reproduction and the ability to promote open communication, negotiation, and discourse between teachers and students and boys and girls. Youth sexuality education programs, especially the media-driven global sex curriculum, must account for these changes.

National Health Strategy:

Bangladesh is still undeveloped in newborn nutrition and medical treatment. Activities to avoid infant death and general development should be adopted as follows: -

- Increase maternal and newborn care quality from pregnancy to postnatal, including improving midwifery.
- Enhance the availability of high-quality services for underweight and preterm babies, including improved neonatal nursing.
- Encourage and empower mothers, families, and communities to demand high-quality infant care and to participate in it.
- Reduce inequities following universal health coverage principles, including addressing the needs of newborns in humanitarian and fragile settings and
- Improve measurement, program tracking, and accountability to count every newborn and stillbirth.

Nutrition Policy 2015:

The following suggestions are made to develop a comprehensive and long-term nutrition policy that tackles all forms of malnutrition:

- Support effective nutrition policy and policies at the national and local levels using a multidisciplinary and multi-stakeholder integrated approach.
- Parents, communities, and local governments should be encouraged to establish and implement nutrition programs actively. The establishment of gardens in local villages' nutrition programs must be uplifted.
- Advocate for including nutrition instruction in all age groups' school curricula. In addition, teacher-training institutes shall be aided in incorporating nutrition instruction into their curricula.
- Examine current school nutrition teaching/learning resources and support adapting or producing new materials to match local needs and conditions.
- Look into possible public-private partnerships to assist health and nutrition education and environmental changes in the community.
- Seek funding from bilateral, multilateral, and non-governmental organizations. Encourage local government to work together with sufficient political will and financial resources to make all localities nutrition-friendly.
- Helping the impoverished obtain food and hunger-free safety and taking the essential precautions to protect their cash flow and nutrition.

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Women's Development Policy 2011:

Gender equality and women's empowerment are important policy goals for every government initiative to improve governance. The following strategic options are suggested:

- Regulate birthing facilities to guarantee that women's autonomy, privacy, and dignity are respected, including respect for women's choice of home delivery if no medical contraindications exist.
- Ensure that sexual and reproductive health is recognized as a fundamental right and that women and girls are the holders of these rights.
- Remove barriers to women's autonomy in receiving sexual and reproductive health care services, such as spousal, parental, or guardian consent.
- Make every government policy gender-responsive, and women should be actively involved in implementing government services and the design and framework of those services.

Menstrual Regulation Policy:

- Increase provider training in MR and MRM delivery, focusing on UH&FWCs.
- Ensure facilities have the equipment, medications, and trained personnel to administer MR.
- Raise provider awareness of national MR guidelines, including information on appropriate reasons for declining MR.
- Provide women with information on MR services. Ascertain that they are aware of this free, legal alternative to unlawful abortion, where to get services and MR's time limits.
- Increase awareness of the correct usage and dosage of misoprostol and mifepristone among drug vendors and their clients through instructional pamphlets or posters and clear, accurate drug labeling to decrease difficulties related to their use.
- To lower high rates of unwanted pregnancy, expand the availability of high-quality contraceptive treatment by offering a wide range of methods (including long-act reversible methods), giving counseling on consistent and proper use, and making method switching easier.

CONCLUSION

This research aimed to identify and evaluate the current SRHR situation in Bangladesh and discover a cost-effective way of promoting SRHR information among adolescents in Bangladesh and figuring out its possibilities and difficulties. From the beginning of the research, the researchers emphasized their hypothesis that the adequate application of existing national legislation and policies with minor modifications or the cost-effectiveness of creating and implementing (if necessary) any new policy/policies would lead to fewer challenges to promote SRHR among the adolescents in Bangladesh.

Based on the research of current national policies, it can be stated that no effective policy exists to increase SRHR awareness among adolescents. While sexual and reproductive health is recognized, sexual and reproductive rights are not. There are no particular laws or regulations that can be enacted if anyone's sexual and reproductive rights are violated. Bangladesh's existing policies address some aspects of SRHR but not all. Most significantly, the bulk of current rules apply to women but not to males. The policies' execution confronts a variety of social, religious, and psychological obstacles. Additionally, the policies lack a binding effect, which explains why they are not being applied effectively. The government is making significant efforts to increase adolescents' awareness of SRHR, but there is still some considerable lacking. As a result, numerous social, emotional, health, and sexual problems such as child marriage, early conception, violence against women, forced marriage, and STDs are increasing rapidly, particularly in Bangladesh's rural regions. Therefore, proper adaptation of national policies/policies regarding the promotion of SRHR knowledge to the adolescents in Bangladesh in a cost-effective manner, as suggested in this research, will be not only prospective but also less challenging and will have a long-lasting future impact on the country's educational and sexual health sectors if recognized as rights.

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