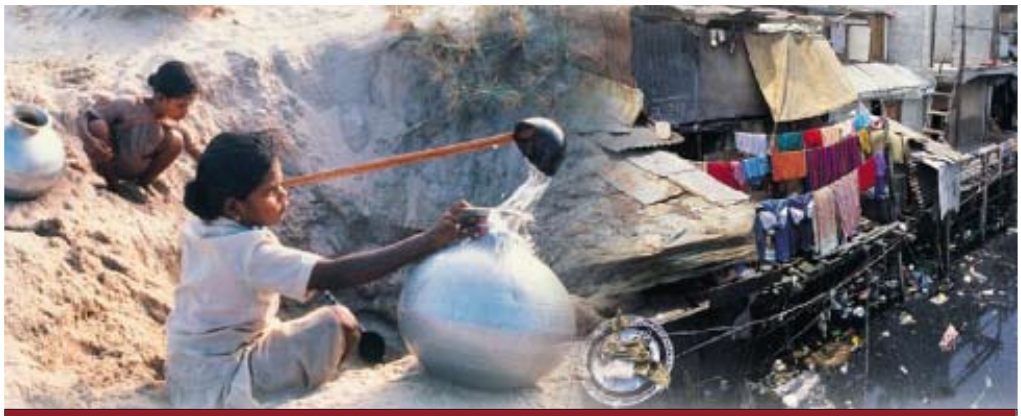
Middle East Journal of Family Medicine

ISSN 148-4196

October 2007 - Volume 5, Issue 7



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From the Editor

Abdulrazak Abyad
MD, MPH, AGSF, AFCHS
(Chief Editor)

Editorial office:
Abyad Medical Center &
Middle East Longevity Institute
Azmi Street, Abdo Center
PO BOX 618
Tripoli, Lebanon
P + (961) 6 443684
F + (961) 6 443685
E aabyad@cyberia.net.lb
W www.amc-lb.com

A This is a special issue of the journal dealing with the Global theme of Poverty and Human Development, with science and medical jiorunals worldwide co-rerleasing in this date. The MEJFM is particularly looking at the effect of poverty on health. It is known that half the world - nearly three billion people - live on less than two dollars a day. In addition the GDP (Gross Domestic Product) of the poorest 48 nations (i.e. a quarter of the world's countries) is less than the wealth of the world's three richest people combined.

We have witnessed a great international interest in the effect of poverty on health and there a number of initiatives by the UN, governmental organizations and NGOs to deal with the issue. Nearly a billion people entered the 21st century unable to read a book or sign their names. In addition less than one per cent of what the world spent every year on weapons was needed to put every child into school by the year 2000 and yet it didn't happen. We felt strongly that the segment of the population most strongly affected are the children, which is why we launched Child Watch movement.

Poverty hits the most vulnerable populations the most with 1 billion children living in poverty (1 in 2 children in the world). 640 million live without adequate shelter, 400 million have no access to safe water, 270 million have no access to health services. 10.6 million died in 2003 before they reached the age of 5 (or roughly 29,000 children per day). Therefore the movement that was started by the Ruler of Dubai to raise a large fund to teach one million poor children in the World is of great importance.

In this issue we have a number of papers related to poverty and development. A paper from Iraq discusses the effect of one of the mounting health crises that civilians are facing in war-torn Iraq. The author stressed that more than 700,000 internally displaced people live in temporary camps in and around Kirkuk and Suleimania cities where access to clean water, basic sanitation facilities, food and health care is rudimentary at best. The author pinpoints that he main cause of this epidemic is the non chlorinated open wells which were dig up unofficially due to the shortage of running tap water and the high temperatures (45-49) C.

A paper from Bangladesh investigated the reality of whether adolescents and young adults are vulnerable to HIV infection. The paper also defines how HIV AIDS has increased, and why adolescents are vulnerable to it. Finally, the paper provides a number of suggestive policy measures that planners and implementers may consider for rescuing them from such socially and culturally humiliating jobs.

In another paper from Bangladesh a multiple linear regression model was applied to study migrants from 505 respondents. It was observed that people migrate to certain places due to economic reasons and migration can alter the lifestyle of individuals and families. People migrate to new places with the hope of improving their social and economic status.

A second paper from Bangladesh discussed Human Rights of Accused Women in Criminal Justice in Bangladesh. Laws are made with the intention to reduce women-related crime and the main aim of this study is to give vent to the inhuman conditions where the accused women are found to be victims of cruel and heartless treatments in the jails.

Motamedi SH and Dadkhah A discussed the social and family factors effect on committing suicide among university students in Iran. The authors utilised a total of 100 students' attempts to investigate the relationship between social and family factors and the idea of committing suicide among university students in Iran. The paper concluded that singles were more inclined to commit suicide than the married

Members of the Executive Board of Child-Watch, Pocock, L.A., Butt M, Al Hilfy T and Beasley J, have provided a paper on the state of global child health and rights on this day, October 22, 2007 and also provide suggested solutions and projects to combat this residual and growing problem.

ADOLESCENTS AND YOUNG ADULTS ARE ESPECIALLY VULNERABLE TO HIV INFECTION

Mahmudul Hasan
Assistant Professor
Department of Population Science and Human Resource Development
University of Rajshahi
Rajshahi-6205, Bangladesh
E-mail: mahmud_ru@hotmail.com

Key words: Adolescents, Young Adults, Vulnerable, and HIV

ABSTRACT

This paper investigates the vulnerability of adolescents and young adults, to HIV infection. The paper also looks at how the incidence of HIV AIDS has increased, and why adolescents are vulnerable to it. It emphatically attempts to identify the patterns of such infection according to the nature of these groups and the people who usually contract HIV AIDS. The secondary sources data in this paper indicates that this is the age when the mentioned groups try to involve themselves with some curious works. The present research indicates they are having sex heedlessly and contracting such infection. The paper is primarily based on the secondary sources of data gathered through searching different reports, articles, and other research documents are also consulted in this research. Finally, the paper provides a number of suggested policy measures that planners and implementers may consider as measures they can implement to prevent this socially and culturally humiliating disease.

Introduction

Today adolescents of both sexes face a serious risk of HIV infection, which is the cause of AIDS. AIDS is a chronic and most often fatal disease. Despite growing understanding and awareness, HIV infection is a serious threat to both heterosexual and homosexual teens. When adolescents take certain risks, they are more likely to become infected with HIV and develop AIDS.

The scale of the AIDS epidemic is enormous. UNAIDS estimates that by the end of 2001, over 40 million people were living with HIV/AIDS, 17.6 million of them adult women, and 2.7 million children under 15 years of age. About 5 million people were newly infected in 2001 alone, and roughly the same as in 1999[31].

Membership in a particular population group does not confer automatic risk for HIV infection. Risk depends on behavior, and millions of the world's youth are engaging in sexual and drug-using behaviors that put them at risk for HIV. In fact, experimentation and risk-taking are considered fundamental to the period of adolescence, and as long as the epidemic exists each generation of the world's youth will need access to the information and skills necessary to make good decisions and to stay healthy.

It should be mentioned here that special attention has been given to adolescents to find their particular vulnerability to HIV infection.

Conceptual Framework

Adolescent and Young Adults

Adolescence, designated by the World Health Organization (WHO) as age-range of 10-19 years[1] and young adults of aged 15-24 are the groups considered in this paper.[33] UNFPA report shows that the terms "adolescents", "youth" and "young people" are used differently in various societies. These categories are associated, where they are recognized at all, with different roles, responsibilities and ages that depend on the local context.

This report uses definitions that are commonly used in different demographic, policy and social contexts:

- Adolescents: 10-19 years of age (early adolescence, 10-14; late adolescence, 15-19).
- Youth: 15-24 years of age.
- Young people: 10-24 years of age.

Vulnerable

Vulnerable means capable of being physically or emotionally wounded.

Risk of AIDS is increased by:

- an increased number of sexual partners
- IV drug use
- anal intercourse
- any sex (oral, anal or vaginal) without condoms
- alcohol and other drug use (sex is more impulsive and use of condoms less
- likely if under the influence of alcohol or other drugs)
- tattoos and body piercing with contaminated (unsterile) needles or instruments

Particularly vulnerable to becoming HIV-infected are certain subgroups within the adolescent population. These include: regular intravenous drug users; those from homes in which family members are substance abusers; those in detention and residential facilities; dropouts; the homeless; migrant children; adolescents who have had STDs; hemophiliacs; and those who adopt high-risk behaviors, such as unprotected sexual intercourse and drug and alcohol use2.

Why adolescents are at risk for HIV Infection:

Although less than 1 percent of persons known to have AIDS are teenagers, this segment of the population presents characteristics that increase the risk of becoming HIV infected3.

1. Perceived Invulnerability

Adolescents characteristically believe that they are impervious to disease, accidents, and death[4]. Ninety-one percent of 16-19 year olds surveyed by telephone did not think they would get AIDS[5], 73 percent of adolescents in another study were not worried about becoming HIV-infected[6]. Even when 79 percent of San Francisco teenagers reported

being afraid of getting AIDS, more than half believed they were not the kind of person who gets AIDS[7].

2. Developing Personal Identity

Sexual orientation becomes clarified during adolescence. One study found 1-2 percent of 16-19 year old boys had had homosexual relationships[8]; 0.5 percent reported bisexual relationship[5]. These boys could serve as agents of transmission to subsequent female or male partners.

3. Unprotected Sexual Intercourse

Adolescents are already at high risk for sexually transmitted diseases (STD). Recent data suggest that 70 percent of teenagers are sexually active by age 20, over half have had sexual intercourse by age 17, and fewer than half use condoms[9].

It is not surprising that slightly under half of all patients treated for STD are under age 25 years[10]. The Centers for Disease Control (CDC) reports that 15-19 year olds have the highest rate of gonorrhea of any age group and that the number of reported cases of STD, an indicator of unprotected sexual intercourse, is increasing among 15-19 year olds.

4. Drug Experimentation

An individual's first experience with drugs typically occurs during the first three years of high school[11]. Over half of adolescents have experimented with psychoactive drugs by high school graduation[9]. Most drug use among 12-17 year olds involves alcohol, although a small proportion, 0.1 percent in a recent study[8] uses heroin and other injectable drugs. Experimentation with non-injectable drugs may impair judgment and lead to behaviors that increase the risk of HIV infection.

During the process of maturation and emancipation, adolescents are at increased risk for contracting HIV for several reasons identified by **'The American Psychiatric Association'** which are given below:

- Adolescence is a time of experimentation. Sexual and drug-using behaviors can place them at risk for contracting HIV. Most intercourse between teenagers occurs without the use of condoms or consistent condom use. Few teenage pregnancies are planned. Drug and alcohol abuse further impairs judgment and decreases the likelihood that safer sex and needle exchange or cleaning will occur. Teenagers who inject drugs often share or do not clean their needles.
- Adolescents are particularly prone to peer influences to take risks and often have false beliefs about what peers are doing.
- Adolescents often believe they are omnipotent and invincible, and they may be unconcerned about future consequences.
- Adolescents may be the victims of sexual abuse, incest, and rape or trade sex in exchange for drugs, money, shelter, or other needs. These problems are particularly acute for homeless youth and those presenting with a conduct disorder. All of these youth should be evaluated for screening for HIV and other sexually transmitted diseases/infections (STD/STIs).
- Psychiatrically ill or developmentally disabled youth may have problems with impulse control, self-destructive urges, suicidality, poor insight and judgment, and hypersexuality and thus place themselves in encounters where they are at risk for contracting HIV. Co-morbid substance abuse often further exacerbates risk behaviors.
- Youth who seroconvert are at risk for suicide attempts, running away or being thrown out of their homes, and not accessing appropriate medical services. This is especially true for gay, bisexual, and trans-gendered teen boys.
- Many parents are unaware of the extent of adolescent HIV risk behaviors or may not have the skills to help their teenagers. Some family dynamics may actually exacerbate risk-taking behaviors.

Vulnerability

Adolescence is a vulnerable period when young adults are exposed to new experiences relating to sexuality and reproduction[12]. For many reasons, female adolescents are more vulnerable than any others and are biologically more susceptible to some STIs, such as Chlamydia and gonorrhea that could facilitate the transmission of HIV[13]. In addition, early age-at-marriage and ignorance about sexuality and reproduction stimulate the risk of early pregnancy among female adolescents in Bangladesh. The source of information and advice on contraception are rarely available or accessible to the adolescents[14]. Susceptibility of female adolescents to HIV infections is rooted in the traditional gender discrimination that denies them the power to protect their health. The traditional gender roles render women less able to control the nature and timing of their sexual activity as men are more able to determine how, when, and with whom sex will take place. This unequal gender role enhances the vulnerability of women to HIV infection, especially when women are economically dependent on men and have under-representation in the decision-making process. In such a situation, when men are the traditional authority of their families, women, particularly young women, are not likely to make independent decisions relating to their health and are often unable to seek crucial reproductive health information and services on their own[15]. The female adolescents in Bangladesh are not sufficiently aware of AIDS. Of great concern is that a sizeable proportion of the adolescents had misconceptions about the fatality and avoidance of AIDS. In addition, the prevalence of STIs among them is relatively high. One recent study, conducted in late 1996 with 2,100 married and unmarried adolescents, reported that 39% of husbands of adolescents had symptoms of syphilis, and 7% reported using condom, indicating that most of them were exposed to unsafe sex[16].

Several factors make youth particularly vulnerable to HIV/AIDS, including their age, biological and emotional development and their financial dependence. From the 'Henry J. Kaiser Family Foundation's' HIV/AIDS Policy Fact Sheet (May 2002), we observe the following factors:

- Surveys indicate that although many more young people across the world have now heard about the HIV/AIDS epidemic, awareness is not universal and many are still unaware of how to protect themselves or harbor misconceptions about HIV

transmission.

- Many sexually active young people at risk for HIV do not perceive themselves to be at risk, even those in countries with very high prevalence. Moreover, most young people living with HIV do not know they are infected.
- Being infected with another sexually transmitted disease (STD) increases the likelihood of both acquiring and transmitting HIV. Studies indicate that the prevalence STDs other than HIV among youth is high.
- Most young people at risk for HIV infection or already living with HIV/AIDS reside in the world's poorest regions; their vulnerability to HIV operates within a broader context of poverty, which may include lack of access to education, economic opportunities, and health-related services.

[32]A recent situation of HIV/AIDS cases has been shown by a following table released by 'Global Statistics' last updated on November 2006:

Table 1. *HIV and AIDS around the World*

HIV and AIDS around the World	
People living with HIV and AIDS	39.5 million*
Adults	37.0 million
Women	17.7 million
Children under 15	15 2.3 million
New HIV cases in 2005	4.3 million
Adults	3.8 million
Children under 15	530,000
AIDS deaths in 2005	2.9 million
Adults	2.6 million
Children under 15	380,000
Total HIV cases to date	64.3 million
Total AIDS deaths to date	23.1 million
*All figures from UNAIDS AIDS Epidemic Update 2006	

The above table indicates a highly significant percent of adolescents and young people are living with HIV/AIDS. So it is our intention to explore the vulnerability of these groups.

[17]Certain subpopulations of youth have been identified as bearing a disproportionate share of HIV's proliferation and/or being at increasing risk[18]:

Young women and girls:

Women comprise an increasing proportion of those living with HIV/AIDS, rising from 41% in 1997 to 47% in 2001. The rate of new infections among girls is as much as 5 to 6 times higher than those of boys in some hard hit countries and young women represent the majority of young people living with HIV/AIDS in sub-Saharan Africa and Asia[18] Biologically, the risk of becoming infected with HIV during unprotected vaginal intercourse is greater for women than men and on average; women are infected at younger ages than men.

Young men who have sex with men (MSM):

Stigma, social exclusion, and lack of information can result in increased risk-taking among men who have sex with men. Male-to-male sexual transmission is a predominant risk factor for HIV in several countries, including the U.S., Brazil, Costa Rica, and Mexico, and may be playing an increasing role in Eastern Europe. Risky behaviors and HIV infection rates among young MSMs may again be on the rise in the developed world.

Injection drug users (IDU):

Injection drug use continues to be a risk factor for many young people, particularly in Eastern Europe, Central Asia, and the Russian Federation.

About 3 million teenagers acquire an STD every year in the United States[19]. This represents roughly one in eight young people between the ages of 13 and 19, and about one in four of those who have ever had sexual intercourse. In addition, about 25% of all young people are infected by any STD by age 21[20]. Approximately a quarter of all reported cases of STDs occur among teenagers[21]. Globally, over 100 million STDs occur each year in people who are younger than 25 years old[22].

Sexually transmitted infections (STIs) including HIV are most common among young people aged 15-24 and it has been estimated that half of all HIV infections worldwide have occurred among people aged under 25 years[23]. In some developing countries, up to 60% of all new HIV infections occur among 15-24 year-olds. Yet, vulnerability to STIs including HIV is systematically patterned so as to render some young people more likely to become infected than others[24].

Young people may also face the increased risks of HIV infection by virtue of their social position, unequal life chances, rigid and stereotypical gender roles, and poor access to education and health services.

One of the most important reasons why young people are denied adequate access to information, sexual health services and protective resources such as condoms, derives from the stereotypical and often contradictory ways in which they are viewed. It is popularly believed that all young people are risk-taking pleasure seekers who live only for the present. Such views tend to be reinforced by the uncritical use of the term adolescent (with its connotations of "storm and stress") in the specialist psychological and public health literatures. This term tends not only to homogenise and pathologise our understanding of young people and their needs, it encourages us to view young people as possessing a series of "deficits" (in knowledge, attitudes and skills) which need to be remedied by adults and the interventions they make[25].

In Nicaragua where virginity is highly valued among young women, having multiple sexual partners is taken as a sign of virility in young men[26] Here, teenage boys face social pressures from older men (including fathers, older brothers and uncles) to have sex as early as possible and, in the recent past, it was not uncommon for fathers to arrange for their son's sexual initiation with a sex worker[26]. So while for girls, public disclosure of sexual activity leads to dishonour, bragging about sex is common for boys. [27]Berglund et al (1997) note that for young Nicaraguan men the pressure to be sexually active and multi-partnered may be so great that those who do not fulfill this expectation are open to ridicule by their peers for not being a real man.

Across the World's Regions Youth Face Significant Rates of HIV Infection

- In sub-Saharan Africa, most new HIV infections occur among people ages 15 to 24 and are sexually acquired. Nearly nine million youth are infected with HIV, and 67 percent of infections occur in young women[28]. Prevalence rates exceed 20 percent in several countries in southern Africa, experts fear rates will rise in West Africa[29,30].
- In Latin America and the Caribbean, about 560,000 young people are HIV-infected[28]. In Latin America (especially in Mexico, Brazil, and Peru), marginalized populations-such as young men who have sex with men-are most affected[28]. In the Caribbean, infection rates are the second highest in the world, and most new infections occur among women ages 15 to 24[28].
- In southern and southern Asia, over one million youth are HIV-infected[28]. Initially fueled in Thailand and Cambodia by the sex trade and injection drug use, the epidemic has been successfully slowed in both countries. Now, India shows alarming increases in HIV/AIDS throughout its diverse population[28,29].
- In eastern Asia and the South Pacific, nearly three-quarters of a million youth are HIV-infected. Most new cases are in China, home to one-fifth of humanity, where UNAIDS warns of an "unfolding epidemic of proportions beyond belief"[29].
- Eastern Europe and central Asia have nearly half a million HIV-infected youth, mostly as a result of injection drug use. Rates are rising rapidly in Belarus, Kazakhstan, Latvia, and Russia, as well as in the Ukraine, where one percent of young women and two percent of young men are now HIV-infected [28, 29].
- Rates remain low, though increasing, in North Africa and the Middle East. Over 160,000 youth in this region are infected[28]. Sexual intercourse and injection drug use are the major routes of transmission; and Djibouti and Sudan have large, widespread epidemics [29, 30].
- In developed nations, nearly a quarter of a million youth are HIV-infected[28]. Higher rates of sexually transmitted infections (STIs) signal a rise in unsafe sex and highlight the need for renewed prevention efforts, especially among youth[30]. Leading factors behind the epidemic vary from injection drug use in Spain, France, and Portugal, to heterosexual transmission in the United Kingdom, heterosexual transmission among disadvantaged women in the United States, and sex between males in Japan, Canada, Australia, and the United States [29,30]. Nevertheless, each of these factors, heterosexual transmission, injection drug use, and sex between males, plays a part in the HIV epidemic in every industrialized nation.

Conclusion and Recommendation

Adolescents are not a homogeneous group; they have significant social, economic and gender differences. They are not only the individual but global concern of the present world. In spite of a lot of anti-AIDS campaigns in the world, the vulnerability among adolescents is still increasing. To protect adolescents and young adults from HIV infection, societies will have to change cultural and sexual norms, values, and practices by adopting a lot of logical programmes.

References

1. *World Health Organization. Young people's health-a challenge for society. Report of a WHO Study Group on Young People and "Health for All by the Year 2000". Geneva: World Health Organization, 1986. 117 p. (WHO technical report series no. 731).*
2. *AIDS and Teenagers: Emerging Issues. (1988). Hearing before the House Select Committee on Children, Youth, and Families, U.S. Congress, Washington, D.C. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office. ED 293 070.*
3. *Summerfield, Liane. (1990). Adolescents and AIDS. ERIC Clearinghouse on Teacher Education Washington, D.C.*
4. *Hochhauser, M. (1998). AIDS: It's Not What You Know, It's What You Do. Paper presented at the annual meeting of the American Psychological Association, August 12-16, 1988. ED 302 761.*
5. *Strunin, L., and Hingson, R. (1987). Acquired immunodeficiency syndrome and adolescents: Knowledge, beliefs, and behaviors. Pediatrics, 79 (5), 825-828.*
6. *Price, J.H., Desmond, S., and Kukulka, G. (1985). High school students' perceptions and misperceptions of AIDS. Journal of School Health, 55(3), 107-109. EJ 316 103.*
7. *DiClemente, R.J., Zorn, J., and Temoshok, L. (1986). Adolescents and AIDS: A survey of knowledge, attitudes, and beliefs about AIDS in San Francisco. American Journal of Public Health, 76 (12), 1443-1445.*
8. *Hingson, R., Strunin, L., and Berlin, B. (1990). Acquired immunodeficiency syndrome transmission: Changes in knowledge and behaviors among teenagers, Massachusetts statewide surveys, 1986 to 1988. Pediatrics, 85 (1), 24-29.*
9. *Guidelines for effective school health education to prevent the spread of AIDS. (1988). Health Education, 19 (3), 6-13. EJ 381 056.*
10. *Yarber, W.L. (1987). AIDS: What Young Adults Should Know. Instructions Guide and Student Guide. Reston, VA: American Alliance for Health, Physical Education, Recreation, and Dance, 1990 Association Drive 22091. ED 290 714.*
11. *horne, C.R., and DeBlassie, R.R.(1985). Adolescent substance abuse. Adolescence, 20, 335-347. EJ 323 323.*
12. *Nahar Q, Amin S, Sultan R, Nazrul H, Islam, Kane TT et al. Strategies to meet the health needs of adolescents: a review. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1999.*
13. *Brookman RR. Adolescent sexual behaviors. In: Holmes KK, Mardh P-A, Wasserheit J, editors. Sexually transmitted diseases. 2d ed. New York: McGraw-Hill, 1990:77-84.*
14. *Khan, M. Asaduzzaman. (2002). Knowledge on AIDS among Female Adolescents in Bangladesh: Evidence from the Bangladesh Demographic and Health Survey Data. ICDDR, B: Centre for Health and Population Research, Bangladesh, 2002.*
15. *Khan MA, Khanum PA. Influence of son preference on contraceptive use in Bangladesh. Asia Pacific Popul J 2000; 15:43-56.*
16. *Haider SJ, Saleh SN, Kamal N, Gray A. Study of adolescents: dynamics of perception, attitude, knowledge and use of reproductive health care. Dhaka: Population Council, 1997. 44 p.*
17. *Impacts of HIV/AIDS on Youth (fact sheet) May 2002.*
18. *UNAIDS. AIDS epidemic update. December 2001.*
19. *Centers for Disease Control and Prevention. Division of STD/HIV Prevention 1992 Annual Report. Atlanta, GA: CDC, 1993.*
20. *Warren WK, King AJC. Development and Evaluation of an AIDS/STD/Sexually Program for Grade 9 Students. Kingston, Ontario: Social Program Evaluation Group, 1994.*
21. *Centers for Disease Control and Prevention. Tracking the Hidden Epidemics: Trend in STDS in the United States 2000.*
22. *World Health Organization 1997. Fact sheet No. 186. "Young People and Sexually Transmitted Diseases".*
23. *World Health Organization (1995). Women and AIDS: an agenda for action. Geneva: Author.*
24. *Aggelton, P. and Rivers, K. (1998) 'Bevaioural Interventions for Adolescents' in L.Gibney, R. DiClemente and S. Vermund (eds.) Preventing HIV Infection in Developing Countries, New York: Plenum Publications.*
25. *Aggelton, P. & Warwick, I. (1997). 'Young People, Sexuality, HIV and AIDS Education'. In L.Sherr (ed.) AIDS and Adolescents. Amsterdam, Netherlands: Harwood Academic Publishers.*
26. *Zelaya, E., Marin, F.M., Garcia, J., Berglund, S., Liljestrand, J., & Persson, L.A.(1997). Gender and Social Differences in Adolescent Sexuality and Reproduction in Nicaragua. Journal of Adolescent Health, 21: 39-46.*
27. *Berglund, S., Liljestrand, J., Marin, F.D.M., Salgado, N., & Zelaya, E. (1997). The background of adolescent pregnancies in Nicaragua: A qualitative approach. Social Science and Medicine, 44(1): 1-12.*
28. *UNAIDS et al. Young people and HIV/AIDS: Opportunity in Crisis. Geneva: UNAIDS, 2002.*
29. *Lamptey P et al. Facing the HIV/AIDS Pandemic. Population Bulletin 2002; 57(3): 1-39.*
30. *UNAIDS. Report on the Global HIV/AIDS Epidemic. Geneva: UNAIDS, 2002.*
31. *The World Bank. Education and HIV/AIDS: A Window of Hope. Washington: World Bank, 2002.*
32. *Global Statistics Fact Sheet 3. URL: http://www.nat.org.uk/document/79, Retrieved on January 28, 2007.*
33. *UNFPA. Overview of Adolescent Life. URL: http://*

CHOLERA

Dr Safaa Bahjat
Ilergy Centre, Kirkuk, Iraq

Introduction

Cholera is just one of the mounting health crises that civilians are facing in war-torn Iraq. More than 700,000 internally displaced people live in temporary camps in and around Kirkuk and Suleimania cities where the access to clean water, basic sanitation facilities, food and health care is rudimentary at best. The camps have no health services whatsoever to offer. The crisis is compounded by continuous insecurity which makes movement dangerous, and putting health staff at risk as they try to reach the people who need medical care. The main cause of this epidemic is the non chlorinated open wells which were dig up unofficially due to the shortage of the running tap water and the high temperature (45-49) C. Till now 8 deaths from cholera have been reported, the cumulative number stands at 4,000 cases since the beginning of August. This article has been written to shed light on the little that has been achieved in Iraq, and globally, in fighting this infectious disease.

An oral, whole cell, killed Vibrio cholerae vaccine combined with the recombinant B subunit of cholera toxin (Dukoral) was approved by the European Union (EU) in April 2004. This vaccine is the second licensed oral vaccine for prevention of cholera; an oral live attenuated vaccine (Orochol or Mutachol) is also licensed in some countries but is not currently being produced.

Epidemiology and clinical manifestations

Cholera is caused by the bacterium V cholerae and is endemic throughout many resource poor regions of the world. Transmission occurs through ingestion of faecally contaminated water and food. Large numbers of bacteria (100000000-100000000000) are needed to establish infection in people with normal gastric acidity. Rapid spread is common in communities where there is poor hygiene, lack of sanitation and poverty. Cholera can be a major problem affecting people in refugee settings. In 2004,101 383 cases of cholera with 2345 deaths were reported to WHO from all continents except Oceania. African countries accounted for 94% of the global total .The reported figures are likely to be considerable underestimates; routine culture of stool samples for V cholera is often not or not available in endemic areas, and some affected countries may not report cases because of concerns about the impact on their travel industry. For example, it is highly likely that cholera is endemic in Pakistan and Bangladesh, but these countries have not reported cases in recent years.

V cholerae serogroup O1 are the main cause of epidemics of cholera.V cholerae O1 can be divided into classic and EIT or biotypes, and the two main serotypes, Ogwa and Inaba. All combinations of serotypes and biotypes may occur. Specific genetic markers are increasingly used to differentiate organisms. The EIT or biotype is responsible for the recent pandemic that began in 1961 in Celebes (Sulawesi), Indonesia. This pandemic moved west, reaching the Indian subcontinent, Africa and eventually South America by 1991. A large outbreak of cholera occurred in Bangladesh and India in 1992. On this occasion a new serogroup O139 (synonym Bengal) was isolated. V cholerae O139 has since spread to at least another 11 countries. Approximately 15% of laboratory – confirmed cases in endemic countries of Asia are caused by V cholerae O139, and 59% of the cholera cases in China in 2004 were caused by the O139 serogroup. Cholera is characterized by the sudden onset of profuse watery stools with occasional vomiting. The incubation period is usually 2-5 days but may be only a few hours. In severe disease, which occurs in 5-10% of those infected, dehydration, metabolic acidosis, and circulatory collapse may rapidly develop. If left untreated, over 50% of the most severe cases may die within several hours; with prompt treatment, mortality is less than 1%. In 2004, the global case fatality rate was 2% and as high as 41% in vulnerable populations .Treatment of cholera is rehydration with oral or intravenous fluids. In severe cases, antibiotic treatment can be given to reduce the volume of diarrhoea and to reduce the duration of excretion of V cholerae. There is increasing resistance of V cholerae to doxacyclin, the antibiotic of choice, so alternatives such as co-trimaxazole (trimetheprim-sulfamethaxazole), erythromycin, chloramphenicol, ciprofloxacin, and aztihoramycin can be used where organisms are sensitive.

Pathogenesis and immune responses:

V cholerae colonise the gut using pilli or fimbriae that enables them to attach to receptors on the small bowel epithelium. Once attached, the bacterium releases a toxin known as cholera toxin that is made up of two subunits: an A (active) unit and a pentameric B (binding) unit. Cholera toxin is similar structurally and functionally to the heat labile toxin produced by some E coli. The B subunit binds cholera toxin to GM1 ganglioside receptors on the surface of intestinal epithelial cells. Once the toxin has bound, the A subunit is internalized and activates the enzyme adynelate cyclase. This activation leads to an increase in cyclic adenosine monophosphate in the epithelial cells, causes active secretion of chloride anions, decreased absorption of sodium, and the resultant loss of electrolytes (e.g. sodium chloride, and potassium), bicarbonate and water into the gut lumen, which can lead to hypovolemic shock and metabolic acidosis.

Following change or infection with V cholerae, human beings mount both systemic and mucosal immune responses that can produce long standing and effective immunity to homologues biotypes. Although systemic vibrocidal (and antitoxin) antibodies develop during illness and vibriocidal titers correlate with a decreased risk of subsequent infection, they may be just a marker of infection, since protection against cholera in vaccine trials may occur despite low serum titers .The mucosal response is thought to have the major role in protection against natural infection, with intestinal antitoxin helping to protect against disease.

Cholera vaccines

Whole cell, killed parenteral vaccines stimulate the development of short-term immunity to V cholerae O1. Approximately 50-60% of people living in endemic regions were reported for 3-6 months. However these vaccines

are least effective in young children who are at high risk from cholera and it's adverse consequences. Protective efficacy in naive people from non-endemic regions is likely to be less. Parenteral vaccines are associated with local reactions in approximately 50% of vaccines and 10-20% develop more generalized systemic reactions such as fever and malaise. A parenteral vaccine consisting of phenol-inactivated whole cell V cholerae strains Ogawa (usually classic biotype) is licensed, but is not yet produced. The vaccine's limited efficacy, lack of utility in control of cholera outbreaks, and frequent adverse reactions make this vaccine no longer useful.

Oral vaccines

The oral vaccines have been licensed for commercial use: the killed whole cell V cholerae plus recombinant B subunit of cholera toxin vaccine (rCTB-WC; Dukoral; SBL Vaccine AB, Stockholm, Sweden), and the live attenuated V cholerae O1 strain CVD 103 –HgR vaccine (Orochol; Berna Biotech Ltd., Berne, Switzerland; known as Mutachol in Canada). Dukarol does not contain the A subunit of cholera toxin and therefore no pathogenic toxin is present.

Phage in the time of cholera

Bacteriophage (bacterial viruses) were heralded as revolutionary therapeutic agents soon after the discovery by Felix d'Herelle in 1917 of an invisible microbe capable of lysing bacteria. Bacterophage appeared to be efficient killers of their bacterial hosts. We now know that their life history is far more complex than first assumed, so the idea of the phage's potential, as curative or prophylaxis spread quickly to research institutes in Europe, North America, and Asia. d'Herelle himself spearheaded many of these efforts, the most famous of which was the initiation of an extensive campaign to use phage in the treatment and prevention of cholera in colonial India. The authors of one such study conclude by noting that 'the results establish sufficient probability in favor of a significant effect of the administration of bacteriophage to form a basis of practical policy in the treatment and prevention of cholera in villages'. The early hopes never fulfilled the expectations, for both clinical and political reasons, and the eventual development of broad spectrum antibiotics provided a more reliable, effective means of control of bacterial infections. The rise of antibacterial resistance has, in turn, revived interests in bacteriophage therapy, despite concerns and uncertainties as to its effectiveness. We consider rather an alternative approach to modern bacteriophage therapy by revisiting the idea of inoculating bacteriophage directly into the environment.

Most tests, theories, and proposals to implement bacteriophage therapy regard the human body as the potential site for intervention. But for many bacterial diseases affecting human health, the pool of infecting bacteria comes from water, soils, foods, and other host organisms; some of these potential sources of infection do not posses a complex immune system capable of selectively eliminating foreign agents. By contrast with agricultural settings, where environmental application of phage as bio-control is already being considered, we believe there exists as an yet overlooked opportunity to reduce the severity, extent, and persistence of some bacterial epidemics by developing ecologically based cures for human disease.

A suitable target disease is cholera. Recent studies have demonstrated a substantial correlation between the increase in density of cholera-specific phage and the decrease in density of V cholera in both water sources and fecal matter from infected patients. The reasons are apparently simple; the presence of V cholera provides an opportunity for the spread, and increase of phage, which leads to decreasing host density, which in turn leads to the washout/death of phage. A comprehensive description of cholera disease dynamics involve many factors including environmental seasonality, long distance dispersal mediated by alternative hosts, as well as life history modalities that enable V cholera to respond to stressful conditions. Without diminishing the importance of these and other factors, in the case of cholera it is apparent that phage and bacteria go through alternating boom-and-bust cycles. What are the practical steps of intervention so as to minimize the likelihood of devastating epidemic booms of V cholera?

Briefly, the peak of phage lags behind the peak of bacteria. Growing O1 and /O139 serogroup-specific phage in the laboratory and then adding phage to at-risk water sources may augment the ability of phage to keep pace with the dynamics of its host and suppress the spread of an epidemic. In a sense we are suggesting altering the (natural course) of host-phage population dynamics with artificial injection of phage. The utility and affectivity of any such ecological inoculation depend on careful balancing of environmental connectivity of infected areas, risks to human populations, as well as the life history and parameterization of biocontrol agent themselves. Ultimately, limiting and/or eliminating an undesirable bacterial population constitutes a problem in co-evolutionary biological control. Likely sources of intervention include source of drinking water, wells, and sewage systems so as to minimize the flow of bacterial agents into water used for drinking and bathing. Assessments of lifetime of phage in local habitats would be necessary because conditions (e.g. temperature, salinity, PH) change over the course of intervention. In addition, the ecohydrology of the affected region may be important, since intervention strategies will depend on whether disease outbreaks are localized to isolated sites, linked to seasonal flooding, or occur in riverine corridors. These concerns notwithstanding, cholera-specific phage are already found in natural environments and strong evidence exists that their presence leads to the decline of cholera epidemics .The risks associated with ecological bacteriophage therapy should be mitigated by the use of virulent, rather than temperate, strains of phage. If the origins of the seasonal cholera epidemics are harbored within environmental pools, then efforts should be made to seek out the most effective means of adding bacteriophage to eliminate the incubation and growth of V cholerae populations when they are at their most vulnerable. Thus far, the spread of cholera has been mitigated by improvements in water quality, low cost preventive measures in-at-risk regions (e.g. filtering water through sari clothes), and by improvement of post infection treatment (e.g. single-dose antibiotic therapy), although the global chloramphenicol has not abated. Bacteriophage could become an additional tool in the public–health struggle against cholera.

HUMAN RIGHTS OF ACCUSED WOMEN IN CRIMINAL JUSTICE IN BANGLADESH

Md. Abdul Hannan [1]
Md. Nazrul Islam Mondal [2]
Md. Shahidul Islam [3]

1. *Department of Law & Justice, University of Rajshahi, Rajshahi-6205, Bangladesh*
2. *Department of Population Science and Human Resource Development, University of Rajshahi, Rajshahi-6205; Bangladesh.*
3. *Department of Law, International Islamic University Chittagong, Chittagong; Bangladesh.*

Correspondence to:
Dr. Md. Nazrul Islam Mondal
Department of Population Science and HRD
University of Rajshahi
Rajshahi-6205
Bangladesh
Phone: +88-0721-751217
Mobile:+88-01716389187
E-mail: nazrul_ru@yahoo.com

ABSTRACT

Laws are made with the intention to reduce women-related crime and our main aim of this study is to give vent to the inhuman condition where the accused women are found to be victims of cruel and heartless treatments in the jails. Our study is also related to human rights and in criminal justices especially, where accused women chained in the jails, experience so much untold and heartless cruelty.

Key words: Human rights, accused women, criminal justice, Constitution of Bangladesh.

Introduction

Bangladesh is a densely populated country with limited resources. The women constitute nearly 50% of the total population and about 74.4 millions female population live in this country; among them 37% aged less than 15 years, 52% aged 15-49 years and only 11% aged 50 and above and the life expectancy of females is 62 years [1]. The term 'human being' is inextricably and indispensably related to two basic concepts, male and female, in the absence of one, the other is meaningless. Male and female, are given protection against violation of human rights equally regardless of their origin, place of birth, nationality or other factors. However, any of those human rights guaranteed as fundamental human rights may be subjected to restriction, suspension or curtailment for several reasons. Accusations brought against a human being is one of the other mentionable grounds, which may be a cardinal factor for the restriction, suspension or curtailment of any of the rights guaranteed to him/her as fundamental human rights. It does not mean the total curtailment, suspension or restriction of the right altogether. Male as well as female segments of the society undeniably have rights even in the event of their being treated as accused. Thus the main objective of this study is to ponder over those rights guaranteed to a woman accused of a criminal offence.

Constitutional guarantees of the women accused

The Constitution of Bangladesh contains some provisions relating to the rights of the accused, either male or female. The Constitution provides that all are equal before law and entitled to equal protection of law [2]. The implication of the term equality before law and equal protection of law is that nobody shall, on the grounds only of religion, race, caste, sex or place of birth be subjected to any disability, liability, restriction or condition. Equal treatment in the courts of law by the authority has been guaranteed to every citizen and non-citizen, male or female alike. Everyone has been endowed with the protection of law and it has been guaranteed that no action detrimental to the life, liberty, body, reputation or property of any person shall be taken except in accordance with law [3]. So, everybody is subject to same treatment regardless of sex in the eye of law.

Anybody's life or personal liberty cannot be curtailed provided the provisions of law for the time being in force, which provide for such infringements [4]. Arrest and detention issues have been properly delineated in the said Constitution. It has also been said that every arrested person shall be communicated with the grounds of his/her arrest within twenty-four hours excluding the time necessary for the purpose of carrying the arrestee to the nearest Magistrate Court from the place of such arrest [5]. Every arrestee shall be provided with the facilities of the right to consult and be defended by a legal practitioner of his/her choice [6]. So, the accused irrespective of sex is on an equal footing, and entitled to such rights. These rights, guaranteed to an accused whether male or female, are not absolute and beyond any limitation. Any person who is arrested under the preventive detention order may be denied any of those rights. An accused is not to be prosecuted and punished for the same offence more than once and it is equally applied to both male and female [7]. It is one of the fundamental rights of an accused to be punished for the commission of an offence which is a punishable offence under the law in force and he/she should not be subjected to a penalty greater than or different from, that which might have been inflicted under the law in force at the time of the commission of the offence [8]. Every accused either male or female

enjoys the right to a speedy and public trial by an independent and impartial court or tribunal established by law [9]. No person accused of any offence is compelled to be a witness against him/herself [10] while no one is to be subjected to torture or to cruel, inhuman, or degrading punishment or treatment [11].

Women as arrested and detained persons

A person may be imprisoned either as an arrested or detained person. Either male or female may fall into this category. The laws regarding arrest and detention are not similar. There exists a separate law to deal with each of the issues. In Bangladesh, the Code of Criminal Procedure (Cr. P.C.), 1898 deals with the provisions regarding arrest.. Chapter V of the said Code expresses the provisions of arrest in Bangladesh [12]. Under this chapter arrest may be made generally [13] and it may also be made without warrant [14]. Both male and female may be arrested under the provisions of this chapter. While arresting anybody under these provisions, the Police Officer or person concerned making arrest has been empowered to make actual touch of the body of the person to be arrested [15]. In case of women the female police would should touch the accused but the practice is different from existing law. The Police Officer or person concerned making the arrest has also been allowed to use all necessary means to ensure the arrest if the person to be arrested makes any endeavour or attempt to evade the arrest [16]. The Police Officer or person concerned making the arrest has also been empowered to cause the death of the person to be arrested in such situation if he/she is accused of an offence punishable with death or with imprisonment for life [17]. Again a Police Officer has been empowered to arrest any person without an order from a Magistrate and without a warrant under the provision of Section 54 of the Cr. P. C. [18].

On the other hand detention is made following the provisions of the Constitution of Bangladesh. Article 33 of the said Constitution speaks of the provisions regarding detention of any person [19]. Under this law, any person whether male or female may be arrested and detained before committing any cognisable offence if reasonable apprehension exists in the mind of the authority that he/she may commit such offence if he/she is allowed to move freely.

Anyway, both male and female who have been arrested and detained both under general and special laws have some basic human rights. It is a common provision that the female prisoners should be separated from the males. Again, an arrested or detained woman who is pregnant should be given special care and attention. If a person is arrested under general law following the order of a Magistrate or without the order of a Magistrate, he/she would be placed before the Magistrate within twenty four hours excluding the time necessary for the journey from the place of arrest to the court of the Magistrate. He/she should be communicated with the grounds of such arrest [20]. But this right has been denied to a person who has been detained or arrested under any law providing for preventive detention [21].

Search and seizure of women accused

Due to the difference of sex, women need to be searched in a special way and the process of searching of a woman is totally different from that of a man. There exists particular provisions' regarding the search of women accused. Search may be of two kinds; the place suspected to be the abode of the accused may be required to be searched in order to find out and ensure about whether the accused is actually there. In that situation, the person acting under a warrant of arrest, or any Police Officer having authority to arrest has reason to believe that the person to be arrested has entered into, or is within, any place, the person residing in, or being in charge of, such place, shall, on demand of such person acting as aforesaid or such Police Officers, allow him free ingress thereto, and afford all reasonable facilities for a search therein [22]. If the demand mentioned above is not fulfilled then the person acting under a warrant of arrest or the Police Officer is empowered to break open any outer or inner door or window of any house or place, whether that be of the person to be arrested or of any other person [23]. If that place where the accused is suspected to be residing is an apartment in the accused's occupancy of a woman, not being the person to be arrested, who according to custom, does not appear in public, such person or Police Officer shall, before entering such apartment, give notice to such woman that she is at liberty to withdraw and shall afford her every reasonable facility for withdrawing, and may then break open the apartment and enter it. After arrest is made, the arrested person, male or female, may be searched by the Police Officer arresting the accused or in case of private individual, the Police Officer to whom the private individual makes over the arrested person and the search should be made in a safe custody [24]. All articles other than necessary wearing apparels found upon him may be searched. The female arrestees are, in a bit, taken under special provision in this case. If it becomes necessary to cause a woman to be searched, another woman shall make the search, with strict regard to decency [25]. So, the safeguards as to search of an accused woman by the Law Enforcing Agency (LEA) reveals that while searching any arrested woman, the rules of decency that is the assurance of honesty, politeness in behaviour that follows the accepted moral standards and shows respect for others should be strictly followed to its entirety. Another meaning of this is that while searching an accused woman utmost respect and honour have to be shown to the magnanimity of her privacy. Inviolability of her privacy as a female should be given due respect [26].

Women accused at fair trial

Right to a fair trial is one the fundamental human rights of every individual. Every individual should enjoy the facility to get justice regardless of the difference of sex, race, caste, colour, place of birth and so on and so forth. The Constitution of Bangladesh says that all are equal before law and are entitled to equal protection of law [2]. Every human being should be treated responding to all of the principles of natural justice.

The women accused shall be provided with the right to consult with a lawyer of her own choice and no one shall be deprived of that for the sake of fair trial [5]. Each should be treated on the basis of the law in force at the time of the commission of offence [7]. None of the accused in police custody shall be prosecuted and punished for the same offence more than once [8]. Speedy and public trial by an independent or impartial court or tribunal established by law is a basic human right and none should be denied of that [9]. The accused under trial shall be guaranteed the right of not to be a witness against herself [10]. The accused if convicted shall not be subjected to torture or to cruel, inhuman, or degrading treatment or punishment [11].

Rights of women prisoners

The life of the prisoners both male and female in Bangladesh is regulated by the provisions set out in the Jail Code. The male and female prisoners are generally classified into under-trial prisoners and convicted prisoners. Besides, there also exists provisions for the children and juvenile prisoners. Life of each class of the prisoners is regulated by some general and special type of provisions contained in the Jail Code. The Jail Code provides that the female prisoners shall be kept in a ward totally separated from the male prisoners and even the under-trial female prisoners, if possible shall be kept apart from the convicts. There shall be a separate hospital for the female prisoners. Everything shall be conducted by the Jailor in the female enclosure. In this regard, the provisions of the Jail Code run as follows:

Female prisoners shall be rigidly secluded from the male prisoners, and the under-trial females shall, if possible, be kept apart from the convicts. The female ward shall be so situated as not to be overlooked by any part of the male jail; and there shall be a separate hospital for sick female prisoners within or directly adjoining the female enclosure. They shall not be required to attend at the jail office. All enquiries and verification of their warrants shall be conducted by the Jailor in the female enclosure [27].

Whatever might be the provisions for women prisoners, for their safety, the condition is not up to satisfaction. The condition of women prisoners in Bangladesh is worsening day by day. The women are not safe either in society due to torture perpetrated by the miscreants of society or in police custody or in prisons because of numerous reasons. The female prisoners are being subjected to the violation of their human rights through rape, molestation, and indecent behaviour by the members of the LEA. Even the safeguards provided by the Bengal Jail Code, because of their being female are not being provided to them. They are subject to all kinds of torture either physical or mental. Yasmin rape and murder case, the Sheema Chowdhury rape and murder case, are outstanding examples out of many by the members of the LEA. Besides these, torture through beating and kicking has been one of the ordinary means of torture of the women accused by the LEA. Out of fear of extreme torture, the female detainees are venturing the risk of running away from police custody at the dead of night. The following incident may be taken into consideration in this regard.

A woman of village Mulbari under Ghatail Police Station in Tangail district fled from the Police Station (PS) in apprehension of torture at midnight of 27 January in 1999. The victim was identified as Khodeza Khatun (37), wife of Abdus Salam of the above-mentioned address. The husband of the victim and local people told the BRCT Fact-finding team on 11 July 1999 that police of Ghatail PS led by SI Mamun arrested his wife Khodeza Khatun at about 11.00 PM on 27 January 1999 on the charge of alleged kidnapping of a girl. Police broke the door of their house, entered into the room, kicked and beat Khodeza when she was alone in her house at that night. Police took her to the PS and could not put her in the female custody of the PS because both of the custodies of male and female were overcrowded. Police asked her to stay outside the custody. At the dead of night when Khodeza got the sentry slumbering, she managed to flee from the PS. BRCT conducted a Fact-finding mission on 10, 11 and 12 of July in 1999 following a report published in a Dhaka based daily news papers which alleged that Khodeza was killed by police and her dead body was concealed. The allegation of the newspaper did not prove true while the husband of the victim, Abdus Salam, asserted that his wife had come back home after a lapse of more than five months [28]. So what is manifested by the above-mentioned incident is that torture of every kind by the police is a trauma for the detainees both male and female alike.

Rape in police custody has been rampant in our country by the very policemen who are supposed to protect them from such torture. In 2000, members of the LEA raped seventeen women [29].

Again in jails, the women prisoners are treated like a male prisoner. The women prisoners are thrown into the police van after arrest where they have to go along with the male prisoners and no special measure for their carriage is taken to protect them from abuse. In Bangladesh, there is a scarcity of women Police Officer who are supposed to deal with the women prisoners. For this reason, within 24 hours of arrest, the women prisoners often get victimized by the middlemen who come in between the process to secure their release.

Torture has not been limited to physical infliction only. The female prisoners of Bangladesh have to undergo mental torture due to the ill treatment of the members of the jail authority. Mental harassment is a constant picture of the jail inmate of Bangladesh. Severe mental torture is inflicted upon them. The inhuman mental torture can be pictured out through the following incident.

"... one day a jail inmate, a young girl, received fried rice and chicken from her home through police. As a female warden saw her taking the food, she rushed to her and kicked the plate down. She hurled abuses at the girl in a very rude way. Unnerved by the abusive behaviour, the girl broke down in tears" [30].

This incident is not an isolated incident in the prisons of Bangladesh

rather it has become a common picture for the jail inmates in Bangladesh. As human beings prisoners deserve to get minimum congenial atmosphere in the prisons. It means that every prisoner male or female should have proper and adequate space facility, medical care and other necessities. Proper supply of food and drinking water should be ensured.

In this connection the provisions of the Bengal Jail Code say that,

"In the female division of every jail there shall be a block of cells sufficient in number for use as punishment cells and to afford separate accommodation for female under-trial prisoners. A female under-trial prisoner may, at the option of the Superintendent, if cell accommodation is available, have the choice of occupying a cell in the female enclosure instead of being confined in the under-trial prisoners ward: provided the arrangements prescribed in Rule 954 regarding the guarding of cells in the female ward and the custody of the keys of these cells can be made" [31].

It is to be mentioned regretfully that the prisoners in Bangladesh suffer from lack of adequate space facility. They are not given enough space to satisfy the minimum requirement for health. Statistics collected from government and non-government organizations showed that the total capacity of the jails in the country is about 25,000; but now there are over 75,000 inmates in the prisons and accommodation available for female prisoners in countries (in 64 prisons) are 1051; but the number of inmates are 51700 [30]. The picture of the plight of women prisoners in Bangladesh is that they are in inhuman condition in the prisons. To ensure the human rights of the women prisoners, adequate space facility should be provided to them.

The provisions of the Jail Code in this context are very clear. According to the Jail Code, no male officer shall have any entrance to any female prisoners' enclosure and if unavoidably necessary, he may enter the same with company of any female warder. In this connection, the Jail Code provides that,

"No male officer of the jail shall on any pretext enter the female prisoner's enclosure alone or unless he has a duty to attend to there. If a male officer has to attend to any duty in the females' enclosure and there is a paid matron or female warder, he may enter the females' enclosure in her company, and shall be accompanied by her to whatever part of the female jail he may have to go; if the matron is a convict, he shall be accompanied by a Head Warder, and the two shall not separate whilst in the females' enclosure at night, the Head Warder on duty shall call the Jailer, and these two officers together, shall enter the enclosure. Warders acting as escorts to official visitors must remain outside the enclosure while prisoners are being inspected" [32].

In the police stations the existing number of female Police Officer is insufficient to treat women prisoners. Though the provisions of the Jail Code very specifically deal with the issue that the women prisoners be totally secluded from the male prisoners, implementation of the said provisions is far beyond reality.

Privacy has to be maintained strictly and the wilful violation of this strictness is the violation of the guarantee as specified and endorsed by different national and international instruments [26]. The provisions of the Jail Code assert that the privacy of the female prisoners has to be strictly maintained and in no way is it be whittled down. For the purpose of having foot prints, finger impressions of a female prisoner or to photograph or to measure her, she shall not be brought out of the enclosure and while doing so, the Police Officer and the Deputy Jailer or a Head Warder shall be in company of a matron or of the female convict warder or overseer in charge [33].

Right to association is one of the basic human rights as loneliness is the cause of instrumental pain and may lead to mental disorder. This basic human right has also been guaranteed to the female prisoners. If there is only one female prisoner in the ward, she shall be allowed to enjoy the visit of her female friend. The Jail Code in this regard provides,

When there is only one female prisoner in the female ward and there is no female warder, the Superintendent shall arrange to allow a female friend to visit the prisoner and live with her in the jail. If the female prisoner has no friend who will stay with her, the Superintendent shall entertain a female as an extra warder to keep her company in anticipation of the Inspector-General's (IG Prison) sanction [34].

Provisions have also been provided to protect the female prisoners from any sort of harassment by the male prisoners or the male staff of the jail. For this purpose it has been provided by the Jail Code that the keys of the female division shall be under the custody of the paid matron or female warder during the day and at night be under the custody of the Jailer and the keys shall remain in her custody until required next morning for the opening of the female wards [35].

Again, for the maintenance of privacy it has been provided by the Jail Code that the locks of the female cells and wards shall be different from those in use in other parts of the jail and the same key shall not be used to unlock the other parts of the jail. The keys shall be under an old and trustworthy officer if there be no paid matron or female warder [36].

Right to observe the religious institutions has been guaranteed as one of the fundamental rights in the Constitution of Bangladesh [37]. It has also been declared as one of the fundamental human rights in the Universal Declaration of Human Rights, 1948 (UDHR) [38]. The Constitution of Bangladesh provides freedom of religion. However, this right to observe the religious institutions has not been guaranteed by the Jail Code entirely. According to the provisions of the Jail Code, at the time of physical training the women prisoners are to remain bare head, hair flowing and with the upper part of the body covered with a *kurta* only [39].

This is the direct violation of the provisions of Islam regarding the dress of the Muslim women. According to the tenets of Islam, women of adult age or women who have attained puberty shall maintain the strict principle relating to dress. Here, they have to

cover their heads with scarf. But the provisions of Jail Code relating to parade of women prisoners express that they have to remain with bare head while they are in parade. This is a violation of the constitutionally guaranteed fundamental right and also the human right declared in the UDHR. However, it does not mean that the women prisoners are all the time asked to remain with bare head. Inside the prison cell, at all other time excluding that of necessary for parading, they are supplied with necessary wearing apparels and are allowed to maintain and observe their religious institutions.

The right to have proper dress meeting the demand of the seasons of Bangladesh, the female prisoners, like all other prisoners, are supplied with necessary wearing apparels under the provisions enumerating in Rule 1159 of the Jail Code. Rule 1159 dealt with the dress of all prisoners in division III sentenced to rigorous imprisonment while Rule 1165 deals with that of the convicted prisoners in division II sentenced to rigorous imprisonment [Appendix-A].

To enjoy the environment suitable for health and hygiene is another human right. This right has also been guaranteed by the Jail Code. As per the provisions of the Jail Code the hair of the female prisoners shall not be cut without the order of the Medical Officer where he considers this necessary on account of vermin or any disease. They are also supplied with comb and four necessary towels or napkins each.

Plight of female prisoners

Laws are made with the intention to reduce crime against women. Offences against women have taken modern aggravated forms, which were more or less absent in the past. Crimes against women have risen after independence. Women in Bangladesh are facing not only aggravated forms of conventional crimes but also new types of crimes. The jail authorities behave badly with convicts or under-trial prisoners. The prisoners suffer torture and various types of abuses. The prisoners are helpless. They can hardly protest. Interestingly, many male prisoners do the same with the female inmates. Male and female prisoners live in separate wards there. However, there is a door connecting male wards with those for the female prisoners. Veteran male prisoners often bribe guards of the female wards and coerce them to have sex with female inmates. Some female prisoners willingly have sexual contact with the men in the hope of getting some facilities. Jails in the country are overcrowded. While many spend time outside their rooms, the real problem occurs when they come back at night to sleep. A 2004 report says more than 74,000 prisoners including more than 2,000 female are kept in the country's 64 jails. At Dhaka Central Jail were lodged more than 11,000 inmates and over 300 of them women. In a paper recently presented at a seminar on Human Rights and Police Custody, sponsored by Human Rights Organisation "Odhikar", researchers Jesmul Hasan and Sajjad Hossain say, "Women and children are also not spared torture in jail. In many police stations of Dhaka City there is no separate hajat for women and children. In some cases, female detainees are kept in the offices of male police officers. Women are subjected to various types of abuse. In Dhaka, there are too few female police officers compared to the need. A police station has only two or three female officers - not enough. Some police stations have to do without female officers. So, male police officers deal with the female detainees, including arrests, interrogation and investigation.

Approach to AIDS Prevention

"There are separate wards/cells for female inmates in jails. Yet the female inmates are not safe there. They are victimised by male officials and supervisors. Such female inmates do not get justice because of abuses by the law enforcers. Women are arrested also under Dhaka Metropolitan Police Ordinance. A female detainee is supposed to be taken care of by a female police officer. But this rule is violated, as there is shortage of female police officers. As a result, female detainees are subjected to abuses and maltreatment. There are about 5.50 lakh cases pending in the courts. The process of trial is slow. There are at least 30 hajatis in a room, which is good for only two female hajatis. At night, the women just remain standing on their feet, as there is no room for sleeping. Any abuse of female prisoners in jail is to be condemned. It is not desirable even though it happens. He urged the media to create awareness against such maltreatment.

Conclusion

Violence agonist women is increasing and indicates generally that the amount of different crimes against women is so high that the time has come to introduce measures to eradicate them. Clearly, the need of the hour is to protect women from violence through the law. The whole issue of violence against women did not project the flaws in the criminal justice system or what else we require, to make the system effective giving proper justice to women, as justice delayed is justice denied. In prisons, most women come from poor families and with rural backgrounds. They mostly comprise of married, unmarried, divorced and estranged women involved in begging, odd jobs and prostitution. They are vulnerable to harassment and sexual abuse. When women and children of the country get various development opportunities for their development and empowerment, jails have been kept totally out of this development question. So, for the utmost and massive development of the country, the condition of the prisons should be improved. The prisoners should be treated as a member of whole human community. Otherwise a considerable portion of the total population will remain away from the light of human rights. It is a matter of hope that, the government in recent years has been paying more attention about the condition of jail inmates and thinking of making some reformation in this regard.

References

1. *Population reference Bureau (PRB), (2005). "World Population Data Sheet-2005". Washington, DC, USA.*
2. *Constitution of Bangladesh, Article 27.*
3. *Constitution of Bangladesh, Article 31.*
4. *Constitution of Bangladesh, Article 32.*
5. *Constitution of Bangladesh, Article 33(1).*
6. *Constitution of Bangladesh, Article 33(2).*
7. *Constitution of Bangladesh, Article 35(1) and the Universal Declaration of Human Rights 1948, Arti-*

cle 11(2).
8. *Constitution of Bangladesh, Article 35(2).*
9. *Constitution of Bangladesh, Article 35(3) and the Universal Declaration of Human Rights 1948, Article 10.*
10. *Constitution of Bangladesh, Article 35(4).*
11. *Constitution of Bangladesh, Article 35(5) and the Universal Declaration of Human Rights 1948, Article 5.*
12. *Code of Criminal Procedure 1898, Chapter V.*
13. *Code of Criminal Procedure 1898, Chapter V (A).*
14. *Code of Criminal Procedure 1898, Chapter V (B).*
15. *Code of Criminal Procedure 1898, Section 46(1).*
16. *Code of Criminal Procedure 1898, Section 46(2).*
17. *Code of Criminal Procedure 1898, Section 46(3).*
18. *Code of Criminal Procedure, Section 54.*
19. *Constitution of Bangladesh, Article 23(3).*
20. *Constitution of Bangladesh, Article 23(2).*
21. *Constitution of Bangladesh, Article 23(3) (b).*
22. *Code of Criminal Procedure 1898, Section Code of Criminal Procedure 1898, Section 48.*
23. *Code of Criminal Procedure 1898, Section 51.*
24. *Code of Criminal Procedure 1898, Section 52.*
25. *Constitution of Bangladesh, Article 43 and the Universal Declaration of Human Rights 1948, Article 12.*
26. *The Bengal Jail Code 1894, Rule 945.*
27. *Bangladesh Rehabilitation Centre for Trauma Victims (BRCT), Dhaka, Annual Report 1999, 21.*
28. *Bangladesh Rehabilitation Centre for Trauma Victims (BRCT), Dhaka, Annual Report 2000, 9.*
29. *The Daily Star, Dhaka (Bangladesh), 25 August 2002.*
30. *The Bengal Jail Code 1894, Rule 946.*
31. *The Bengal Jail Code 1894, Rule 950.*
32. *The Bengal Jail Code 1894, Rule 951.*
33. *The Bengal Jail Code 1892, Rule 948.*
34. *The Bengal Jail Code 1894, Rule 952.*
35. *The Bengal Jail Code 1894, Rule 953 f.*
36. *Constitution of Bangladesh, Article 41.*
37. *Universal Declaration of Human Rights 1948, Article 18.*
38. *The Bengal Jail Code1894, Rule 956.*

Appendix

A list of dresses of the women prisoners under the provisions of the Rules 1159 and 1165 of the Bengal Jail Code is given below:

2 cotton chemises or kurtas

10 yards of cotton cloth 42 inches wide

2 gumchas

1 blanket coat

1 tatputtee for bedding

2 blankets

1 aluminium cup

1 aluminium plate

A square (2ft.×2ft.) of coarse gunny or matting

1 comb

Convicted prisoners in Division II sentenced to rigorous imprisonment shall be furnished with the following jail equipment:

a) For the hot weather

Accustomed to European mode of living		Accustomed to Indian mode of living	
Cotton skirts	2	Saries (pairs)	2
Cotton blouses	2	Cotton blouses	2
Cotton shirts	2	Chemise or shirts	2
Cotton drawers (pairs)	2	Drawers (pairs)	2
Cotton stockings (pairs)	2	Stockings (pairs)	2
Garters (pair)	1	Garters (pair)	1
Leather belt	1		
Cap	1		
Sola topi	1		

b) For the cold weather and rains

Accustomed to European mode of living		Accustomed to Indian mode of living	
Cotton skirt	1	Saries (pairs)	3
Cotton blouse	1	Cotton blouse	1
Woollen shirt	1	Woollen blouse	1
Woollen blouse	1	Flannel shirts or chemise	2
Flannel shirts	2	Cotton drawers (pairs)	2
Cotton drawers (pairs)	2	Stockings (pairs)	2
Cotton stockings (pairs)	2	Garters (pair)	1
Leather belt	1		
Garters (pair)	1		
Cap and Sola topi	2		

SOCIAL AND FAMILY FACTORS' EFFECT ON COMMITTING SUICIDE AMONG UNIVERSITY STUDENTS IN IRAN

Seyyed Hadi Motamedi, *MD*

Asghar Dadkhah*, PhD*
University of Social Welfare and Rehabilitation science, Tehran

Abbas Tavallaee*, MD*
Baghiatallah University of medical science, Tehran

Fatemeh Nasirzadeh
University of Social Welfare and Rehabilitation science

Correspondence to: Dr Asghar Dadkhah, University of Social Welfare and Rehabilitation, Evin, Kudakyar Avenue, Tehran 19834, Iran, E-mail: asgaredu@uswr.ac.ir

Key words: Social and family factors, suicidal idea and attempt, university students

ABSTRACT

In all societies people of different ages and races commit suicide, and it is considered as one of the top ten causes of death. There may be several reasons for suicide and their recognition has always been of great importance for the authorities who are supposed to control it.

In fact, committing suicide among young people, especially university students is a great social problem. It is also a matter of concern for mental health specialists. The aim of this study is to investigate the relationship between social and family factors and the idea of committing suicide among university students in Iran. 100 university students (50 male, 50 female) from University of Welfare and Rehabilitation sciences were randomly selected and participated in the study.

A 59 question demographic questionnaire about family situation, personal features and the idea of committing suicide was constructed and also a Beck questionnaire about depression and disappointment. The questionnaires were filled out in a private interview.

The samples were taken randomly. So it was found out that the singles were more inclined to commit suicide than the married ones. Divorce, failure in education, and family background also increase it. Among the other increasing factors, old age and female sex should be indicated.

Introduction

The word suicide is a French word that consists of two parts: sui which means self and cide which means killing (Dorckhime, 1999)..Pierre Mourn indicates that suicide is an intentional work either consciously or subconsciously in order to destroy one's self (Moron, 1997). Aristotle believes that suicide is different from sacrifice (Azkia,1985). Freud believes that sexual relationships with others is an important factor (Roiters, 1994). According to Eric Frum the disintegration of social and traditional beliefs is an effective factor (Khosravi, 1960). This theory is confirmed by Halbwachs (Shabani Fard Jahromi). Dorkhime claims that economical welfare decreases suicide (Halbwachs, 1930). Henry and Short confirm this idea with and emphasis on aggression (Henry, 1965). Gibbs and Martin emphasize the contrast of roles (Gibbs, 1965). Some people believe that social isolation is the only cause of suicide (Alec Ray). Sometimes suicide finds an elevated value in the society (Heidary, 1997). Of course in this respect, the amount of suicides in society and the social position of the people should be considered as determining factors (Jahan Pajuhesh). There are even a lot of glorious examples of suicide in literature such as the examples in Shakespeare's Works including the suicide of Juliet in Romeo and Juliet, that of Ophelia in Hamlet and that of Cleopatra in Antony and Cleopatra, and also suicide in the works written by Victor Hugo.

We read of the suicide of some famous people, such as Ernest Hemingway.

It is estimated that 6% to 14% of people have the idea of suicide, and 10% to 14% of those with the idea finally committed suicide. Statistics show that it is increasing, especially among young people, all over the world (Mohseni, 1987). Research shows that the number of women who have to stay in hospital because of suicide is more than that of men (Burke,1978,7-11) and concerning the seasonal effects, it increases a bit in spring and autumn and decreases in Winter.

Suicide is a great social pathology and also a matter of concern for those who deal with mental health. This problem is worse especially when it is about young people and university students who are the hope of our future. (Shopfropfer 2001).

People of all different ages, races, and social classes may commit suicide. (Jilianeh and Jeifer 1993). When the number of young people increases in a society, the number of suicides increases too. For example after the second world war with the large number of children the problem was that a lot of young people committed suicide (Caplan and Sadud 2000, Merk 2002).

It seems that the increase of suicide is the result of different factors including social environment, a change in the way we look at suicide, and availability of its tools (Hawthon and Kate 1997)

Among the other causes of suicide we can also refer to severe depression, misuse of drugs, and criminal behaviours (Caplan and Saduk 2000, and Merk 2002) and (Sarason,1994). In this respect there are two groups of causes: those that make the victim inclined and those that make his tendency evident. In the first group we can refer to family background, mental disorders, physical problems, and also a family tendency toward suicide, especially the parents. In the second group the crises of conformity, quarrel with parents, friends, and classmates, joblessness, divorce or separation, bereavement, and other stressful events of life(Caplan, Saduk and Gereb, 1996). Men are more successful in suicide than women. In this respect China is an exception. Iran is the 58th country in the world in which out of each 100,000 people only 6 attempt suicide (Table 1 shows the rate of suicide in some countries for the two sexes.)

It is reported that in 2001 there were 3,000 suicides in Iran (65% men, 35% women) which is about 1% of total deaths. In developed countries this rate changes to 1% to 2% of total deaths (Ganil, 2000). The number of suicidal attempts is more than successful suicides. For example in our country it is reported about 2 to 50 times more and this number changes in different provinces.

In different countries women usually attempt suicide 3 to 4 times more than men but men have successful suicides 3 times more than women (Caplan and Saduk, 2000).

In Iran men usually have successful suicides 2 times more than women. But in some provinces such as Ilam, Bushehr, Khuzestatn, Kohkiluye and Boyerahmad, Fars, and Kerman the number of women who commit suicide is more than men. It is reported that the highest rate of successful suicide is in Ilam (26 in 100,000) and in Kermanshah (23 in 100,000) and the lowest rate is in Tehran and Sistan and Baluchestan. The oldest statistics about suicide in Iran can be taken from an article written by Dr. Mirsepasi in 1970 and published in a magazine about psychology. Manoochehr Mohseni in 1884 announced 229 cases of suicide in Iran (1.3 in 100,000). In research made by Dr. Naghavi in 1994 it is reported that among the population of villagers, the rate of suicide is 5 in 100,000. Killing by fire is one of the most frequent ways of suicide among women in some provinces. According to the study of Kamalzadeh and his colleagues the rate of suicide in Tehran has gone up three times higher in comparison with the last decade. Based on research in Kerman it is observed that women attempting suicide is 1.5 times more than men, but successful suicide among men is 1.5 times more than women (Abbasizadeh, 1999). Studies about this matter are so expanded that it is not possible to deal with all different aspects and texts, so some of the outstanding points will be given as follows:

Although the rate of suicide normally increases among the middle–aged and elderly, (men after 45 and woman after 55), it is also increasing very rapidly among the young people especially boys between 15-24 years old (Tehran University, 1996). Depression and schizophrenia are the two main causes of suicide, and the background of its attempt shows how serious it might be (Caplan and Saduk,1999). The idea of suicide is more common among men, old people, and single or divorced people (Caplan and Saduk, 1999). Suicide is more common in urban and industrial areas in contrast with rural and non-industrial areas (Sheibani, 1973). The matter of suicide is rarely observed among children only in urban areas (Mohseni, 1967, 9-11). Higher social position and descending in social rank are two other causes of suicide (Caplan and Saduk, 1999). The other cause is social disorder that leads to personal disorder (Caran,1965). Suicide is very common among the medical doctors, especially female doctors, and its main causes are depression and addiction. Psychiatrists and then ophthalmologists and anesthetists in contrast with the other specialists have a greater tendency to commit suicide). The unemployed people have more tendency to do this work (Caplan and saduk,1999). And in general in high and low positions it is more popular than in average positions (Mohseni, 1987). The rate of suicide among whites is more then blacks (Caplan and Saduk, 1999). The acceptance of a person in the family is the basis of his physical and moral health and as a result decreases the danger of suicide (Mohagheghi, 1985). Marriage and having children decrease the rate of suicide enormously. It is observed that suicide among singles is twice that of married people and also among the divorced people is two times more than the singles (Caplan and Saduk, 1999). Disintegrated families increase the rate of suicide especially among girls (Ministry of the Interior, Iran, 1990). Jews and Protestants commit suicide more than Catholics and the Moslems less than the others (Mohseni, 1987). Porterfield believes that impiety is closely related to suicide (Caran, 1965). Regardless of ethical, religious, and philosophical matters, psychologists investigated the subject of suicide based on clinical cases and their attempt to understand the reality of suicide (Caplan and Saduk, 1999). There is a close relationship between physical health, sickness, and suicide (12% to 15% of suicides) (Mohseni, 1987). Women are more likely to commit suicide during their monthly period, especially on the first day (Hassanpur, Mashhad and Beca and colleaques, Spanish). But it rarely happens during pregnancy (Abbasizadeh, 1999). Having children is one of the factors that immunizes women more than men against suicide (31). Imitation is one of the increasing factors but for a limited time (Dorckhime, 1999).

Educational Basis

Collegians and students, according to the studies of Dr. Mohseni in 1973-76 in Tehran, observed that 17.5% of suicides were related to collegians and students. Failure in educational matters, especially in exams, increases the rate of suicide among university students (Alishiri, 1991). Revolution doesn't affect the rate of suicide, but war decreases it (Eslami Nasab, 1992). Social complications increase it (Eslami Nasab, 1992). When the rate of homicide increases in a country, the rate of suicide decreases consequently (Eslami Nasab, 1992). Availability of the device is very important in determining the type of suicide, for example in America gun is a very common

device. In winter, suffocation by gas, and in summer drowning in water are very common (Elahi, 1987). There are some other factors that increase the danger of suicide including social forces, sudden strong stresses, family problems and crises, death of a close relative, dismissal, the sense of failure, and also strong criticism by others (Ghaem Magham, 1985). Addiction to alcohol and drugs can be added to the list (Oryan, 1998). The common people suppose that poverty increases the risk of suicide, but the fact is exactly in contrast (Dorckhime, 1999). Of course in some countries such as India and Uzbekistan, it is observed that there is a close relationship between economic crisis and poverty with suicide (Sotudeh, 1994). Studies confirm the same point even in Iran (The Entekhab newspaper). Although the relationship between modernity and suicide has not been proved (Sotudeh,1994), old studies and statistics express the point that the movement of society toward modernity increases the rate of suicide (Shabani Fard Jahromi). In Iran increasing immigration of villagers to cities is considered as another cause (Hesamian, 1984).

Finally we are going to have a look at different causes of suicide in Iran: in Lorestan, addiction and poverty; in Ilam, depression, poverty, and accusation of someone's chastity; in Gilangharb, sexual privation, limitations, and chastity affairs (Hesamian,1994); in Kermanshah, family problems, and psychological and mental problems (Province council of Kermanshah, 1997); in Mazandaran, family conflicts (Province council of Mazandaran, 1997); and in Kerman, family problems, and cultural poverty (Province council of Kerman, 1997).

Based on the studies about women, we can classify some of the causes of suicide among women in this way: husband's addiction, great difference between the ages, maladjustment, the existence of several wives for a man, lack of ability to make a decision, the interference of others in the family affairs, marriage in the early ages, and also considering divorce as a very undesirable work (Asgari,1997). It is interesting to know that in Iran suicide is very popular among young married women while in western countries it is popular among the old unmarried men. (Asgari, 1997). There are several researches about different causes of suicide in Iran: according to research conducted in 1994, the causes are mentioned respectively as loneliness, age, irremediable disease, and failure in life and love (Gudarzi, 1994). In another research, the causes are pointed out as marital problems, undesirable condition of family life, psychological problems, failure in love, mental and personal disorders, poverty, joblessness, addiction, urban and industrial life and disintegration of social groups (Sotudeh, 1994). Based on another research the factors are mentioned respectively as marital problems, undesirable condition of family life, poverty, joblessness, addiction, psychological problems, personal and mental disorders, failure in love, and urban and industrial life (Mohseni, 1987).

Materials & Methods

The students of bachelor level at the university of Welfare and Rehabilitation in Tehran made up the society of statistical research. A sample group of 100 people (50 male, 50 female) was taken randomly from the same society.

The device of measurement:

a demographic questionnaire about information and two Beck questionnaires about hopelessness and depression, which were filled out respectively in a private and face–to–face situation. At the same time all the questions of the samples were answered.

The type of research:

This is a kind of retrospective research

The variables of research:

The independent variables are social and family factors and the dependant variable is suicide.

Statistical methods:

The software SPSS (9.5) is used in this research and then the method of one sample T test is used in which the relationship between the main variables and those that affect the number and rate of depression (which determines the rate of suicidal thought) is considered. The important point is the meaningful level that is about 0.0005 in the four cases of divorce, failure in education, marital status, and family background.

Results

50 men and 50 women took part in this research. Their ages were between 17 and 26 and the highest percent belonged to the age of 22 that was 23% of the whole. 15% of the samples were married, 58% stayed at the dormitories and 42% lived at home. 8% of the samples had experienced failure during their education. 32% of the samples had the idea of suicide and 6% attempted unsuccessful suicides. 28% had experienced the loss of a close relative in the last 6 months. In the family of two of them there was a background of suicide. Among the samples, there was a significant relationship between depression and divorce, failure in education, marital status, and family background. Of course the relationship between depression and family background was stronger than the others (Table 2). About the marks of hopelessness we can conclude that they took from 1 to 15. Most of them were between 2 and 8. The highest percents were for mark 3 by 17%, mark 2 by 16%, and mark 5 by 10%.

Discussion & Conclusion

For many years in Iran nobody paid attention to comprehensive research about suicide (Mohseni, 1987) and little research has been done about. Studies about educational matters in America and especially at some universities such as Yale, Kernel, and Harvard support the fact that in these cities the university students commit suicide more than the other groups of people. According to the research of Dr. Mohseni about suicide in Tehran (1973-74), it is observed that 17.5% of suicides were related to collegians and students, which supports the above- mentioned point. In this research, some factors such as failure in exams, lack of educational success, and family conditions are considered as the main causes of suicide (Alishiri, 1991). Based on research in Kermanshah (97-98) 3% of suicides were because of failure in education (Province council of Kermanshah, 1997). In

our sample test 8 people had experienced some failure and two of them had thought of suicide. Separation from family is another cause of the same thought, especially among girls. The reason is that they are dependent on their families for social, economical, and emotional matters (Ministry of the Interior, Iran, 1990). Research in Tabriz (1978-79) shows that the death of close relatives is the main cause of suicide (Karbasi) and another research made in 1994 supports the same point in the whole country (Gudarzi, 1994). In our research, 28 people had experienced the separation of a close relative in the last 6 months and 19 of them had thought of suicide and 3 of them committed suicide. Among the samples there were also 58 students who lived in the dormitories far from their families, from which 21 students had thought of suicide. Research shows that the rate of suicide among unmarried people is two times that of married people (Caplan and Saduk, 1999). In our research there were 85 singles and 15 married, and 30 of the singles (35%) and 2 of the married (13%) had thought of suicide. Also from the 6 students who committed suicide 5 were single. Of course in Iran marriage can be considered as a controlling factor especially for men (Asgari, 1997) and as a result, marriage decreases the amount of suicide (Mohagheghi, 1985). Research shows that suicide has increased in extended families in comparison with the nuclear families (Ministry of the Interior, Iran, 1990). In our research, there was a background of suicide only in the family of 2 samples, but neither of them had tendency to the same. Of course the problem is that our statistical society is limited. Most of the research confirms that family problems are the main causes in Iran (between 54% and 80%) (Mohseni, 1987, Province council of Kermanshah, 1997, Malek, 1994). The immunity of women against suicide is more than men (Malek, 1978). According to old research women committed suicide more than men in Iran (Asgari, 1997) but new research shows the opposite situation (Asgari, 2004). In our recent study 32 people out of 100 had thought of suicide (19 women and 13 men) and of course 6 of them committed suicide (4 women and 2 men). Increasing age is also an important factor (Tehran University, 1996). Suicide is increasing very fast among the men of 15 to 24 years of age (Tehran University, 1996). In our recent study we observed that there is a direct relationship between increasing age and suicidal thought. The results of this study proved all our hypotheses: there is a significant relationship between suicide (thought and attempt) and divorce, failure in education, marital status, and family background. Age and sex also have a significant relationship with suicide (thought and attempt).

Limitations

1. Lack of ability to apply this research to the whole society because the selected people may not represent the society.
2. Limitation and small size of the selected group that is considered as a pilot study.

Table 1: The rate of suicide in different countries for the two sexes (in 100,000 people)

Number	Country	Suicide rate women	Suicide rate men
1	Canada	5.4	21.5
2	Norway	6.9	17.7
3	The United States	4.5	19.8
4	Sweden	9.2	21.5
5	Australia	4.7	21
6	France	10.7	31.5
7	Finland	11.8	43.4
8	Germany	8.7	32.2
9	Denmark	11.2	42.2
10	Italy	4	12.7
11	Spain	3.7	12.7
12	Chile	1.4	10.2
13	Costa Rica	1.8	8
14	Poland	16.7	50.6
15	Venezuela	1.9	8.3
16	Mexico	1	5.4
17	Colombia	1.5	5.5
18	Cuba	14.9	25.6
19	Latvia	15.6	79.1
20	Thailand	2.4	5.6
21	Iran	3.4	3.8

Source: the report of human expansion 1999 (undp)

Table 2. The rate of correlation between depression and the four Hypotheses:

	Number	Correlation	Meaningful level	Average	Standard marks	Meaningful level 2- Tailed
1. Divorce and depression	100	- 0.10	0.31	1.46	0.78	0.000
2. Failure in education and depression	100	- 0.29	0.01	1.66	0.71	0.000
3. Marital status and depression	100	- 0.42	0.67	0.89	0.70	0.000
4. Family background and depression	100	- 0.003	0.97	1.7	0.64	0.000

In this table the variables are considered in pair and there is a significant relationship between depression and the four hypotheses.
The important point in this table is the positive correlation between depression and family.
1. The relationship is significant. 2. The relationship is significant.
3. The relationship is significant. 4. The relationship is significant.

References

1. *Dorckhime, Emil " Suicide " translated by: Salarzadeh Amiri, Nader. Tehran: Allame Tabatabaee University publication, 1999.*
2. *AlecRay, M. B. "Family history of suicide in Affective disorder patients". J.clin psychiatry.*
3. *Heidary, Senobar " Suicide and its Survey in Iran" Ph.D. thesis in psychiatry, Iran University of Medical science, Tehran, 1997.*
4. *Moron, Piere " Suicide, formation and causes and treatment" translated by: Sahand, Maziar,Tehran: Rasam Publication, 1997.*
5. *Azkia, Mostafa " A Survey of causes of suicide in Tehran" Etelaat Publication, 1985.*
6. *Roiters, George "Sociological theses" translated by: Gharavizad, Ahmad Reza, 1st ed., Tehran: Jahad Daneshgahi Publication, 1994.*
7. *khosravi, Khosro " Suicide in Iran " Bachelor thesis, Faculty of social science, Tehran University, 1960.*
8. *Halbwachs, M., " les causes da suicide K. " Paris Alcon, 1930.*
9. *Shabani Fard Jahromi, Ali Akbar, " The pathology of suicide".*
10. *Henry, A., and Short, J., "Suicide and Homicide", New York: The free press, 1965.*
11. *Jahan Pajuhesh Institute, " A contrastive survey of suicidal rate in Iran and industrial countries".*
12. *Gibbs, J., and Martin, W. "Status Integration and Suicide ; A Sociological Study", V.O. Oregon books, 1965.*
13. *Mohseni, AliReza " A survey of the rate and causes of suicide in Ilam."*
14. *14: Caran, R., "suicide", New York: Ressell and Ressell, Inc, 1965.*
15. *Caplan and Saduk, "A synopsis of psychiatry "Rafiee, Hassan. Arjmand Publication, Tehran, 1999.*
16. *Mohseni, Manuchehr, " Social Deviations, Motives and causes of suicide " Tehran: Fadaee Publication, 1987.*
17. *Abbasizadeh, Masumeh," The report of suicide ", The office of the social injured, Teharn, 1999.*
18. *Sarason, Iron J. and Barbara R., Sarason, " Pathological Psychology ", Dr. Najarian, Bahman, Dr. Asghari, Mohammad Ali; Dehghani, Mohsen, Roshd Publication, Tehran, 1994.*
19. *Elahi, Faeze, " The Pattern of suicidal attempt for people ", Bachelor thesis, The Faculty of Social science, Allame Tabatabaee University,Tehran, 1987.*
20. *Eslami Nasab, Ali, " The Crisis of Suicide ", 1st ed., Tehran, Ferdos Publication, 1992.*
21. *Alishiri, Behruz, " A Survey of social and psychological causes of suicide in Tehran", Master thesis, Azad University of Tehran, 1991.*
22. *Mohagheghi, Fariba, " The causes of suicide among women in Torkaman Sahra after revolution", Bachelor thesis, Azad University of Tehran, 1985.*
23. *" A survey of effective causes of suicide in Lorestan from 1986 to 1990", The department of political, Social, and security assistance in the Ministry of the Interior, Iran, 1990.*
24. *W.H.O. "Suicide and Attempted Suicide", Geneva: W.H.O. 1974. P.15, 83, 89.*
25. *Burke, A.W. "Attempted Suicide Among Immigrants in Birmingham". International Journal of psychiatry. Vd.24 No. 1. 1978. P.P.7-11.*
26. *" The schedule of analysis of suicide in Tehran" The Faculty of Health, Tehran University, 1996.*
27. *Sheibani, A., " Statistics of suicide ", Tazehaye Ravanpezeshki magazine, No.1, 3rd year, 1973.*
28. *Mohseni, Manuchehr. " Suicide: the problem of our century" Mehre Khanevade, No. 1, 1967, P. 9-11.*
29. *The Entekhab newspaper, " Social crises and suicide in Izeh, Khuzestan."*
30. *Hesamian, Farokh, " Urban life in Iran ", Tehran, agah Publication, 1984.*
31. *Asgari, Samie, " Women: the main victims of suicide in Iran ", Farhang va Tose'e Magazine, 1997.*
32. *Gudarzi, Faramarz, " The book of Medical Jurisprudence", Tehran, Einstein Publication, 3 rd ed, 1994.*
33. *Shariati Rudsari, Mostafa, " The causes of suicide ", Tarbiat Magazine, 10 th year, Tehran, 1994.*
34. *Province council of Kermanshah, administration of social affairs, " A survey of the rate and causes of suicide in Kermanshah", Iran, 1997.*
35. *Province council of Mazandaran, administration of social affairs, " A survey of the rate and causes of suicide in Mazandaran", Iran, 1997.*
36. *Province council of Kerman, administration of social affairs, " A survey of the phenomenon of suicide from 94 to 97", Iran, 1997.*
37. *Sotudeh, Hedayatollah, " Social pathology, sociology of deviations ", Tehran, Avaye Noor publication, 1994.*
38. *Ghaem Magham, Faraht, "Psychological disease, suicide ", Tehran, The Publication of Distribution and Human Culture Organization, 1985.*
39. *Oryan, Behzad, " Suicide is the only alternative ", women Rights social Periodical, No. 7, 1998.*
40. *Asad Beigy, Hossein, " suicide and intervention in it ", Tehran, 2004, P. 56.*
41. *41: Malek, Ayoob, " A survey of suicide in 1991 in Sina hospital and Emam hospital", Ph. D. thesis, Tabriz, 1994.*
42. *Karbasi, Foroogh, " A Research about Suicide " P. 100.*

LIVING STANDARD OF MIGRANTS: A STUDY OF KATAKHALI POURUSOVA IN RAJSHAHI DISTRICT, BANGLADESH

Dr. Md. Rafiqul Islam [1]
Ahmed Omar Faruk [2]
Md. Golam Mostofa [3]
Professor Dr. Md. Entazul Huque [4]

1. Associate Professor and Chairman. Department of Population Science & Human Resource Development, Rajshahi University, Bangladesh. E-mail: rafique_pops@yahoo.com
2. Department of Population Science & Human Resource Development, Rajshahi University, Bangladesh. E-mail: Faruk.bwcci@gmail.com
3. Assistant Professor, Department of Population Science & Human Resource Development, Rajshahi University, Bangladesh
4. Chairman and Head, Department of Business Administration Bangladesh University, Dhaka, Bangladesh

ABSTRACT

The purpose of the present study is to observe the living standards of migrants of Katakhali Pourusova in Rajshahi district. The sample data was collected from 505 respondents using direct interviews. This information was procured by purposive sampling method. In this study, a multiple linear regression model was applied to study migrants. It was observed that people migrate to certain places due to economic reasons and migration can alter the lifestyle of individuals and families. People migrate to new places with the hope of improving their social and economic status.

Introduction

Bangladesh lies in the north eastern part of South Asia between 23034/ and 26038/ North latitudes and 88001/ and 92041/ East longitudes. The country is bounded on the north and the west by India, on the east by India and Myanmar and on the south by the Bay of Bengal. It has a total area of 147,570 sq km (56,977 sq miles) of which 8236 sq km is rivers and 1971 sq km is forested. The population of the country has increased over the years. According to the Population Census 2001 (BBS, 2003), the total enumerated population of the country stands at 123,851,120 of which 63,874,740 were males and 59,956,380 were females. Of the total population 28,605,200 live in urban areas and 95,245,920 live in rural areas, and thus the percentage of urban and rural population is23.1% and 76.9% respectively.

Bangladesh is a poverty stricken and agrarian based country. Due to increasing poverty and landlessness as well as underemployment and unemployment, Bangladesh rapidly goesthroughdeteriorating pconditions. In such a situation, a large number of people seek overseas employment especially, internal migration has occurred to unlock the opportunity of employment status. Migration is a form of geographical or spatial mobility involving a change of usual residence between clearly defined geographical units according to United Nations. Migration occurs due to the perception of spatial differentials of opportunities – the idea that different geographical locations offer different level of potential well being to various sections of the human population.

Migration is a relatively permanent moving away of a collective group, called migrants, from one geographical location to another proceeded by decision making on the basis of hierarchical order (Mangalam, 1968). Zelinsky (1971) said, “migration is a physical and social transaction, not just an unequivocal biological event”. The study of population migration has been a rapidly developing branch of several academic disciplines. Economists, sociologists, historians, psychologists, demographers and geographers all find the residential movements of the human population to be of importance to their respective subjects and for this reason the study of migration is both a multidisciplinary as well as an inter-disciplinary field (White and Woods, 1980).

There are two main types of migration, internal and international. Internal migration is an integral part of the development process. It is influenced by development (such as the building of roads, economic activities and employment opportunities in certain areas) and it influences development (destination areas gain in skills and capital while areas of origin lose out) (Chandra and Chandra, 1998:60). There are relationships between and among migration, urbanization and socio-economic development. According to Skeldon (1992), “there is a clear relationship between economic development variables. The most developed countries have the highest levels of urbanization and they have low fertility and low rates of infant mortality. The least developed countries, however, have low levels of urbanization”

Migration reflects people’s responses to many different factors such as social and economic inequalities, social and cultural conditions and constraints, and other infrastructure and accessibility aspects at places of origin and destination. Studies have generally indicated that migration occurs mainly for economic reasons (Todaro, 1969, 1976, 1985; and Young, 1994). Economic motives, such as the search for employment, improvements to, and upgrading of, jobs, resulting in increased wages and salaries, improvements in education for employment-related needs and relocation to gain close proximity to jobs are important determining factors for migration. Skeldon(1992) indicates that “migration allows the circulation of goods, money and ideas, as well as people sub-urban sectors. It concentrates a population that can create a dynamic economy and society”. Consumption expenditure is one of the indicators of the living status of a person.

Therefore the main objectives of this study are:

1. to study the living status, that is, the socio-economic characteristics of the migrants, and
2. to investigate the effects of some socio-economic variables on migrants' living status through linear regression analysis.

Data & Methodology

Data source

The data of this study was collected under the project of "Strengthening the Department of Population Science and Human Resource Development" sponsored by United Nations Population Fund (UNFPA). The pattern of data was collected in three broad sections namely, fertility, mortality and migration, along with socio-economic characteristics of the respondents. The data of 505 respondents was collected from the Katakhali Pourusova residential area of Rajshahi District using the interview method and by using purposive sampling technique, with a set questionnaire. The 2004 voter list of Katakhali Pourusova was used to identify respondents.

Methodology - Regression model

Multiple regression model expresses a dependent variable as a function of several independent variables, both qualitative and quantitative. Therefore, a multiple linear regression model is considered in this study and the form of the model is

$$Y = a + b_1X_1 + b_2X_2 + b_3X_3 + \text{----------} + b_kX_k + U$$

Where Xi is the regressor, a is constant, bi is the parameters, Y is the dependent variable and U is the stochastic error term of the model such that U~NID(0,σ2).

F-test

To verify the overall significance of the regression model as well as the significance of R2, an F-test is used. The formula for F-test is

$F = \frac{R^2(K-1)}{(1-R^2)(n-K)}$ with (k-1, n-k) degrees of freedom

Where, n is the number of cases, K is the number of parameters to be estimated and R2 is the coefficient of determination (Gujarati, 2003).

Model Validation Technique

To check the stability of the model, the cross validity prediction power (CVPP), ρ^2_{cv} , is applied. Here

$$\rho^2_{cv} = 1 - \frac{(n-1)(n-2)(n+1)}{n(n-k-1)(n-k-2)}(1-R^2)$$

where, n is the sample size or number of cases, k is the number of predictors in the model and the cross validated R is the correlation between observed and predicted values of the dependent variable. The shrinkage of the model is Shrinkage = ρ^2_{cv} - R2 ; where ρ^2_{cv} is CVPP & R2 is the coefficient of determination of the model. Moreover, the stability of R2 of the model is equal to 1- shrinkage (Stevens, 1996).

Results & Discussion

Migration & Age

Table 1 shows that the prime ages for migrants was in the age range of 30-34 years. 22.80% heads of household of Katakhali Pourusova migrated at the age of 30-34. In any age range above or below this age group, the percentage is lower. This table proves that the children and old age people are less interested in migration. Most migrants first leave their village at the lower end of their working age period. This is probably because the longer a migrant is expected to remain in working life, the greater are the number of years over which he/she can earn extra returns from work after migration.

Occupation

From Table 2 it is seen that among the total household heads most of the migrants are service holders and businessmen whose percentages were 44.8 and 26.5. This is due to the fact that people of this area are more literate and they are involved in service and business rather than another occupation. Economical requirements and human life is interrelated. For this reason people employ themselves in various jobs to have better standards of living. Five distinct categories of occupation were surveyed in this study area. These categories were farmer, service, business, labor and others (miscellaneous) and are presented in Table 2.

Educational qualifications

From Table 3 it is found that the illiterate are 15.85%. The signatory rate is 3.7% whereas19.80% of household heads had primary level education. 25.74% of household heads had education up to class ten, 12.28% had completed their school education. 9.91% had completed their college studies and 6.91% were graduates and 5.9% obtained M.Sc. degree in this area. So we may conclude that migrants live in moderately educated areas. In Bangladesh there is a lack of opportunities for youths to acquire sufficient, as well as better, qualitative education in the rural sector. They are devoid of such facilities, which are necessary to raise their personality to a level at par within this study area.

Migration income pattern

From table 4 it is found that 17.4% of heads of household had an income in the range of Taka <2000 per month in this study area. 21% and 16.6% migrants earned taka 2500-3000 and 6000+ respectively. Others were shown in Table 4. Agriculture is the main sector for employment. They earn most of the income from this sector. But this sector cannot provide full employment to all labor forces due to various reasons.

Stream of migration

The migrants of heads of household were living predominantly in urban areas. From Table 5 it is seen that the rural-rural area had 7.5% of the migrants of heads of household, while the 53.7% of the rural-urban migrants were distributed. The urban-rural and urban-urban were 3.8% and 35% migrants of heads of household. The majority of both rural and sub-urban migrants were living in urban to urban areas. Table 5 shows the extent and pattern of recent rural-urban and intra-urban migration, and urban-rural and intra-rural migration. Recent rural-rural migration is more pronounced than rural-urban migration. Slightly more destinations than origin moved from urban-rural locations. Recent rural-urban and urban-rural migration was also significant. So we may conclude that recent rural-urban migration, however, is more pronounced than urban-rural migration. However, it does not show any specific pattern of step-wise migration; migrants do not necessarily move from rural areas to small towns and from there to a large

city. The data shows that sizeable proportions of migrants move from rural areas to the largest urban centre.

Place of migration

When the distance of place of migration from the place of origin of the respondents is concerned, the long-distance migration was found in Table 6 among 53.5% migrant population in high agricultural growth areas, and the remaining 46.5% migrant population in low agriculture growth areas. Short distance migration is 34.7%. The pattern of long-distance migration is generally rural-urban. The choice of urban place by the migrants is generally dependent on the ability of bearing the migration cost, extent of risk that migrants take to be successful and opportunities available to the place, like easy contact with house, availability of jobs and various amenities, improved transport and communication facilities, etc.

Cause of migration

From Table 7 it is seen that the maximum number of people migrated for economic reasons, whose percentages were 88.7. The remaining few are due to the causes of marriage, religious, educational and other migrants, whose percentage were 4.4, 0.2, 0.2 and 6.5 respectively. So it is concluded that maximum number of migrants had to migrate to improve their financial condition. Migration from the villages to the towns and cities bears a close functional relationship with the progress of industrialization, technological advancement and other cultural changes which characterize the evolution of modern society in almost all parts of the world. It is due not only to push of the villages and pull of the towns and cities but also to the interaction of several factors. When increasing population in rural areas starts spreading into cities, the influx of excess population occurs at a much larger scale than the town and city can absorb. Broadly speaking, migration of people is a very common phenomenon. It can result from many causes such as socio-economic, political, cultural, natural calamities, and so on, while the causes of migration from rural to urban areas appear to be many. These are the remarkable ones found in the Table Consumption facilities of heads of household migrants

Many middle and upper middle class families migrate to cities and towns for improving their educational credentials and also to get suitable employment, apparently in a quest for social advancement and also to enhance their status in the marriage market. For this reason heads of households should lift up their income which provided access to better consumption. In general urban life provides better facilities of various aspects so that the migrant gets better opportunities through consumption. From Table 8 it is seen that the multiple regression line, educational qualification is positively related to monthly consumption expenditure; the regression coefficient is 92.877 with level of significance 0.000. Monthly income is positively related to monthly consumption expenditure; the regression coefficient is 0.497 with level of significance 0.000. Age at marriage has to positively relate to monthly consumption expenditure; the regression coefficient is 16.161 with the level of significance 0.543. Land before migration has to negatively relate to monthly consumption expenditure; the regression coefficient is -126.398 with the level of significance 0.009. Land after migration has to positively relate to the monthly expenditure, the regression coefficient is 72.636 with level of significance 0.049. Therefore, the fitted regression model is

$$Y= 596.192+92.877X1+0.497X2+16.161X3-126.398X4+72.636X5$$

From the above findings, the coefficient of determination (R2) of this fitted model is 0.568, i.e. the independent variables such as educational qualification, monthly income, age at marriage, land before migration, and land after migration can explain 57% of the dependent variable, that is, monthly consumption expenditure. The calculated value of F-test is 131.22 with (5, 499) degrees of freedom (d.f) but its corresponding value is only 3.02 at 1% level of significance. Moreover, the stability of the fitted model is 56% and its shrinkage is only 0.009582 where n is 505 and k is 5. And the stability of R2 of this model is more than 99%. Hence the model fits well. From the above results it reveals that after migration the heads of house holds have to achieve almost a positive effect. It is found that educational qualification, monthly income, age at marriage, land before migration and land after migration rises as monthly expenditure increases. Hence it may be concluded that for increasing effects of education, monthly income, age at marriage, land before migration and land after migration lift with the consumption level and monthly expenditure. Before migration although they had some land they do not have sufficient consumption. So in this study migration plays a positive role in developing the life status of the migrants.

Conclusion & Policy Implications

In the micro sense, migration behavior is an individual's response to improve his/her economic standing but in the macro sense migration is interpreted as an adjustment of population to economic and social change (ESCAP, 1982). People migrate to a certain place with hopes of improving their social, economic and health status. These migrants have different levels of aspiration as far as demographic condition is concerned and the changes no matter how insignificant have distinct factors attributed to each, (at instances assisted by catalytic agents). The major findings on the socio-economic conditions of Katakhali Pourusova, based on the questionnaire survey show that:

- The maximum number of migrants have to migrate in the age range 30-34 years.
- All most all of the migrants have to migrate due to economic reasons.
- The maximum number of migrants have to migrate to improve their life status. So they are obliged to migrate to earn money.

Policy implications

It is s difficult to formulate any easy and simple solutions to solve the problem of destitute people.

The following recommendations are suggested:

- The government may invest resources for the improvement

of sub-urban economies through different sub-urban development projects and by creating job opportunities in the rural and sub-urban areas.

- The government should put emphasis on sub-urban industrialization. This industrialization would be an instrument of employment and income generation for the sub-urban landless poor; present or pre-employment migration already burdened urban centers.

Table 1: Age of Migrant Heads of Household

Age group	No. of migrants	Percentage (%)
15 - 19	14	2.80
20 - 24	74	14.7
25 - 29	90	17.8
30 - 34	115	22.8
35 - 39	111	22.0
40 - 44	68	13.5
45 – 49	33	6.50
Total	505	100.0

Table 2: Occupation of Heads of Household

Occupation	No. of migrants	Percentage (%)
Farmer	22	4.40
Service	226	44.8
Business	134	26.5
Labor	112	22.2
Others	11	2.20
Total	505	100.0

Table 3: Educational Attributes of Heads of Household

Educational level	No. of migrants	Percentage (%)
Illiterate	80	15.85
Signatory	18	3.70
Up to class v	100	19.80
Up to class x	130	25.74
SSC	62	12.28
HSC	50	9.91
B. Sc. degree	35	6.91
M. Sc. degree	30	5.90
Total	505	100.00

Table 4: Monthly Income Distribution for Heads of Household

Range in Taka	No. of migrants	Percentage (%)
<2000	88	17.4
2000-2500	40	7.9
2500-3000	106	21.0
3000-3500	38	7.5
3500-4000	61	12.1
4000-4500	7	1.4
4500-5000	50	9.9
5000-5500	0	0.00
5500-6000	31	6.1
6000+	84	16.6
Total	505	100.00

Table 5: Recent Pattern of Stream of Migration for Heads of Household

Types of migrants	No. of Migrants	Percentage (%)
Rural-Urban	271	53.7
Rural-Rural	38	7.5
Urban-Rural	19	3.8
Urban-Urban	177	35.0
Total	505	100.0

Table 6: Distribution of Migrants According to the Place Of Origin From the Place of Destination for Heads of Household

Place of migration (per kilo)	No. of migrants	Percentage (%)
0-20	175	34.7
21-40	33	6.5
41-60	27	5.3
61+	270	53.5
Total	505	100.00

Table 7: Cause of Migration for Household Heads

Cause of migration	No. of Migrants	Percentage (%)
Economic	448	88.7
Religious	1	0.2
Education	1	0.2
Marriage	22	4.4
Others	33	6.5
Total	505	100.00

Table 8: Results of Regression Model for Heads of Household

Variables	Unstand. Coefficient		Significance
		Stand. Error	
Constant	596.192	412.482	0.149
Educational (X1)	92.877	16.723	0.000
Monthly income (X2)	0.497	0.024	0.000
Age at marriage (X3)	16.161	26.521	0.543
Land before migration (X4)	-126.398	48.050	0.009
Land after migration (X5)	72.636	36.787	0.049
Sample size	505		
R2	0.568		

Dependent variable (Y): monthly consumption expenditure

References

1. *BBS (2003). Bangladesh Population Census 2001, Government of the People's Republic of Bangladesh, Dhaka.*
2. *Chandra and Chandra (1998:60). Assessing the impact of Participatory Research.*
3. *ESCAP (1982). Global Migrants, Local Lives: Travel and Transformation in Rural Bangladesh" Gujarati, Damodar N. (2003). Basic Econometrics, Third Edition, McGraw Hill, Inc., New York.*
4. *Mangalam (1968). General Theory in the Study of Migration: Current Needs and Difficulties; International Migration Review, Vol. 3, No. 1 (Autumn, 1968), pp. 3-18 doi: 10.2307/3002178*
5. *Skeldon (1992:45). Migration and Development: A Global Perspective*
6. *Stevens, J. (1996). Applied Multivariate Statistics for the Social Sciences, Third Edition, Lawrence Erlbaum Associates, Inc., Publishers, New Jersey.*
7. *Todaro, MP (1969). A model of labour migration and urban unemployment in less developed countries, The American Economic Review, 59:138-148.*
8. *Todaro, MP (1985). Rural - urban migration: theory and policies, In. Economics for a developing world, Longman, Second edition. 209-220pp.*
9. *Todaro, M.P. (1976). Internal Migration in Developing Countries. International Labor Office, Geneva.*
10. *White, P. and Woods, R. (ed). (1980). Migration the Geographical Impact. Longman, London.*
11. *Young (1994). International labour migration from Bangladesh: A decent work perspective*
12. *Zelinsky (1971). Mobility Transitions within a Global System: Migration in the ESCAP Region.*

THE CHALLENGE OF CHILD RIGHTS & HEALTH ON A DYING PLANET

Lesley Pocock [1], Manzoor Butt [2], Dr Thamer Al Hilfy [3]

1. Lesley Pocock (corresponing author)
   Publisher and Managing Director
   medi+WORLD International
   World CME
   572 Burwood Road,
   Hawthorn 3122 AUSTRALIA
   Phone: +613 9819 1224
   Fax: +613 9819 3269
   Email: lesleypocock@mediworld.com.au
2. Maqbool Clinic,
   Research & Training Centre,
   Dhoke Kala Khan, Shamsabad,
   Rawalpindi. Postcode: 46300
   Landline: +92-51-4423929
   Cell Phones:+92-333-5101196;
   +92-300-9707549
3. Head of community and
   family medicine department
   Assistant Professor,
   Alkindy College of Medicine,
   Baghdad, Iraq
   Mobile. +9647901734108
   Email: thamer_sindibaad@yahoo.com,
   thamer_center2005@yahoo.com

ABSTRACT

Our children are our future. Many times have we heard this said but have we thought about the reality of the statement and the kind of humanity and state of condition our global tribe of children will inherit? If we have not got it right up to this point, in the collective history of our global human population, can we really expect them not to do an even worse job, when inheriting a greatly depleted, and more hostile and overpopulated world.

Our culture of destruction and violence has not worked and has nearly destroyed the very earth we inhabit, and the lot of every child on this very day, is a 50/50 chance of being severely abused and deprived during their childhood. And when they grow up and realise their constant hunger was not due to a global famine; the shame and the indignity they bore was not due to their own innate unworthiness; and that their childhood was not lost to some great rite or initiation of humanity, or to some great political or religious or national cause, but lost to greed, pettiness, brutalism and ignorance, they will view us just as we unfortunately are.

The answer to the many problems facing children are extremely complex, but yet, we would argue, also relatively simple, as a caring, compassionate, equitable and enlightened world could easily turn the situation around, The human political legitimacy principle proposed by the philosopher Lyndon Storey tells us that "political legitimacy is advanced by developing policies that are consistent with all of humanity having an equal opportunity to benefit". Surely all of humanity includes children and the time is ripe to do something now as philosophers such as Storey continue to draw attention to the need for a global policy framework. The need for conscious evolution as a united planetary people, from this point onwards, is becoming increasingly evident.and is surely worth considering.1

The Special Rapporteur of the UN in his paper Child Rights 1995 has put it far more succinctly: "There is no way to thoroughly enumerate the various ways in which children around the world are economically exploited and physically mistreated. But the numbers are great - and the suffering widespread. Behind the hideous imagery - of children beaten or sexually abused by parents; ravaged beyond their years by hard living and drug abuse on the streets; maimed by landmines or turned into killers by war; stricken with AIDS -- are the all-too-common struggles against disease, hardship, and family or social traditions that compromise children's humanity or subject them to physical and emotional suffering."

Whether exploited as child labourers or prostitutes, drafted as young teenagers into armed forces, forced as young girls into a lonely, abusive life as domestic workers, deprived of an education to work on the family farm, or denied adequate nutrition and health care, children need help and protection from an adult world that perpetrates most of the abuse." 2

Whoever has been running the world all these years, has obviously not been doing it very well, and humanity has been downtrodden and exploited in the main, while abuse, disrespect, intolerance, commodity and hype has been made the norm, if not the holy grail. Then there is the dogma of many forms; much of it the same primitive dogma that has contributed to the appalling state we are in, and that has actively worked against enlightenment and advancement of all humanity, for millennia.

So it is time for decent people to speak and act with courage; there is little left to lose and much to gain. We are living, conscious pieces of the universe, evolved to the stage where we are the universe contemplating the universe, yet alone out of all the species on this beautiful planet, we prey on and exploit our own children, and pollute, poison and destroy our own habitat and food sources - all for the most senseless and worthless earthly ambitions: money and power.

But this paper is not to add further weight of condemnation; the hour is getting late and we need to take on new values, like protect, inspire, respect, empathise, dignify, sanctify, - moral obligation, adult responsibility, - and basic rights and protection for the innocent and powerless of the planet.

And it is possibly the family doctor and their ilk, who have the greatest opportunity and most privileged position to do this. And many, many family doctors do. They offer a beacon of rationalism, and a centre of solace, in a mad world, and family medicine encompasses the social, physical, mental and psychological health of a child, and their need for basic amenities, access to nutrition and clean water, a safe living environment and safety from ignorance and brutalism.

If we could just open our eyes and minds and assist all who want to change our prehistoric predilections for chaos, and bring up one generation unharmed, that is, break the cycle, then there may be a future for all. But the good people out there need to be assisted and encouraged and this paper's aim is to cut through the dross and distractions of life and shed light on the true state of (in)humanity, and particularly its most vulnerable and aggrieved section, our own children. We therefore also, in this paper, concentrate on pragmatic solutions and set out to provide honest information on the real state of humankind, and its children, on October 22, 2007.

On planet earth 2007 we witness the great debasement of all. The hour is getting late and perhaps it is not the time to be destroying the last natural place, or cutting down the last stand of trees, or exploiting, commoditising and abusing each other and our own young, but time to take a stand and to take on new values like protect, inspire, respect, dignity, sanctity, moral obligation, adult responsibility, and unquestionable rights for the innocent and powerless.

While the many problems outlined above by the Special Rapporteur of the United Nations, are complex, oppressing and widespread it is also not that hard to fix things – it just takes people to do the 'right thing' every time they are faced with a choice and to think about the wider, global ramifications of what they do.

"But the more direct injustices are perpetrated largely by adults, and manifested in the large numbers of children exploited as labourers and prostitutes or maimed by war – and these require further public exposure and protective laws that are actually enforced.2 "

In the last decade, an estimated two million children have been killed in armed conflict, many of them by some of the 100 million landmines thought to be concealed in 62 countries. A total of perhaps four to five million more have been disabled as a result of their experience in war, and more than 12 million have been made homeless. 3

Changing the attitudes of adults unfortunately will take quite a few more millennia of continuing enlightenment or perhaps the short, sharp, shock, which we are most likely in for.

Fortunately there is a wide range of organisations and institutions committed to peace, equality and human development but these do not necessarily extend to the realm of family or national politics, to enshrine basic rights. Also all humans do not have the capacity to comprehend the longterm results of their actions of their practices, and cultures so rights need to be enshrined in law and disseminated into communities via public education and practices.

Those with the intellectual capacity to look at issues of problem solving on a global scale, that is an academic approach, need to – this can fall to family doctors, teachers and on the macro scale academics looking at all the issues that cause intra-human conflict.

Laws need to enforce what is issued via public education as we have managed, fro example, to identify murder, globally, as an antisocial act, and plants and animals seem to have worked out the need to protect their offspring,– why not the same for a human child? The progenitors of the seed usually do their utmost to ensure the optimum survival of their offspring, but unfortunately child abuse and neglect while proliferated by poverty and inequity, occurs almost equally where this is not a factor, leaving us with almost a unique situation of endemic acts of violence against our own young.

Coupled with human society's primeval urge to prey on human society and exploit and conquer, and no doubt our unrecorded history (our REAL history) has been just as littered with such abuse; so we have to look at the fundamental basis of our society, those who perpetuate the atrocities, which are often part of the basic structure of many societies.

The rights of women and status of women are linked very closely to the status of children. An empowered mother would fight to save her children from the many forms of abuse, and a society that supports a mother's rights, also supports children's rights. Educating and empowering women and girls can only improve the situation on so many fronts.

So we need to respond on a personal, familial, community, national and global level to combat those who have a vested interest in the disempowerment of women and children, those who would prosper from such and those who refuse to see. Human thought and action, on a personal scale is the essence of the process.

An academic focus on the very nature of the problem is one we have sought to develop through Child Watch where we encourage articles such as this, looking at the global issues working against children and their rights and empowerment, as a necessary step to identifying them and solving the problems. Coupled with this is the need to rescue those children who are living their lives in abject misery.

Creative responses

While the problems for the children of planet earth are immediate and every day and if we are to break the pattern that they go on to abuse and degrade their own children, having 'learned the ways of the world' then frankly we need to think and act creatively

Such responses need to look at a broad range of issues: dignity, rights to a safe and secure environment, adequate nourishment, rights to education, a future, a habitable planet.

At least if society is educated then we have a yardstick to respond by. Educating society that children are people too, – provides a moral and practical basis to the protection of children. Treating children with dignity, shows children and other adults the same.

And educating children about their own rights provides them with some measure of protection and dignity, at least to gauge their own lives against.

While with Child-Watch we provide small missions like ridding blind institutionalised girls of lice and scabies in impoverished nations, approaches such as "Scholarships for Life' have a more longterm affect. 4The main Child-Watch mission therefore is to 'buy' children out of slavery and provide them with an education. Slavery is not necessarily a sign of parental or familial neglect it may be a necessary means of survival for far too many children and their families, with the responsibility therefore falling to those who are benefiting from the child labour or those who are necessitating it through unfair national or cultural denial of basic rights.

In many poor countries, children work to supplement meagre family income or otherwise to help the family business. Although they may not always work under the most desirable conditions, most are not

being intentionally exploited by their families. The real issue in such cases is not whether the children work or not, but whether the conditions under which they work are just, and whether they are being denied other basic rights because of their work -- such as the right to education, to freedom from abuse, and to proper health care.

As for child labour, while experts agree that there are few accurate statistics available, the best estimates from the ILO are that there are nearly 80 million children under 15 working as labourers. It is also estimated that the number of children under 18 involved in prostitution exceeds two million, one million of whom are in Asia and 300,000 in the United States. 2

One creative response to this kind of complex dilemma has come from Bangladesh. In reaction to United States Congressional legislation mandating a boycott of companies in the garment industry that use child labour, companies in the garment industry in Bangladesh began ousting children from their jobs -- as many as 50,000 in a four-month period. The result was that many of the children were worse off than they had been when they were working, having taken other, less desirable jobs or living in the street -- but not going to school. 3

In July 1995, after negotiations with non-governmental organizations (NGOs), as well as UNICEF and the International Labour Organization (ILO), the Bangladesh Garment Manufacturers and Exporters Association (BGMEA) signed a Memorandum of Understanding stipulating that BGMEA would ask "that no under-aged worker will be terminated until the appropriate school programmes for the workers can be put in place".3

"Poverty cannot be accepted as a pretext and justification for the exploitation of children," wrote Vitit Muntarbhorn, until 1995 the Special Rapporteur on the sale of children, child prostitution and child pornography. "It does not explain the huge global demand with, in many instances, customers from rich countries circumventing their national laws to exploit children in other countries. 'Sex tourism' has spread its illicit wings wide, and paedophiles search for their victims in all parts of the globe. The problem is compounded by the criminal networks which benefit from the trade in children, and by collusion and corruption in many national settings". 2

Iraq represents the depths to which we have sunk as a global community and is a constant source of shame, and deserves a focus of its own.

Despite the country's rich resources, Iraq's human development indicators are now among the lowest in the Region. In 1989, health care in Iraq reached approximately 97% of the urban and 79% of the rural population. Subsequently, these gains were halted and during the 1990s there was a rapid increase in infant mortality rates and deterioration in other health indicators. Health outcomes are now among the worst in the Region, with high maternal and child mortality. At present the infant mortality rate is 108 and the under-five mortality rate 130.5 per 1000 live births. The country is suffering from a double burden of disease. There are major infections, such as diarrhoeal diseases, acute respiratory infections, malaria, tuberculosis and leishmaniasis. 5

Educational reform is one of the high priorities in the re-building of Iraq. Enrolment and attendance rates have diminished progressively, including a rate of only 50% of girls attending in rural areas. Family poverty is a major cause of drop-out.

These figures, derived from several surveys, confirmed the serious nutritional status of young children in Iraq. About one in every five children was underweight (low weight for age) in 2000, and almost one third of children under 5 were chronically malnourished (low height for age). Malnutrition declined in 2002 and Iraq was approaching the levels at the beginning of the sanctions in 1991. The recent Iraq multiple indicator rapid assessment survey (IMIRA) conducted in 2004 however does not confirm the improvements. It shows that malnutrition (weight for age) affects up to 13% of children and malnutrition (height for age--stunting) affects 25%. Also, the UN Millennium Indicators Database gives a rate for moderate and severe child malnutrition in Iraq of 15.9%. Iraq is one of only three Arab countries (with Yemen and Comoros) in which incidence of low birth weight exceeds 10%. Although more than 40% of adult males are overweight, chronic malnutrition is common, as is anaemia in children, adolescents and pregnant women. 5

The orphans of Iraq also deserve a special mention, not only as one section of society in greatest need, not just of food and shelter, but love and kindness, and especially as they are an integral part of the future of Iraq and its people, - and what an opportunity for us to get it right.

And we all like a happy ending, which is why we focus our final chapter on our colleague, and a family doctor, Dr Manzoor Butt who works in impoverished areas of Pakistan, and treats the poorer members of the community and who has developed many strategies aimed at the multiplicity of factors that can lead to poor health and impoverished lives, particularly of women and children of the region.

Dr Butt is an example of an ordinary person (indeed a hero in our midst) who makes the right decision every time he is faced with a dilemma or problem. This can extend to training of Female birth attendants and women's health workers, to deal with obstetrics and gynaecological cases for women whose religion or culture prevents them from being treated by a male doctor, taking proactive and practical steps to counter malnutrition in his patient population, providing modern medical care where 'traditions and cultural practice' may be harmful to human health, providing access to making an income by purchasing, for example a sewing machine for impoverished female family heads, to allow them to work for a living when no other means was available; and by recognising that blind institutionalised girls and other insitutionalised children plagued by lice and scabies, deserve dignity and relief , and then taking the steps to provide such. Mostly our colleague stands up for what his right, every time , and often at great personal cost.

And while one person cannot do it all, one good person can make a huge difference. So on this day, in the history of humankind, we encounter our final opportunity to address the full scope of our humanity, before our current choices put an end to the age of man and an end to our place in the unfolding of the universe.

References

1. *Story, L Humanity or Sovereignty (page9)*
2. *United Nations Department of Public Information * DPI/1765/HR--December 1995*
3. *UNICEF website*
4. *www.Child-Watch.org*
5. *Country Cooperation Strategy for WHO and Iraq 2005-2010*

Table 1. Undernutrition among children under-5 years

Year	1991	1995	2000	2002	Arab States average
Acute malnutrition	3.0	11.0	7.8	4.0	9%
Underweight	9.0	23.4	19.5	9.4	20%
Chronic malnutrition	18.7	32.0	30.0	20.1	28%