economic characteristics. 53% of ever-married women have experienced physical violence since age 15 with 46% experiencing violence in the 12 months before the survey. A larger percentage of women reported experiencing physical violence "often" in the past year (31%) than "sometimes" (15%) in the previous year.

Violence during pregnancy is also fairly common. Almost 1 of 5 (16%) ever-married women who have ever been pregnant has experienced physical violence during pregnancy.

Experience of physical violence since age 15 increases sharply with age and women's number of children. For example, 33% of women age 15–19 have experienced physical violence since age 15 compared with 60% of women age 40–49.

The likelihood of experiencing physical violence during pregnancy generally increases with number of living children. About one in five ever-married women with 5 or more children has experienced physical violence during pregnancy compared with 7% of women with no children. Women who are employed but are not paid in cash (63%) are more likely than unemployed women (52%) and those who are employed for cash (53%) to have experienced physical violence. Women's experience of physical violence varies greatly by province. Less than 1 in 10 women report experience of physical violence in Helmand (6%) and Badakhshan (7%), compared with more than 9 in 10 women.

Women who have no education are twice as likely (56%) as women who have secondary education (28%) to report the experience of violence. Fifty-six percent of ever-married women reported ever experiencing spousal violence (physical, sexual, or emotional) perpetrated by their husband and 52% reported experiencing such violence in the past 12 months, either often (36%) or sometimes (16%). Women's experience of spousal (physical, sexual, or emotional) violence increases substantially with age and number of children. Thirty-one percent of ever-married women age 15–19 have ever experienced spousal violence compared with 61% of women age 40–49. Thirty-three percent of women with no living children have experienced spousal violence compared with 60% of women with 5 or more children. Eight in 10 women who seek help ask their own family for help and about one-third (34%) ask their husband's family for help. The next most common source of help is neighbors (18%). In Afghanistan women who seek help to stop the violence are unlikely to seek help from doctors, police, or any other civil or social organization.

Women and girls constitute nearly half of the country's population. However, the social structure in Afghanistan is still characterized by male dominance, leaving the status of women at the bottom of the social hierarchy. Gender inequality in Afghanistan is one of the highest in the world. The gender development index (GDI) in 2014 for Afghanistan at 0.310 was second lowest among all countries.

Moreover, there is a lack of gender sensitivity in data collection and analysis. Core development policies are guided more by security and military priorities rather than by concerns for sustainability and the fulfillment of human rights. Women's overall representation in decision-making positions in various government sectors is still low at 23%, in the health sector it is 24.1%.

Crisis Situations: Migrants and IDPs

The population of Afghanistan is around 34 million as of 2018 which includes roughly 3 million Afghan citizens living as refugees in both Pakistan and Iran. The nation is composed of a multi-ethnic and multilingual society, reflecting its location astride historic trade and invasion routes between Central Asia, Southern Asia, and Western Asia. Its largest ethnic group is the Pashtun, followed by Tajik, Hazara, Uzbek, Aimak, Turkmen, Baloch and a few others.

that was unsuccessful. Menstrual regulation was introduced in 1979, and has since been the go to legal procedure for termination of pregnancy, but only in the first trimester.

According to the Guttmacher Institute, the rate of abortion in 2014 was 29 per 1000 women between the ages of 15–49. 430,000 had undergone MR procedures while 1,194,000 underwent induced abortions in most likely, unsafe conditions. An estimated 384,000 women had suffered from post-abortal complications such as hemorrhage, shock, sepsis, etc., and 91% of clinics capable of providing treatment for such complications, had done so. Urban women are approximately 1.8 times more likely to receive treatment for complications following abortion than rural women. This begets the question of whether menstrual regulation is sufficient for the country. In 2014, a National Demographic and Health Survey showed that half of married women had never heard of MR before. Only 53% of public sector facilities and 20% of private sector facilities, that were registered to provide MR services, actually did so. The reasons for this may be a lack of trained staff or proper equipment or both. Only one-third of the private facilities, having both trained personnel and proper equipment provided MR services in 2014, citing social reasons such as lack of husband's consent, marital status of the girl, age of the girl, etc. behind their decision. Even though most facilities provided the necessary counseling to post-abortal patients, very few provided contraceptive methods.

Multiple organizations are now working to provide their services in the field. A Bangladesh NGO, Marie Stopes, runs 132 clinics in the country, and provides family planning counselling and contraceptive methods, MR services and post-abortion care, antenatal and postnatal services as well as aids in management of STDs. Naribhandhob, an organization in collaboration with the Dutch organization Women on Waves, Women on Web, Asia Safe Abortion Partnership, runs a free hotline that gives women access to information regarding drugs, procedures and post-abortal complications and care. The Federation of Gynaecology and Obstetrics (FIGO) has been running the initiative for unsafe abortion and its consequences in Bangladesh since 2008. They have contributed to the increased usage of manual vacuum aspiration in place of sharp curettage and have also legalized the use of a combination of Misoprostol and Mife pristone in 2012.

Crisis Situations: Refugees

In the 73rd United Nations General Assembly, Prime Minister Sheikh Hasina said that as of September 2018, there are 1.1 million Rohingya refugees in Bangladesh. The Muslim minority from Myanmar, have been slowly making their way across the border into Bangladesh since 1970s, however, the number has risen exponentially following the escalation of tensions in August 2017. The world's "most persecuted minority" have found shelter in the Kutapalong and Nayapara areas of Cox's Bazaar district in Bangladesh, where they now outnumber the locals by a 2:1 ratio. The majority are woman and children with 40% children under the age of 12 and 16% women single mother. According to a report by the Washington post, these children are suffering from severe mental trauma, malnutrition, diarrhea, while a majority of women are pregnant by sexual assault and are themselves in dire need of treatment and counseling.

According to a UNHCR report in 2017, 3422 cases of skin disease, 10846 cases of respiratory disease among the refugee population (United Nations Children's Fund. Bangladesh Humanitarian Situation report-10 (Rohingya Influx) New York: UNICEF, 2017). Another UNICEF report found 419 cases of measles in the same year (United Nations Children's Fund. Bangladesh Humanitarian Situation report-10 (Rohingya Influx) New York: UNICEF, 2017). As of February 2018, there

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Though child marriage is a rare event in Bhutan now but teenage pregnancies contribute a significant number in total births. According to Ministry of Health in 2008, 11% of total births were of mothers at a younger age and risks identified were there was lack of awareness among this age group about reproductive and sexual health. This area has not shown any progress in its indicators as adolescent fertility rate has rose up to 28% in 2012.

Contraceptive Prevalence Rate

Contraceptive prevalence rate (CPR) is 65.6% which is better than many other countries in this region.

Under Five Mortality Rate

In 2000 under five mortality rate was 84 /1000 live births and in 2016 reported as 37.3/1000 live births with a major chunk due to deaths of newborns, i.e. 21/1000 live births.

HEALTH FACILITIES FOR MATERNAL AND CHILD HEALTH

With the cooperation of UNICEF 1005 health workers are trained in early essential newborn care (EENBC) and Kangroo Mother Care (KMC) among ten high load delivery hospitals. This will result in decrease in perinatal mortality rate in upcoming years. Maternal and child health staff is trained in 20 districts for infant and young feeding, lactation management and nutrition counseling. Health assistants in rural areas are appointed at basic health units and this is major step towards reduction in unattended births. Moreover, initially emergency obstetric care (EmOC) was available in referral centers but now this essential service is available across the country and basic health units. This step has resulted in a significant fall in maternal mortality over the years. For the children health, the healthcare providers or healthcare assistants assess weight, height of a child and provide vitamin A and de-worming tablets till a child reaches five years of age.

Violence

According to National Health Survey of Bhutan in 2012, in currently married women aged 15–75 years, 6.1% experienced physical violence by their intimate partner and 2.1% of currently married women aged 15–75 years experienced sexual violence by their intimate partner, in the same group of women aged 15–75 years, psychological violence by their intimate partner was 3.2%.

The knowledge and skills about how to protect oneself from violence was given to 3000 adolescents, 300 young monks and nuns, these trainings were supported by UNICEF as reported by UNICEF in 2017. Research on violence against children in Bhutan conducted by UNICEF reveals that commercial sexual exploitation has emerged as a serious issue in southern and south-eastern dzongkhags and girls experience sexual violence and harassment.

The emergence of drayangs, where women dance in bars to entertain men has been criticized as institutionalized prostitution. In National Assembly this issue has been raised. According to the Bhutan Infocomm and Media Authority (BICMA) records, there are 42 drayangs in the country today providing employment mostly for women. While the drayang owners deny the practice of commercial sex, people who visit the drayangs report that commercial sex is being practiced there.

In the year 2017, there was implementation of many recommendations from the 2016 Violence against Children research, with the Government initiating a review of the National Plan of Action for Child Protection (2013–2018). National Strategy and a Plan of Action

ceremony performed on preadolescent girls in non-standard health care settings. This is called *khafz* or *khatna*. The practice is thought to regulate sexuality and instill a moral temper in the girl as she grows up. A similar practice is also seen amongst some Muslim sects in Northern Kerala and is called *sunnathkalyanam*.

As per the definition given by the World Health Organization, these practices constitute Type 1 female genital mutilation. The practice exposes women to acute problems such as pain, bleeding, local infection and urinary tract infections. It may also have long-term implications in the form of chronic lower urinary tract symptoms, sexual dysfunction, abnormal vaginal discharge, dyspareunia and body dysmorphology. From the perspective of a professional gynecologist, it seems unlikely that removal of the clitoral hood alone without removing a part of the clitoris can be done by surgically untrained persons.

In India, a public interest litigation (PIL) has been filed in the Supreme Court contending that this practice is against the fundamental constitutional freedoms of right to life, right to equality and especially violates children s rights. The Dawoodi Bohra community has contested these claims. They have contested that restricting such practice is a restriction of the fundamental right to practice religion freely. The Government has taken a stand that there has been no official statistics on the prevalence of this practice. However, the Minister for Women and Child Development has expressed that such practice should be stopped voluntarily by the community or it would be banned by law.

SPECIAL SITUATIONS

SATI

This ancient custom has long stopped being practiced in India. The custom involved Hindu women sacrificing their lives by climbing the funeral pyre along with their deceased husbands. The practice was banned by the colonial government in 1829 in the Bengal province and it was further extended to the rest of the country in 1861. The Sati Prevention Act of 1988 criminalizes any type of aiding, abetting and glorification of this practice. The practice received some attention recently due to a Hindi film (Padmavat) depicting the event in a bygone era.

Child Marriage

The legal age for marriage in India is 18 years for girls and 21 years for boys. Due to a number of religious factors, traditions and cultural norms, it is common for girls, especially, to be married earlier. India has the largest number of girl brides globally. This has important implications for the girl in terms of exposing her to sexual intercourse and consequently infections and pregnancy at an early age. Pregnancy at an age younger than 15 years carries significant obstetric and medical risks. Child marriage and subsequently the burden of family responsibilities limits the opportunities that the girl has for education and financial independence. The cycle tends to repeat itself over generations.

The possible reasons behind such practices vary by religion and specific cultures. Child marriage is much more prevalent in rural areas, and amongst the socially and economically backward sections of society. The law is not implemented and there is protectionism by local leaders and tribal chiefs. The lack of action against such practices is largely a reflection of the lack of political will and fear of electoral backlash. The underlying thread in the prevalence of the practice on a national and possibly on a global level is the low social status that girls are accorded. They are usually looked upon as a burden to be passed on at the earliest to the husband s family in exchange for dowry. The other reasons for such a high prevalence is sham marriages used as a front for trafficking young girls.