Health & Rights

Committed to Improving Sexual and Reproductive Health and Rights (SRHR)

Volume: 2, Issue: 1 January- March 2009

Editorial Board
Quazi Suraiya Sultana
Maswoodur Rahman Prince

Editor
Altaf Hossain

Advisory Editor
Shahnoor Wahid

Assistant Editor
Sitara Sultana

In this issue

- The high cost of unsafe abortion
- Poor health status driving the indigenous people to worst condition day by day
- "Whether married or unmarried adolescents must be given information to make informed decisions for themselves and they must have access to the health services they require"
- Violence Against Women A great hindrance to Women health & Rights
- Instructions for clients receiving MR services
- Performance Statistics on MR Services

Design, Desktop & Layout
Abul Kashem, RHSTEP

Performance Compilation
Suraiya Aktar, BAPSA

The high cost of unsafe abortion

Every eight minutes a woman dies somewhere in a developing country due to complications from an unsafe abortion. She most likely had little money or support to obtain safe services. She probably first tried to induce a termination herself. Failing that she would have turned to an unskilled, but relatively inexpensive, provider.

The cost of unsafe abortion-related ill-health and death was the subject of a technical meeting held at the Institute of Development Studies (UK) on 18 and 19 April 2007. It was funded by the Hewlett Foundation and brought together experts on unsafe abortion and economists specialising in costing methods. The meeting reviewed recent work estimating the cost of unsafe abortion to the health sector. Participants also discussed the economic costs to health systems, individuals and households, and the links between unsafe abortion and poverty. This article of id21 health focus highlights the findings reviewed at the meeting and points to important lessons for decision-makers.

Unsafe abortion carried out by individuals lacking the necessary skills and/or in unhygienic conditions, is a major global public health problem. The practice occurs where abortion is legally restricted, and where access to safe services is inadequate although the law may broadly permit the procedure. Unsafe abortion causes death and ill health in women, and burdens households, health systems and society.

Each year, there are an estimated 19 million unsafe abortions worldwide, most in low-income countries. About 5.2 million of these women are hospitalised for serious complications, while an unknown but possibly equal number of women suffer similarly serious complications but cannot obtain treatment. As a result, around 68,000 women die each year, making unsafe abortion a significant cause of maternal mortality. This number has remained unchanged since 1990.

In 2000, the consequences of unsafe abortion were greater in Africa than in Asia and Latin America. In Africa, 709 women die per 100,000 unsafe abortions, compared to 324 in Asia and 100 in Latin America. Nearly half of all deaths due to unsafe abortion occur in Africa, although Africa accounts for only 13 percent of all women of reproductive age in developing countries.

Abortion service provision is changing

In recent years, countries such as Nepal have responded by liberalising their abortion law. When accompanied by expanded access to safe services, as in South Africa, this greatly reduces complications and deaths from unsafe abortion. Another promising trend is the increased use of new drugs such as mifepristone and misoprostol - the 'abortion pill' - in very early pregnancy. These are an effective alternative to surgery and further reduce the risk and severity of complications.

Key policy lessons that emerged from the workshop include:

- Women need better access to contraceptive information and services to reduce unintended pregnancies and abortion (unsafe and safe).
- Where the law broadly permits abortion, safe services need to be expanded so that women do not need to resort to unsafe methods.
- Where the law is highly restricted, access to services for permitted criteria should be provided. Advocacy should highlight the unacceptable cost of unsafe abortion and the benefits of expanding the criteria for legal abortion.
- The quality and coverage of post-abortion care in developing countries need urgent improvement.

Number of reported unsafe abortions per 1,000 women aged 15 - 44 years, 2000

Source: id21 health focus, August 2007, web: www.id21.org

Poor health status driving Hill people to worst conditions

Chittagong Hill Tracts -CHT is located in the Southeast part of Bangladesh. The north and east surrounded by the Indian States of Assam and Tripura and the southeast by Myanmar. It consists of three districts - Bandarban, Rangamati and Khagrachari. Formally these three districts together formed one district - CHT. It was divided in three zones for administrative convenience.

Administration: There are one regional council and three Hill Tract districts councils. The Regional Council includes circle chiefs in its membership and its overall responsibility for coordination or development in the area. The Hill Tract districts councils act as stronger representation of tribal and women. The three District Council's authorities cover land and land management, local police and tribal law and social justice which include 12 departments.

In CHT there are three circle chiefs (i) The Chakma Raja is the circle chief of Chakma circle which consists of most of Rangamati district and one or two Thana in Khagrachari (ii) the Bomong Raja is circle chief of Bomog circle, includes all of Bandarban and one Thana in Rangamati (iii) the Mong Raja is Circle chief of Mong circle which includes the balance of the Khagrachari district.

Photo: Internet

Population: Members of 14 ethnic groups of indigenous 11 are living in CHT. Each group has its individual entity, specific racial background, language, heritage and culture. They are economically less developed and educationally as well. Because of their individual characteristics they live in forests and hilly regions.

District	Population	Upazila	Villages	Mousa	House hold
Rangamati	525100	10	1353	159	102820
Bandarban	298120	07	1501	95	50000
Khagrachari	525664	08	1581	120	109190

Administrative areas of CHT Districts, BBS

Their livelihood mainly depends on agriculture - 75% of the area is unfit for agriculture. Every ethnic group and local communities are disintegrated. Most inhabitants of the region are poor.

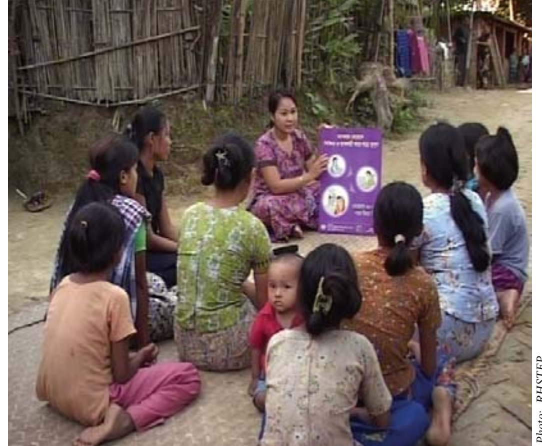


Photo: RHSTEP

In a study conducted by CARE, Bangladesh found the average annual income per household only Tk.18, 878 in CHT which is consider as ultra poor family.

The 11 ethnic groups are mostly lived in three CHT districts - Chakma, Tripura, Marma are in Khagrachari. Chakma, Tripura, Marma,Tanchagya, Lusai, Panchua, Kheyang in Rangamati and Marma, Mro, Bawm, Tripura, Tanchuagya, Khumi and Chak in Bandarban. The other major population can be identified Bengali plain people which are 49% of total population of CHT according to population census, 1991.

Health status: The incidence diseases in CHT are diarrhea, descentry, malaria, dengue fever; measles etc is high due to unsafe water, unhealthy sanitation and vector (mosquitoes), lack of health consciousness etc. Only 4 per cent peoples use sanitary latrines in the rural areas while another 15 per cent use pit, 47 percent and 33 percent people use open latrines and open spaces respectively that is not sound on health and environmental point of view. District /Divisional level data are presented here which reflects general overall low performance on various indicators.

Maternal health indicators, such as antenatal care visit, assistance during delivery by medically trained personnel

National/ Districts	% of tribal population of total population	Poorest household (%)	Antenatal Care visit (At least one visit) (%)	Delivery assistance by medically trained personnel (%)	Any Postnatal care received for mother (%)	Maternal Mortality Ratio (%)
Bangladesh	1.13	23	47.6	11.6	16.1	322/100000
Bandarban	48	57.8	26.6	10.2	6.3	
Khagrachhari	48.91	29.4	30	9.9	6.6	
Rangamati	55.63	31.7	41.4	15.1	16.7	

Source: Bangladesh Maternal Health Services and Maternal Mortality Survey, 2001

and post natal care for mother are lower than that of national or divisional figures. Health security in CHT region is very poor in comparison with other plain district.

Low level of awareness, backdrop of high rate of illiteracy, lack of adequate facilities and difficulty getting access to the available health care facilities are the main reasons for poor health status. To serve this purpose, THNPP (the Tribal health nutrition and population plan for HNP sector programme 2005 to 2010) under the HNPSP is suggested to provide the interface for effective implementation of HNP programme in tribal areas and for tribal people. The components of THNPP are identifying areas (unions) with 25 per cent tribal population; empowering tribal people to plan for their HNP services and participate in stakeholder committees at District, Upazila and Union Level; And give a choice for establishing village level health centres; training of fieldworkers for providing services at these centres or hiring of qualified doctors; training of providers operating at District, Upazila, Union, and CCs (community clinics) to be sensitive to the needs and expectations of tribal people in those areas; developing and implementing a BCC strategy for providers (to bring about attitudinal change) and users (to encourage them to seek appropriate care); an effective monitoring and evaluation process to be ensure completion of all these activities with desired outputs and outcomes. The structure was planed but not still properly functioning in many grounds due to inadequacy of resources. The efforts of the government and NGOs, effective and efficient health network, in terms of accessibility and quality care are lacking - not having adequate trained medical personnel, drug-supply. Health infrastructure puts severe constraints upon effective health care in CHT regions inhabited by very poor tribal people.

Photo: BAPSA

Government health facilities in three CHT districts:

District	Service Stations	
Rangamati	Genral Hospital - 01 Upazila Hospital - 03 Police Hospital -01 Upazila Health Complex-11 TB clinic - 01 Diabetic centre - 01	MCWC (Mother & Child Welfare Center) with EOC service - 01 MCWC without EOC service -01 Union Health & Family Welfare Centre - 26 Community Health Clinic- 34
Bandarban	General Hospital - 01 Upazila Hospital - 07 MDS (Army Hospital) -01	MCWC (Mother & Child welfare Centre)- 01 Union Health & Family Welfare Centre - 22
Khagrachari	General Hospital - 01 Upazila Hospital - 07 Police Hospital - 01 Upazila Health Complex -08	MCWC (Mother & Child welfare Centre)- 01 Union Health & Family Welfare Centre - 11 Community Health Clinic- 49

Source: Zila Parishad

In CHT region there are no significant private health facilities like other plain district. One private hospital in Chandraghona and two clinics in Rangamati district are placed. Total 72 NGOs working in CHT region by name (42 in Rangamati, 18 in Bandarban & 14 in Khagrachari) but very few NGOs working in Health related field (FPAB, BRAC, MSF Holland etc). Very recently RHSTEP & BAPSA joined in Sexual and Reproductive health field with the collaboration of government in three CHT districts.

A Survey, conducted by ADB indicated that there is presence of health service public sector centers in CHT but the people of CHT are not benefited from them for difficulty getting access due to bad communication, lack of competent health personnel, medical services and medicines.

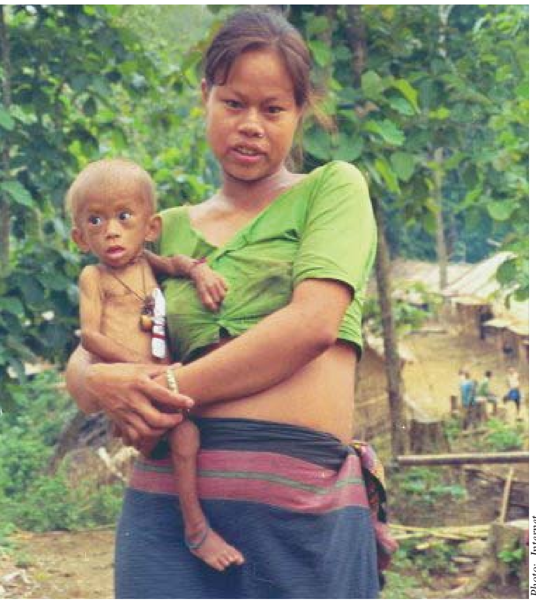


Photo: Internet

As a result health status of the tribes who live in remote areas go from bad to worse. So, they need more services. Special initiative in health policy for them according to need based health facilities should be taken by from both Govt. and Non-government organisations. CHT region is very poor and a much neglected district. So, we have to think about the people of CHT, like their minimum health facility right, education facility right and need to take more new initiative for them.

- Dr. Luna Chakma, Manager - Programme, Project Management Team, RHSTEP

"Whether married or unmarried adolescents must be given information to make informed decisions and they must have access to health services they require"

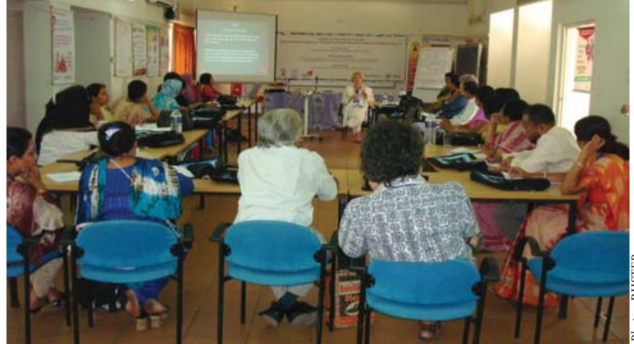
- Christina Rogala, Coordinator, Training and Education, RFSU.

Though sexuality education in schools has been compulsory since 1955 in Sweden (recommended since 1942), the struggle to come to this decision had not been without conflicts - it had been a process during 40 years. But 1955 almost every one saw the sexuality education as something positive and needed, said Christina Rogala, Coordinator, Training and Education, Swedish Association for Sexuality Education (RFSU) in the **Follow-up Training of Trainers: International Programme on Sexual and Reproductive Health and Rights (Part: 2).**

The programme was jointly organised by RHSTEP and BAPSA and conducted by RFSU at CCDB Hope Foundation, Baroipara, Savar, Dhaka on 23 March this year.Describing the journey of sexuality education in school curriculum in Sweden Christina said, sexuality transmitted diseases such as syphilis and gonorrhea were extremely common during that time and there were not any effective cure for these diseases. And this was the first argument and voice for claiming sexuality education for all people.

During these decades RFSU and many other organisations, politicians, members of the parliament, journalists and the public agitated for sexuality education in schools. But many arguments and debates were come out in this agitation like other countries.

But, today the young people in Sweden have good knowledge and pretty well know where to go with their questions, they are talking about their sexual debut mostly with positive words and that they did it when they felt mature to do it. Sexuality education is also in practiced in out of school settings like youth clubs and youth friendly clinics of Sweden.



Ms. Christina Rogala, Coordinator, Training and Education, RFSU was delivering her speech on youth friendly services.

Photo: RHSTEP

Arguments against sexuality education in schools

1. You should not give sexuality education to children and young people, sexuality belongs within marriage!
2. Children are not mature enough to understand what it is about!
3. Pupils will interpret sexuality education at school as a clear signal for early sexual debut and promiscuity.

Arguments for sexuality education in schools

1. All children want straight answers to their question: where do I come from?
2. Sexuality education can help young people to act in a responsible manner.
3. If the young people do not receive information about contraceptives, the frequencies of unwanted pregnancies and sexually transmitted diseases will rise.

The convenient location of the clinic, convenient working hours, information about the clinic, IEC material for the waiting room, networking and referral systems are needed for Youth Friendly Services (YFS) revealed through the presentation of "the quality assurance for youth friendly services."

Today the young people in Sweden have good knowledge and pretty well know where to go with their questions, they are talking about their sexual debut mostly with positive words and that they did it when they felt mature to do it.

Following the presentation Christina Rogala also discussed on the "right perspective of youth friendly Sexual and Reproductive Health Services" and said that the overall objectives for rights to YFS are: to promote physical and mental health, to strengthen young people in the development of their identity so that they can deal with their sexuality and to prevent unwanted pregnancies and sexual transmitted infections including HIV/AIDS.

The programme was chaired by Dr. Sabera Rahman, President, RHSTEP while Quazi Suraiya Sultana, Executive Director of RHSTEP, Dr. Altaf Hossain, Director, BAPSA and Ms. Mahnur Rahman, Vice President, BAPSA delivered their speech in inauguration session.

Ms. Maria Hellvig and Ms. Christina Rogala from RFSU facilitated the whole sessions through lecture, group works, open discussion, role play etc. methods. The previous training sessions briefly explained by Dr. Nasrin Khairun Nessa, Program Coordinator of RHSTEP during open discussion.

A total of 22 participants comprising medical practitioners, counsellors, and high officials from RHSTEP, BAPSA, FPAB and Bandhu Social Welfare Society attended the 1st training joined this follow-up programme. The participants were rewarded through certificates at the end of the training.

Violence Against Women
A great hindrance to Women Health & Rights

International Women's Day was 2009 observed worldwide on March 8 giving importance on VAW issue. The slogan of the day was "Women and men united to end violence against women and girls".

Like the other year, the RSH consortium (RHSTEP and BAPSA) members marked the day with due enthusiam in different districts and upazilas throughout the month of March 2009. The programme comprised of awareness meetings, rallies and free treatment with medicine services for general and reproductive health problems. The awareness programme focused on the forms and types of violence against women and girls; the adverse impact and the empowerment of women on their own rights.

Women face discrimination and violence at all sphere of her life. Every year huge numbers of women and girls are subjected to rape and sexual abuse by their relatives, other men, security officials or armed miscreants..

According to Odhikar (a leading national NGO) in 2008 a total of 269 women were victims of dowry related violence in Bangladesh which was the highest category of violence that year. Odhikar said that they believe the actual figure is higher than this as many women in Bangladesh depend upon the earning of the husband and due to social pressure and having no where else to go, they have to live with dowry related violence.

01 January - 31 December 2008

Rape	202 women	252 girls	Total: 454
Gang rape	110 women	70 girls	
Killed after being rape	68 women	30 girls	
Committed suicide	01 women		
Raped by law enforcement agencies:	04 women/girls (3 by police and 1 by RAB)		
Victim of acid attacks	73 women, 34 men and 26 children. Total: 133		
Dowry related violence	269 women		

Source: O dhikar

In another study conducted by Bangladesh Mohila Parishad revealed that 34,506 women were violated in rape, dowry, killing, fatwa and police torture during 2002 to2007 in Bangladesh. But the annual report of police 2007 revealed that only 11,068 women filed cases against their violence during the period 2002- 2006 means all victims are not taking legal action against the violence.

The gender role creates the massive discrimination between a man and a woman from the beginning of the life and thus extends the abuses and violence. The following cycles of abuses are manifests in several forms throughout women's lives[1] :

Pre-birth: even a girl is born she has risks becoming a target of sex selective abortion.

Childhood: girls face neglect, discrimination and abuse which often manifested in infanticide, differential access to food, health care, and education, incest and sexual abuse.

Adolescence and reproductive period: girls undergo sexual harassment and violence both in private and public spheres and have to accept marriage under pressure; and also marital rape, physical and psychological violence, coerced pregnancy and abortion.

Old age: women suffer from violence mostly in the form of deprivation of support and care.

Forms of VAW:

Violence against women and girls takes many forms like prenatal sex selection, female infanticide and systemic neglect due to son preferences; practices of Female Genital Mutilation (FGM); child marriage; sexual assault and rape; trafficking; harassment; and non-sexual battering.

According to World Health Organisation (WHO) the nature of VAW may be:

- Physical
- Sexual
- Psychological and involving deprivation or neglect.

It may happen in different context or place such as: within the family relationships-domestic violence, in public and in workplace-trafficking, sexual harassment, rape etc.

Physical Violence against Women includes-

- Sex-selective abortion and infanticide
- Physical violence against wives
- Physical violence during pregnancy.
- Manifestation of physical violence in different culture (e.g. family member, maid/servant etc.)
- Dowry related assaults, stove-burning, "honor killing", sati/widow burning etc.

Most women in Bangladesh do not enjoy their reproductive right to make decisions concerning their fertility and sexuality free of coercion and violence. Social insecurity and family pressure lead to early marriage and repeated pregnancy, and often force them to keep unwanted pregnancies or to have unsafe abortions.

Sexual abuse is wide spread violence. It refers to:

- Incest
- Marital rape and
- Sexual harassment.

Incest is one of the most hidden forms of child abuse. It is extremely difficult to identify incest cases and victims who are identified do not usually talk about their experiences (Nepal). 90% of child sexual assault cases are not reported in Pakistan. It was found that 40% of the total cases of child abuses are incestuous, with the abuser

See page 6

[1] Presentation on Sexual Abuse and Violence Against Women, Professor Mahmuda Islam, President, Women For Women.

From page 5

being uncles or male cousins (India). The magnitude of marital rape in South Asia is astounding. Different study revealed that the majority of women reported violent sexual initiation after marriage. Many of them are even under-aged when they are married off. A study in Bangladesh found high proportion of the ever-married reproductive aged women faced sexual violence within marriage (37% and 50%). Appalling is the fact that physical force was reported to be most commonly used in sexual abuse of wives. (2002, Naripokkho, ICDDR'B study).

An ever-increasing number of girls and women especially in South Asia are being sold to sexual bondage across national borders. So, there is also an increasing recognition that HIV/AIDS and other sexually transmitted diseases are often a consequence of sexual violence and prostitution, are having a devastating effect on women's health (particularly the health of young women and adolescent girls subjected to sexual and gender-based violence), trafficking and other forms of violence which place them at high risk of trauma, disease, and unwanted pregnancy.

Psychological abuse is defined as any act or omission that damages the self-esteem, identity or development of the individual. According to a study conducted by ICDDRB and Naripokkho, 43% of the ever-married reproductive women in Dhaka and 31% in Matlab being emotionally abused. Psychological violence is a major health issue. Different studies noted that many women are more disturbed by psychological than physical violence.

Consequences of VAW:

- Health consequences-physical and mental health consequences. Violence causes immense emotional and physical pain and suffering; results in lost productivity; halts development; and infects in sexual and blood transmitted diseases.

- Economic health consequences- It creates women economically vulnerable too. According to Centre for Policy Dialogue (CPD) there are 1 crore and 81 lacs of women are the victims of violence in Bangladesh among the 4 crore, 34 lac married/divorced/separated women. That victim women has to cost about 343 crore annually (19,000/- per person) due to her treatment, salish, legal activity, wastage of working days, homelessness which is over 10% of total GDP rate. Around 132 crore has to pay only for physical treatment service after the violation which is 4% of the GDP.

- Impact on children- Another consequence of VAW is the adverse impact on children. If a woman takes the continuous mental stress, fear and frustration during pregnancy, it creates effects to her children. The physical assaults may lead death to mother and children too. According to USAID, POPPHI, EngenderHealth, 14% of maternal death occurs for violence during pregnancy in Bangladesh.

The laws relating with violence against women[3]

- Dowry Prohibition Act 1980 and its amendment in 1986 make dowry practice an offence punishable by fine and imprisonment.
- National Women Development Policy 1997 and its amendment in 2004.
- Prevention of Women and Child Repression Act 2000 provides for effective and efficient way of dealing with cases of violence against women such as rape, acid attacks, forced prostitution and trafficking.
- The Suppression of Immoral Traffic Act 1933 provides for detention of women under 18 years of age if found in a place where prostitution is being carried out.
- The Family Court Ordinance 1985 provides for the exclusive jurisdiction of the court on matters relating to marriage, dowry, maintenance and guardianship, and custody of children.
- The Cruelty to Women (Deterrent Punishment) Ordinance 1983 amends relevant section of the Penal Code and provides the penalty of life imprisonment for kidnapping, abduction, trafficking in women, cruelty because of dowry, and rape as well as abetment of such offenses.
- Trafficking in Women and Children Act 1993 provides a maximum penalty of up to three years for forced prostitution and its abetment.
- Recently the government enacted a law primarily to restrict import and sale of acid in open market and death penalty for acid attack offences.
- A law has recently been enacted to address the issue of sexual harassment in the workplace.
- Some non-governmental organizations (NGOs) have prepared a guideline to be followed by universities to protect women-students from sexual harassment.
- The government has also signed the SAARC Convention on Preventing and Combating Trafficking in Women and Children.
- National Women Development Policy 2008.

The factors causing and aggravating the situation of Violence Against Women are[2]-

- Patriarchal values and attitudes are primarily responsible for violence against women.
- "whenever women are in a subordinate position to men , the likelihood for sexual assault is great'(Dianne Herman: the Rape Culture 1984).
- Even incase of rape, study of offenders' psychology reveals that rape is rather the sexual expression of male power and anger and vindication of male superiority over women. Similarly, sexual harassment of women at work arose from men's need to maintain control of women's labour.
- Discriminatory laws
- Traditional practices
- Weakness of the implementation of laws
- Lack of awareness of women's human rights and
- Son-preference causing deprivation of girls resulting in discrimination.

[2] Presentation on Sexual Abuse and Violence Against Women, Professor Mahmuda Islam, President, Women For Women.

[3] Salma Khan, former Chair of UN CEDAW.

South Asian for Human Rights (SAHR) stated that women rights are violating in massive way in six South Asian Country like Bangladesh, India, Pakistan, Sri Lanka, Afghanistan and Nepal through rape, physical assaults, early marriage, and forceful sex trade. According to SAHR violence against women are increasing in South Asia due to:

- Patriarchal social system;
- Lack of awareness;
- Male controlling over financial matter;
- Lack of job opportunity; and
- Silence role of the policy makers.

Conclusion: Violence against women will not remove overnight from our country. The attitudes, gender based discrimination that is continuing since long have to be changed from our society first. Through a consensus based on the above mentioned findings, to eliminate violence against women in Bangladesh needs to:

- Hence, the unequal power relations often result in the dominance exercised through violence. So, change the existing 'rights' and 'roles' of men and the social control mechanisms that reinforce the superiority of men and subordination of women.
- Create mass awareness to change gender-biased attitude is the most important precondition to enable solutions to materialise. Media as well as GO-NGO collaboration is needed in this regard.
- The economic empowerment of women needs to be addressed with related training for essential skills.
- Training of police, judicial and law enforcement officers on gender sensitivity and domestic violence is crucial.
- Stop early marriage, dowry and trafficking of women and children in internal and external.
- Facilities for the counseling of victims of violence and their families need to be enhanced.
- Support services for the victims of violence and their families should be approached on an interdisciplinary basis inclusive of employment opportunities, housing facility, legal aid and day care facilities.
- Implement all national and international laws, convention, treaty related this issue appropriately.
- And finally formation of law against the conjugal violence to stop violence against women.

- Sitara Sultana, Manager-Advocacy & Communication, PMT, RHSTEP

Instructions for clients receiving MR services

The MR service receiver has to follow the following eight instructions carefully to stay safe from any post-MR complications:

1. Don't do hard labour

MR service receiver has to keep away from hard labor at least for 15 days

2. Keep clean

There is some possibility for infections after MR. So, the service receiver must maintain personal hygiene.

3. Use healthy sanitary pad

The service receiver has to use healthy sanitary pad. If she cannot afford can use clean and soft clothes instead of sanitary pad.

4. Abstain from intercourse for two weeks

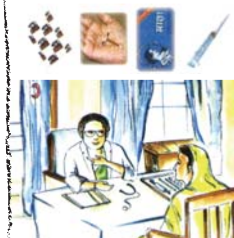
If MR service receiver doing intercourse in this period, may face various complications. So, to avoid the complications she must abstain from having intercourse for two weeks after MR. Husband too has to be aware in this regard.

5. Need to take Tetanus injection

If the service receiver did not take tetanus before, she has to take one dose immediately and has to know the date of the next dose simultaneously.

6. Take medicine properly

MR service receivers are prescribed some pain killer and antibiotic as per her necessity. The instruction of taking medicine has to be known and use them accordingly.



7. Use post MR contraceptives

The MR service receiver has to take the perfect contraceptive method to use and follow the using instructions properly. And menstruation will start again within four to six weeks.

8. Follow up visit

The follow up visit is an important part in quality service procedure. So, MR service receiver has to go for follow up visit to clinic to examine if there is any physical problem or not.

Performance Statistics

MR Services

Type of Centre	Last three months (January to March 2009)	Since beginning of financial year (July'08 to March'08)	Previous financial year
Training/Service centres	36,985	1,09,435	1,13,039

MR Training

Name and Location of the Centre	Year of MR Training Facilities Established	Turnout of Fresh Trainees						Turnout of Refresher Trainees		
		Jan to Mar 2009		Jul 2007 to Jun 2008		Total turnout		Jan to Mar'09	Jul 2007 to Jun 2008	Total turnout
		Doctor	Paramedic	Doctor	Paramedic	Doctor	Paramedic	Paramedic	Paramedic	Paramedic
MFSTC	1975	-	2	6	190	399	1,416	-	-	686
RHSTEP	1979									
DMCH	1979	6	8	10	23	1,516	362	-	13	745
SSMCH	1979	5	6	3	22	1,492	390	-	11	177
CMCH	1979	-	13	2	16	870	661	-	17	256
RMCH	1980	2	2	22	21	1,135	618	-	14	266
SBMCH	1981	8	2	24	17	1,282	552	-	9	222
SMCH	1981	-	1	-	11	807	413	-	14	197
MMCH	1981	4	1	8	12	1,008	696	-	12	182
PGH	1981	-	1	-	12	266	589	-	11	277
KMCH	1981	4	-	-	10	444	712	-	14	237
RIMCH	1988	2	2	7	12	693	290	-	8	271
NSH	1991	-	4	-	1	27	103	-	13	230
COMCH	1998	8	2	15	13	222	92	-	14	106
FMCH	1989	5	1	12	12	117	71	-	11	75
CBSH	1999	-	-	-	2	10	19	-	-	22
JGH	2001	-	-	-	2	7	8	-	-	19
MCD	2003	-	-	-	-	-	-	-	-	-
BMCH	2005	-	-	-	-	-	-	-	-	-
DIMCH	2005	-	-	-	-	-	-	-	-	-
Total		**44**	**43**	**103**	**186**	**9,896**	**5,576**	-	**161**	**3,282**
BAPSA	1983									
MRHC-1	2002	-	-		-	-	-	11	38	226
MRHC-2	2002	-	-	-	-	-	-	-	-	-
RRHC	2002	-	-	-	-	-	-	-	-	5
Total		-	-		-	-	-	**11**	**38**	**231**
Grand Total		**44**	**45**	**109**	**376**	**10,295**	**6,992**	**11**	**199**	**4,199**

Publisher

The SRHR Consortium-

RHSTEP

Reproductive Health Services Training and Education Program (RHSTEP)
House # 264/5, West Shewrapara, Begum Rokeya Sharani
Mirpur, Dhaka-1216, Bangladesh.
Tel: +880-2-9011195, 8031845, Fax: + 880-2-9013872
E-mail: info@rhstep.org, rhstep@bangla.net
Website: www.rhstep.org

Book Post

If not delivered the Newsletter please return to:

Bangladesh Association for Prevention of Septic Abortion (BAPSA)
House # 71, Block # C, Avenue # 5, Section - 6
Mirpur, Dhaka 1216, Bangladesh.
Tel: +880-2-8012392
E-mail: bapsab@dhaka.net
Website: www.ibiblio.org

To

....

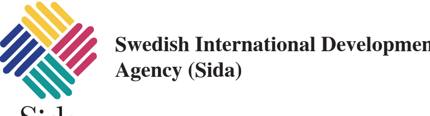
....

....

....

....

Supported By



Swedish International Development Agency (Sida)