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**Sexual Health and Reproductive Rights: Articles 21, 22(1), 23 and 24 of the
United Nations Declaration on the Rights of Indigenous Peoples**

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**Report on Sexual health and reproductive rights: articles 21, 22(1), 23 and 24 of
United Nations Declaration on the rights of indigenous peoples - Chittagong Hill
Tracts Context**

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-Tuku Talukder, Bangladesh

Introduction:

The Chittagong Hill Tracts (CHT) in the southeast region of Bangladesh comprises of three hill districts, Rangamati, Khagrachari and Bandarban .In Bangladesh, there is about 45 different indigenous groups spread across the country. The proportion of the indigenous population in the 64 districts of the country varies from less than 1% in majority of the districts to 56% in Rangamati, 48.9% in Kagrachari and 48% in Bandarban in the Chittagong Hill Tracts (CHT) .

The area of the CHT is 13,295 sq km, which is approximately one -tenth of the total area of Bangladesh. The total estimated population of CHT in the 2008 census was 15, 59,717. Around 50% of its population is indigenous and the rest is from different communities. the 11 ethnic groups of Chakma, Marma, Tripura, Tanchangya, Chak, Pangkhua, Mro, Bawm, Lushai, Khyang, and Khumi have their own languages, social structures, cultures, beliefs and economic activities.

The population distribution is scattered in the CHT and they are living in poor socio-economic conditions. Most of them inhabit in hard to reach areas such as hilly terrains or the forest areas where access is generally difficult. This area is considered as a post conflict area and clashes still persist between the indigenous and non indigenous population mainly due to land issue and ethnic conflict.

The main occupation of the people of the CHT is agriculture where a traditional system is called ***Jhum cultivation*** is practiced. Indigenous people at remote areas mostly depend on village doctors or traditional healers for health care services; this diverse health seeking behavior limits the use of existing modern health facilities.

Sexuality, Taboos and Education: As patriarchal society of indigenous communities sexuality is addressed as hidden, closed chapter and secret part of life. Elders do not feel comfortable to discuss this chapter in front of young and adolescents, besides youth and adolescents also feel shy to share sexual related issues or quarry due to cultural barriers. These cultural practice/barriers also not static or stable, it may change through providing behavioral change communication (BCC,) awareness raising activities there is no intervention from Govt or NGO for proving sexuality education for indigenous youth and adolescents. Some communities have taboo as do not touch women cloths (Marma, Tanchangya and Chakma community) and women are not allow to prepare food during menstruation period.

HIV/AIDS and Sexually transmitted infections: There are also no specific interventions of Govt to educate youth and adolescents for developing their life skill and NGO interventions also very less. Due to lack of awareness and information about comprehensive sexuality education, youth and adolescent girls always live in risk and lead a vulnerable life. As a result it is found that adolescent girl become pregnant, before marriage it is not welcome in the indigenous society.

Although HIV prevalence is low in CHT, it is important to provide HIV preventive services and raise awareness as CHT has a porous border with India and Myanmar where prevalence of HIV is high. At present, level of knowledge regarding HIV is low. Only 46% of the population has heard of HIV and only 13% of women have complete information on HIV transmission. As it currently stands there is little or no HIV/AIDS related intervention in the three hill districts despite it being a potentially high risk (street, hotel and residence based sex workers, drug users etc¹).

Access to maternal health and family planning: One of the key determinants of maternal mortality is reproductive health. In 2005, a survey on Reproductive Health of Young Adults found that at least 76% of adolescent girls (median age of 16.9 years) in Bangladesh have no access to health facilities. The percentage of adolescent pregnancies is high at 35%. In CHT 52% of the girls get married before their eighteenth birthday, which increases the risk of dying due to complications related to early pregnancy².

The Chittagong hill Tracts as a geographically remote area, still women of the communities, who live in that areas, they have very least opportunity to access maternal health and family planning services. Mostly they are deprived of all health facilities, due to remoteness, lack of awareness, inadequate health service facilities, poverty etc.

Maternal Health Care: As per report on **Socio-Economic Baseline Survey of the Chittagong Hill Tracts by CHTDF-UNDP-2009**, very least peoples have knowledge or information about danger signs of pregnancy and they have lack of information about Pre-natal, ante-natal and post-natal care services (do not know where to go and facility/provider too far)³ Availing ANC and PNC check up facilities is low among some communities (such as Khiyang, Khumi and Mro), who are living in remote areas.

The maternal mortality in the CHT at 4.71 per 1000 births (UNFPA) is still high. Infant mortality in the CHT is also higher than the national figures, for example, 61/1000 births compared with 45/1000 births nationally (BBS, 2006). These statistics could be attributed to the high number of births performed at home without the assistance of skilled birth attendants. In the CHT districts deliveries performed by Skilled Birth Attendants are very low.

The Bangladesh Multiple Indicator Cluster Survey reports that only 17% of deliveries in the CHT were assisted by medically trained personnel in 2006. Only a limited number of ambulances exist at District Level and none at Upazila level.⁴

Another reason for high maternal and infant mortality in the CHT could be the lack of knowledge within communities on the importance of Ante and Post Natal Care (ANC and PNC). ANC and PNC visits by women are lower in the CHT than the national average, 32.7% and 9.8% respectively (BMMS, 2001). CHT women very rarely attend ANC and PNC clinics unless they are coming to the clinic for other reasons. It

¹ Report on Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011 to 2016, MINISTRY OF HEALTH AND FAMILY WELFARE, April 2011

² Report on Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011 to 2016, MINISTRY OF HEALTH AND FAMILY WELFARE, April 2011

³ Socio-Economic Baseline Survey of the Chittagong Hill Tracts by CHTDF-UNDP-April-08,2009,

⁴ Source: website of CHTDF-UNDP

is therefore very difficult to follow up on mother and child health unless this is done at the community level.

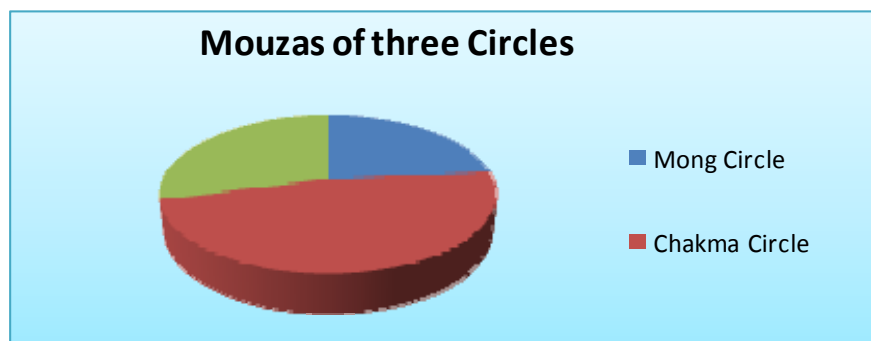
Local beliefs and customs also influence what food is consumed during pregnancy and given to newborn and children in the indigenous community. The socio-economic needs, health-seeking behavior, perception of family planning, practices affecting nutritional intake and aspirations vary from one indigenous/ethnic community to another.

Access to contraceptive: Indigenous community currently most using method is oral pill, then Injectable, condom and Tubectomy, use of Vasectomy is very less. Indigenous communities also use traditional method for family planning. It is found that women are main responsible for family planning matters and sometimes supply of contraceptive materials are insufficient in remote areas.

Safe abortion: In some areas, women of indigenous community do not have access to safe abortion, due to limited services (only District and some upazila level) from Go and NGO, not only that financial ability also one of obstacles to get the services. It is found that sometimes traditional healers conduct the abortion, which is harmful and risk also.

Customary system of indigenous communities: Each indigenous community has their own languages, beliefs and culture with traditional system of administration formalized under the CHT Regulation of 1900. Under this system, there are three administrative Circles in the CHT (Mong, Chakma and Bohmong) each with their own Chief or Raja (King). The administrative areas of the Mong, Chakma and Bohmong circles broadly correspond to the decentralized Local Government administrative areas of Khagrachari, Rangamati and Bandarban Hill Districts. The Circle Chiefs are advisors to their relevant HDC(s) and are engaged in other formal governance networks. Each circle is subdivided into Mouzas, where the Headman is the head of the mouzas. Each Mouza has several Paras (villages), where a Karbari is the leader. Headmen are appointed by the Deputy Commissioner (Head of general administration) on the recommendation of the Circle Chiefs and Karbaris are appointed by the Circle Chiefs. Headmen and Karbaris have responsibilities for maintaining social law and order, revenue collection and land registration of their communities.

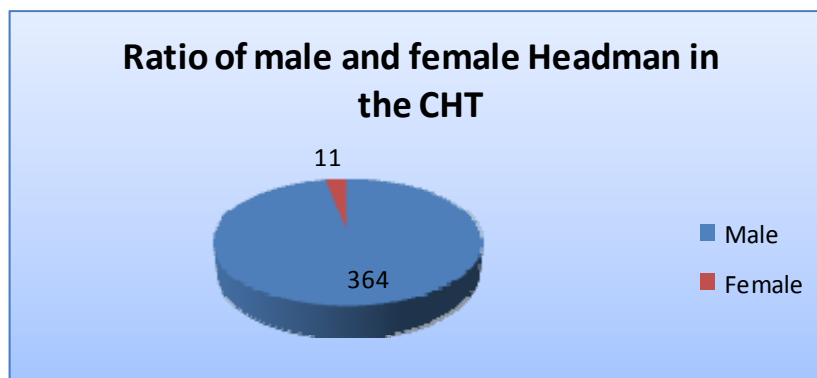
Table-1: Mouzas of three Circles



Gender equality, discrimination and violence: Women of the indigenous communities are victims of multi-dimensional discrimination in terms of as female, poor and ethnicity. Women from indigenous

communities are living in the CHT have far more physical mobility, they are actively engaged in productive work along with performing their reproductive and community roles. Therefore they have lack of actual control over productive resources and always remain a marginalised section, though they share more burdens in addition to their usual workload. Women are almost totally absent from the community decision-making process. Their passive roles are one aspect of the systematic deprivation and discrimination of women in the CHT. Women have little access to information and linkages with outside communities/ institutions/ services in particular had to bear the burden arising from this strenuous socio-political situation. Almost all the traditional leaders (*Headman, Karbaries*) are man. All three Circle Chiefs (the highest authority among the traditional leaders) – the Chakma Circle, Bohmang Circle and Mong Circle are men. In many cases, women have been, and continue to be, the worst victims of various forms of discrimination and rights violations, except for the women from the Marma communities (only in Bohmang Circle) women in general do not inherit property

Table-2: Ratio of male and female Headman in the CHT



Social arbitration process: Earlier mentioned that Headman and Karbari maintain and look after social law and order in their respective mouzas and villages in the indigenous communities. They conduct women related social arbitration, though women have least opportunity to participate in the process to claim their right or express them. So their voices remain unheard and also it is not possible to ensure equal justice for women. Because it is found in some cases that as judgment women are accused given punishment them through auction, physical assault, force to marriage rapist (same caste/community).

Sexual violence against indigenous women: During self-determination movement indigenous peoples in the CHT women were often targeted of sexual violence and violated by Bangladesh Army mostly. After peace accord still sexual violence and killing of indigenous women and girl has been remained, only perpetuator has been changed, nowadays women and girl are targeted and killed as consequence of land dispute between indigenous and Bangali settlers and violated by Bangali settlers.

Professionally marginalized groups: Various groups are socially marginalized and excluded because of their professions. Sex workers are also impoverished. This marginalization leads to limitations in accessing to various government services, whether it be education, health or other benefits. However their professions are related to various health and security risks. They are often unaware of the health consequences of their professional activities, unable to take the necessary preventive or curative

measures and are unable to switch occupations due to various social constraints. The health services providers are often unwilling to treat or advise such patients and also not always capable of dealing with their specific needs. In order to ensure equity in access for all, both the clients and the service providers have to be motivated to see the health services available and to enable these groups to access these services with dignity and respect.

Health policies of Bangladesh: To make necessary basic medical utilities reach people of all strata as per Section 15(A) and develop the health and nutrition status of the people as per Section 18(A) of the Bangladesh Constitution the Health Policy-2011 had been introduced, the particular objectives of Health policy-2011 are;

1. To ensure availability of primary and emergency health services to all
2. To expand availability of easy access to qualitative health services on the basis of acceptance and equality
3. To motivate peoples to accessing health services for reducing and preventing disease on the basis of right and dignity

To achieve the Goal and objectives of National Health policy-2011 indentify sixteen principles and work strategies, they are mentioned below;

Firstly : To create awareness among and enable every citizen of Bangladesh irrespective of cast, creed, religion, income and gender, and especially children and women, in any geographical region of the country, through media publicity, to obtain health, nutrition and reproductive health services on the basis of social justice and equality through ensuring everyone's constitutional rights.

Secondly: To make essential primary health care services reach every citizen in all geographical regions within Bangladesh.

Thirdly: To ensure equal distribution and optimum usage of available resources to solve urgent health-related problems with focus on the disadvantaged, the poor and unemployed persons;

Fourthly: To involve the people in planning, management, local fund raising, spending, monitoring and review of the procedure of health services delivery etc. with the aim of decentralizing the health management and establishing people's rights and responsibilities in the system;

Fifthly: To facilitate and assist in collaborative efforts between the government and the non-government agencies to ensure effective provision of health services to all;

Sixthly: To overall improvement and quality-enhancement of health service, and to adopt strategies for priority-based Human Resource Development and restructure of acceptable administrative system, decentralization of service delivery procedure and the supply system, to create access of all citizens to such services.

Seventhly: To encourage adoption and application of effective and efficient technology, operational development and research activities in order to ensure further strengthening and usage of health, nutrition and reproductive health services;

Eighthly: To ensure the availability of birth control supplies through integration, expansion and strengthening of family planning activities;

Ninthly: To integrate Nutrition interventions with health services effectively.

Tenthly: To aware about health related rights, opportunities, responsibilities, obligations and restrictions of all peoples

Twelfth: To establish self-reliance and self-sufficiency in the health sector by implementing the primary health care and the essential services package, in order to fulfill the aspirations of the people for their overall sound health and access to reproductive health care.

Thirteenth: To ensure qualitative health for all citizens through providing innovative information and communication technology and E-Health and Tele-medicine systems

Fourteenth: To update the list of essential drugs and to ensure the availability everywhere and to take necessary steps for expansion and development of local medicine industry.

Fifteenth: To establish health related security for ensuring medicine and equipments supply as emergency relief to the disaster and climate change affected peoples

Sixteenth: To expand the health services in inclusion of alternative health service system such as Homeopathy, Herbal etc. Besides existing health services

Challenges of National Health policy-2011: In the policy already mentioned some existing challenges and gaps to access and availability of health services in the different communities due to provide overall services such as;

1. Weak management,
2. Limitation of resources,
3. Weak and non-qualitative services

Another challenge is overall service receiver and demand related such as;

1. lack of ability to receive health services
2. Not to following lifestyle according to hygienic method and knowledge

Health system in the CHT:

In the CHT, a decentralized Local Government system is being followed, with responsibilities for the management of health services delegated to the Regional Council and three Hill District Councils (HDCs). The Ministry of CHT Affairs (MoCHTA) is responsible for overseeing all activities in the CHT. All transferred department and departmental heads report to the HDC Chairman.

As per the three HDC Acts of 1989 (as amended by the 1997 CHT Peace Accord), a total of 33 subjects are supposed to be transferred from the Ministries to each of the three HDCs. Of these, Health was transferred from the Ministry of Health and Family Welfare (MoHFW);

In the CHT the Civil Surgeon and the Deputy Director of Family Planning both report to the HDC Chairman. The HDCs with their own funds or fund received from the Government may formulate and implement development plans on the subjects and department transferred to them. The concerned Ministries, Divisions or Departments are required to implement through the HDCs, all national development works on the subjects transferred to the HDCs.

The Hill District Councils (HDCs), through the Civil Surgeons' offices and the offices of the Deputy Directors of Family Planning, supervise over 300 doctors and nurses, and over 800 communities' health workers. They are responsible for delivering health services across all Upazila in the CHT, and are responsible for over 235 health facilities, at district, upazila (subdivision), union and community level

Health Interventions in the CHT:

The Ministry of Health & Family Welfare (MoH & FW) is responsible for policy, planning and decision making at the macro level. There are four directorates.

1. Directorate General of Health Services
2. Directorate General of Family Planning
3. Directorate of Drug Administration
4. Directorate of Nursing Services

Each of the six Divisions in Bangladesh has a Divisional Director of health from both the Health and Family Planning department. At the District level, the Civil Surgeon reports to the Directorate of Health Services and is responsible for general health services and the services at district hospital. The Deputy Director Family Planning (DDFP) looks after family planning, MCH and reproductive health services at district level.

Interventions of INGO & NGO:

UNDP: The long term strategy of CHTDF-UNDP is aimed at supporting the Government of Bangladesh in its efforts to implement the HNPSP/Tribal HNP Plan in the CHT. The project seeks to strengthen the government health system in this regard through improving

- i) the physical infrastructure of the existing health, nutrition and population facilities in the CHT,
- ii) human resource policy development in the health sector,
- iii) delivery of appropriate health service packages and
- iv) training for health service providers.

Accordingly, UNDP established 15 Satellite Clinics in 2006 and gradually increased those up to 75 mobile clinics across 15 Upazila of the CHT out of a total of 25 upazila. The clinic locations were determined following a series of consultations with local stakeholders and decision makers at union,

upazila and district level, with the final decision in each district resting with the HDC Chairman. The clinics are staffed by mobile teams on a one day per week rotational basis, and receive on average 1,000 patients a month. In addition to running Satellite Clinics, UNDP, through the HDCs, has recruited and trained over 1000 women as Community Health Service Workers (CHSWs). Each CHSW is responsible for between 120 and 140 households in the village in which they reside and the surrounding area. They provide a basic package of health services including malaria testing and treatment of malaria, diarrhea and ARI, basic health education, referrals and maternal services etc, and are fully supported by Satellite Clinics.

UNICEF and WFP also support community-based health initiatives in the CHT. UNICEF, through the Integrated Community Development Project (ICDP) has supported the Government in establishing a network of Para Centers in selected communities throughout the CHT. These are community-based facilities run by Para Workers. ICDP uses the Para Centre as a base from which to offer a range of community development activities, organized by the Para Workers. It focuses primarily on educational activities and early childhood development, but also supports awareness raising and promotional activities for health, water and sanitation.

UNFPA provides technical support to the Mother and Child Welfare Centers (MCWCs) in each district, prioritizing Antenatal Care (ANC) and Postnatal Care (PNC), Safe Delivery and Emergency Obstetric Care (EOC). At the community level, UNFPA is providing Skilled Birth Attendants training to Family Welfare Assistants (FWAs) and Health Assistants (HAs). With this training they are able to provide 'safe delivery' at home and are able to support and provide midwifery training to Family Welfare Visitors (FWVs). UNFPA also supports family planning services to distribute contraceptives and provide counseling for long-term methods of contraception.

WHO does not work directly in the CHT, but works with Government Ministries and other stakeholders at the national level to improve health management systems and good governance in the health sector. WHO provide technical support to immunization and involved in active and passive surveillance of communicable disease in CHT.

UNAIDS also does not work directly in the CHT, but supports campaigns nationally to raise awareness on HIV and AIDS. In addition to the work being done by the Government and UN Agencies, there are many International and National NGOs working in the health sector of the CHT, including Bangladesh Rural Advancement Committee (BRAC), the Christian Mission Hospital, Family Planning Association of Bangladesh (FPAB), the Leprosy Mission, World Vision, Save the children UK, Sajeda Foundation and also a growing number of local NGOs. The scope of these agencies is often limited, both geographically and by sector.

Given the multiple stakeholders and resources available, better coordination among the various agencies working in the CHT could substantially improve the coverage and quality of services being provided, maximizing limited resources and consolidating benefits for CHT communities.

Ministry of Health has a similar health setup in the CHT like in other district of Bangladesh. Most of the health facilities in the CHT are underused for many reasons. Many middle- and low-income countries suffer from severe staff shortages and/or mal-distribution of health personnel which has been more recently by the disintegration of health systems in low-income countries and by the global policy environment. One of the most damaging effects of severely weakened and under-resourced

health systems is the difficulty they face in producing, recruiting, and retaining health professionals, particularly in remote areas. Low wages, poor working conditions, lack of supervision, lack of equipment and infrastructure made the health services more ineffective. Communal conflict and fear of abduction among the health staffs from outside also create loss of interest and risks to working in these remote areas. In this situation, so many development partners and NGOs are keen to improve the situation through different strategies focusing on different areas of interest.

Tribal Health, Nutrition and Population Plan: The Government has made provisions for a Tribal Health, Nutrition and Population Plan (THNPP) which recognizes the specific social, cultural, economic and special factors to be taken into account for HNP service delivery in tribal areas. The THNPP calls for 'tribal sensitive' and participatory implementation of HNP services in tribal areas. Tribal areas are defined as those having (over) 25 percent tribal population, and include the CHT. The THP has not been implemented since formulated and already expired in 2010. In the new government proposal from July 2011-June 2016 (HPNSDP), there is separate budget line for CHT health which was submitted for approval and under process.

Activities suggested for improving HNP status of tribal/ethnic people

"Based on the review of available literature, one-to-one consultations and inputs from the stakeholder consultation the following activities could be included under the new sector program (HPNSDP). These are applicable to both CHT and non-CHT areas

- Recognizing social, economic, cultural and linguistic differences of tribal/ethnic communities, to ensure reach of services a tribal/ethnic plan may be considered to channelize the resources and implementation of HNPSP.
- Redesign service delivery model in tribal areas and for tribal/ethnic groups. Doorstep delivery of services may have to be encouraged. As the tribal/ethnic population live in areas with low density, which means smaller population spread across larger geographical areas, and considering the fact that they live in hilly regions and forest areas, there could be one trained health visitor and family welfare visitor for every 500 households.
- Reviewing coverage of Community Clinics in tribal/ethnic areas: For households at a distance of more than 3 Kms or cut off by stream/river or steep slope, satellite clinics or mobile clinics should be considered to extend the coverage.
- Support to infrastructure and service delivery in the public sector to fill in gaps and make the services more user friendly. Supplement the public sector service delivery by engaging the private sector and NGOs at all levels, more so at the community level.
- Manpower development by way of better recruitment, training and rewards systems. Preference to be given for recruiting individuals from tribal/ethnic community, as they understand their community and needs.
- Training and working with other systems of medicine and tribal/ethnic system of medicine practitioners.
- Developing a need based and culturally sensitive Communication Program
- Development of a referral system for institutional deliveries, emergency obstetric care and terminal method of family planning"⁵

⁵ Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program, (HPNSDP) 2011 to 2016

Revitalization of Community Health Care Initiatives in Bangladesh (RHCIB) MoHFW:

The present Government during its previous tenure in 1998 planned to construct 13,500 Community Clinics and recruit community health care providers to extend Public Health Clinic at the door step of rural people to promote accessibility, availability and community participation. Aim of the **Revitalization of Community Health Care Initiatives in Bangladesh** to establish 18,000 community clinics at village/ward level, one clinic for 6000 populations.

Table -01: List of Community clinic and Union Health & Family Welfare Centre

S/L	District	Community Clinic(CC)	Union Health & Family Welfare Centre (UH & FWC)
1	Rangamati	34	26
2	Khagrachari	49	22
3	Bandarban	29	22
	Total	112	70

Source: Civil Surgeon Office of Rangamati, Bandarban, Khagrachari

Govt. constructed 10,723 Community Clinics at Community people donated land and 8,000 started functioning till 2001. In 2001, due to change of govt. community Clinic activity was stopped and remained as such till 2009. Now the Present Govt. has taken revitalization of Community Clinic as priority program & is being implemented through **Revitalization of Community Health Care initiatives in Bangladesh ((RHCIB)** under MoHFW⁶

Health and family planning assistance, Assistance health and Family planning inspectors and community health care providers of existing working places take initiative to form community group in cooperation with Union Parishad. Formation of Community group by selected community representatives of respective village to ensure clinic construction, management, community participation in health services and access to services etc.

Services of Community Clinics: Community clinic will be treated as primary stage of essential services. According community needs the clinics will be operated as one stop service centre through providing nutrition service, family planning, specific qualitative integrated health services without payment. The following services are providing given below;

- Maternal and neonatal health care services

⁶ Presentation on Revitalization of Community Health Care Initiatives in Bangladesh (**RHCIB**) MoHFW by Dr. Makhduma Nargis, additional secretary & Project Director-2011

- Integrated Management of Childhood illness (IMCI)
- Reproductive Health and FP services
- Expand Program Immunization
- Registration of newly married women, pregnant women, birth & death, preservation of EDD
- Nutritional education and micro-nutrient supplements
- Health, Nutrition and FP Education & counseling
- Identifications of emergency & complicated cases & refer to higher facilities
- Treatment of Common diseases & first aid
- Establishing referral linkage with higher facilities

Addressing CHT health issue in the planning and policy: It is found that maximum policy and development plan of Bangladesh Govt. are top down approach and do not address proper issues and challenges. It seems that The **Revitalization of Community Health Care Initiatives in Bangladesh** project also does not fulfill requirement because of geographical context, scattered villages and remoteness etc.

Recommendations:

1. CHT based Sexual and Reproductive Health related policy and planning should be developed in consultation with indigenous communities through considering geographical context, scattered villages and diversity of indigenous communities.
2. Initiate and steps should be taken to strengthen the capacity local government institutions, Health service providers and personnel responsible for the delivery of SRH services to indigenous women and child by increasing budget allocation and resources, improving equipment and facilities appropriate for indigenous women and men that include training and raising their awareness on the particular concerns, needs and conditions of indigenous peoples.
3. Indigenous women's role and contribution in sustainable resource management and enhancement of traditional knowledge should be recognized along with the respect of their land rights, access to resources, basic and appropriate health and social services for their good health and wellbeing, livelihoods and environment, which will provide an enabling environment for survival and development of indigenous communities.
4. Skilled Birth Attendants (SBA) and training facilities for Traditional Birth Attendants(TBA) at grassroots level should be developed and expanded
5. Separate budget should be allocated for sexuality and reproductive health sector of the Chittagong Hill Tracts and number of service providers at Govt, NGO and private level should be expanded and encouraged.
6. Community clinics should be expanded and health governance system of local govt. institutions (Union parishad, Traditional leadership-Headman and Karbari) should be strengthened to delivery qualitative and effective health care service

7. Research on traditional medicinal knowledge should be conducted