National Report
Bangladesh

GLOBAL STUDY ON CHILD
POVERTY AND DISPARITIES

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The cover design of this report was inspired by the *Global Study on Child Poverty and Disparities*, a multi-country initiative to leverage evidence, analysis, policy and partnerships in support of child rights. The overlapping, multi-coloured frames symbolize the national, regional and global contributions to the Global Study, which form the basis for exchanging experiences and sharing knowledge on child poverty.

The design encapsulates three central tenets of the Global Study: ownership, multidimensionality and interconnectedness.

Ownership: Although children's rights are universal, every country participating in the study has its own history, culture and sense of responsibility for its citizens. The analyses aim to stimulate discussion and provide evidence on how best to realize child rights in each country.

Multidimensionality: No single measure can fully reflect the poverty that children experience. A multidimensional approach is therefore imperative to effectively understand and measure children's well-being and the various forms of poverty that they experience.

Interconnectedness: Today's world is increasingly interconnected through economic, social, technological, environmental, epidemiological, cultural and knowledge exchanges. These exchanges have important implications for child poverty and can also help provide avenues for its reduction.

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November 2009

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Planning, Monitoring and Evaluation Section
United Nations Children's Fund
BSL Office Complex
1, Minto Road, Dhaka-1000
Bangladesh

Telephone: 88 02 9336701-10
Email: dhaka@unicef.org
Website: www.unicef.org.bd

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FOREWORD

The Millennium Development Goals (MDGs) represent an international commitment to eradicate extreme poverty and hunger and foster global collaboration for development by 2015. That deadline is looming and, very soon, we will know whether or not that commitment has been honoured.

Despite gains on many MDG targets, South Asia remains the poorest performing sub-region in Asia and one of the poorest performing regions worldwide. About 600 million of its 1.5 billion people are living in poverty – about one-third of the world's poor. In Bangladesh, as shown in the MDG Progress Report in 2008, more than 37 per cent of the population is living in poverty.

About half of all Bangladeshi children are living in poverty, with one-quarter in persistent poverty, and will find it hard to reach their full potential. In terms of deprivation, 64 per cent are deprived of sanitation, 59 per cent of information, 41 per cent of shelter, 35 per cent of food, 16 per cent of health, and 8 per cent of education.

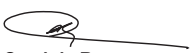
Most of the MDGs relate to children, and their achievement will be impossible without a focus on child rights and needs. Bangladesh has made progress on child mortality and hunger, enrolment in primary education, gender parity in education, and immunization coverage. However, there is no room for complacency. As in many other countries, child poverty in Bangladesh is still a grave concern.

UNICEF Bangladesh, in line with UNICEF as a whole, has a deep organizational commitment to find the evidence, carry out the analysis, and build the partnerships and policies that will fuel progress towards the MDGs, promote gender equality and deliver results for children. As part of this commitment, in 2008 UNICEF supported Bangladesh as one of 46 countries in seven regions to participate in a Global Study on Child Poverty and Disparities, and is working closely with government and non-governmental organizations to coordinate activities, and pool expertise, knowledge and evidence to benefit children and women.

The resulting Report has generated an extensive knowledge base on child poverty and disparities in Bangladesh. It provides information and evidence to strengthen the profile of children and women at the national policy table. In particular, it aims to influence the policies that determine resource allocations, putting children at the centre of national programmes to address poverty, health, education and child protection.

The Bangladesh Country Report includes practical policy interventions that could be extremely effective, despite the current global economic crisis, that support country-level advocacy and technical efforts to address structural poverty, influence national policies, and sensitize national stakeholders to the critical importance of reducing child poverty and inequality.

We reiterate our commitment to support the Government of Bangladesh in its efforts for children and women, and look forward to the day when all children in Bangladesh will have an equal opportunity to realize their full potential, freed from the poverty of the past.



Carel de Rooy
Representative
UNICEF Bangladesh.

GLOBAL STUDY
ON CHILD POVERTY
AND DISPARITIES

Table of contents

Executive summary.....05

Chapter one: children and development 09

Children, poverty and disparities: conceptual framework 09
Methodological issues pertinent to the study 11
What this study tells us about children in Bangladesh 13
Children and the Millennium Development Goals (MDGs): progress and disparity 15
The political, economic and institutional context 15
Macro-economic strategies and resource allocation 18

Chapter two: poverty and children 22

Children affected by Income poverty and deprivations 22
Child survival and equity 28
Causal analysis: underlying factors in poverty levels and trends 29

Chapter three: the pillars of child well-being 36

Nutrition 36
Health 42
Child protection 52
Education 59
Social protection 65

Chapter four: addressing child poverty and disparities: a strategy for results 70

Recommendations for children and development 70
Building blocks and partnerships for a strategy on children and development 75

References 78
Annex I: Statistical template 83
Annex II: Policy template 139
Abbreviations 187

GLOBAL STUDY ON CHILD POVERTY AND DISPARITIES

EXECUTIVE SUMMARY

Introduction

Children account for 45 per cent of the total population of Bangladesh (estimated at 140.3 million people in 2006). One in every six children is a working child, with an estimated 7.42 million working children across the country.

To date, however, there has been no comprehensive study on child poverty and deprivation based on hard evidence, and no published data on child poverty and deprivation at the national level. This report aims to fill that gap.

In 2008, Bangladesh became one of 46 countries in seven regions to participate in the *UNICEF Global Study on Child Poverty and Disparities*. The resulting report sketches the current scenario of child poverty and deprivation in Bangladesh, drawing on secondary analysis of relevant national surveys and the Government's policy and programme documents.

The study has generated evidence and insights that can be used to influence national development plans. The findings are expected to inspire and inform poverty reduction and sector-wide strategies that will, in turn, lead to child-sensitive poverty reduction strategies and policy interventions for Bangladesh.

Methodology

The study and report follow the standardized methodology provided by the *UNICEF Global Study Guide on Child Poverty and Disparities 2007-2008*. The study was conducted by Human Development Research Centre (HDRC) in 2008. National data are available only for household poverty levels in Bangladesh. As a result, a working definition was used in which it is assumed that if a household is poor, all members of that household are poor. Data were generated using three methods: (i) a measure based exclusively on food intake – the *Direct Calorie Intake* (DCI) method; (ii) a measure based on the monetized amount of basic consumption needs – the *Cost of Basic Needs* (CBN) method; and (iii) the *International Poverty Line* ($1 per day, per person). Child deprivation was examined through the lens of the framework developed by the Bristol Group using seven indicators: shelter; sanitation facilities; safe drinking water; information; food; and health.

Key findings

Bangladesh has made remarkable progress on many human development indicators over the past two decades. Great strides have been made on health, education, nutrition, and employment generation, and the creation of social safety nets for the poor through social security programmes has helped reduce regional disparities in the impact of other development programmes. Even so, many challenges need to be overcome to maintain and expand progress, and the lack of child-specific data, policy review and programme evaluation raises questions about the progress made to date on child-related indicators. The country has many Acts of Parliament, policies, strategies, programmes and Plans of Action in such fields as education, health, nutrition, law and social security and, in almost every case, there is an emphasis on special provisions for children. Without proper monitoring and evaluation, however, the implementation of all these policies, strategies and programmes seems like mere *window dressing*. For example, there are policies and programmes in place to enrol each school-aged child in school and, in line with this policy, children are indeed being enrolled. But many children drop out after one or two classes and there is no corresponding policy to prevent this.

While household income is seen as important in policy documents, programmatic intervention is inadequate. Unless land, agrarian and aquarian reforms are implemented and rapid industrialization is promoted, a few income promotion and safety net programmes will not be enough to increase household incomes and reduce vulnerability.

Similar drawbacks are evident in every sector, from education to poverty reduction, and must be addressed if Bangladesh is to reach its national goals and targets for children, as well as the Millennium Development Goals (MDGs).

The key findings of the study reveal the challenges of disparities and poor achievements, and propose possible solutions.

Overall child poverty and deprivation in Bangladesh

Around 26.5 million of the 63 million children in Bangladesh live below the national poverty line, regardless of the measurement method used (46 per cent according to both the DCI and CBN), and more than half of all households (51 per cent) with children are poor in terms of international poverty line below the $1 Purchasing Power Parity (PPP) threshold. Poverty increases as the number of children in a household increases, irrespective of the measurement method employed.

Around 58 per cent of all children are severely deprived of any one of the six deprivation indicators: shelter; sanitation; water; information; education; and health, with around 20 per cent suffering from at least two severe deprivations. Around 64 per cent are deprived of sanitation facilities; 59 per cent of information; 57 per cent of proper nutrition (stunting, wasting, or underweight); and 41 per cent of adequate shelter.

Poverty and deprivation are more pronounced among non-Muslim households with children than among similar Muslim households. For example, 63 per cent of Buddhists are living below the upper poverty line, compared to 41 per cent of Muslims. Around two-thirds of Christian and Buddhist households with children suffer from at least one severe deprivation, compared to less than three-fifths of Muslim households. The share of households suffering from at least one severe deprivation is considerably higher within indigenous communities, ranging from 63 per cent to 93 per cent, compared to 58 per cent for Bangalee households.

Poverty levels fall as the educational attainment of parents rises: 53 per cent of households where the head has no education live below the upper poverty line, compared to only 19 per cent of those where the head has post-secondary education. Children from about 74 per cent of households where the heads have no education suffer from at least one deprivation; while the same is true for about 29 per cent of households where the heads have post-secondary education.

Around 13 per cent of all children aged 5 to 14 years are engaged in child labour and 97.5 per cent of these are unpaid. But child labour is no solution to household poverty. Of those households that send at least one child under the age of 15 to work, 56 per cent still live below the poverty line.

Child mortality, nutrition and health care

Although the under-five mortality rate (U5MR) in Bangladesh has been more than halved over the last decade, 88 children still die before the age of five for every 1,000 live births, rising to 121 among the poorest income quintile. However, the U5MR for girls has fallen at a faster rate than that for boys.

About 46 per cent of all children under-five are stunted and 40 per cent are underweight. Around 42 per cent of rural children are underweight, compared to 30 per cent in urban areas, and 49 per cent are stunted, compared to 36 per cent of urban children. Stunting, wasting and underweight among children are affected by the level of education attained by their mothers.

Food transfer programmes have been implemented to improve food security status and meet nutritional requirements, but despite these, and other nutrition policies and programmes, more than half of all children (57 per cent) are still under-nourished. Current programmes reach too few people, and total public expenditure has fallen in recent years from Tk. 1,670 million in 2005-2006 (around $24 million as of November 2009), to Tk. 1,200 million in 2006-2007 (just over $17 million).

Facility-based Integrated Management of Childhood Illness (FIMCI) has been implemented in 274 upazila (sub-district) health complexes out of 444 upazilas (excluding district headquarters), and in 41 district hospitals (out of 64 districts).

More than 7 per cent of children under five still suffer from diarrhoea, with the highest prevalence (11 per cent) among those aged 6-11 months. Almost half of children under five with diarrhoea do not receive oral rehydration therapy (ORT) – the simple, cheap and effective treatment for the dehydration caused by diarrhoea.

Around 12 per cent of children under five suffer from pneumonia and 78 per cent of these do not receive antibiotic treatment.

Around 16 per cent of young women aged 15-24 have comprehensive knowledge about HIV prevention. There is a huge knowledge gap (two-fold) between urban and rural young women (24 per cent vs. 12 per cent). The level of education and wealth is closely linked to the level of knowledge on HIV.

Child protection issues

Only 36 per cent of all children in Bangladesh (as of 2006) had been reached by the birth registration programme.

About 6 per cent of all children are orphans; and relatively more orphans (30 per cent) are from female-headed households.

About 39 per cent of girls are married before the legal age for marriage of 18 years. More girls in rural areas (36 per cent) get married before the age of 15 than those in urban areas (27 per cent). In all, 71 per cent of girls in rural areas and 58 per cent in urban areas are married before the legal age.

Despite the number of education policies and programmes in place, almost one-fifth of children of primary school-age (6-10 years) are deprived of school enrolment.

"Protection of Children at Risk" is a Tk. 194 million (just under $3 million) project for children living and working on the street and children without parental care, which covers a small portion of such children. A large proportion of the three million child labourers in Bangladesh live and work on the streets.

Despite constitutional recognition of the right to shelter for all citizens, 41 per cent of all children are deprived of adequate shelter. At policy and programme levels, there is little provision for providing shelter facilities to poor, homeless households, or children living on the streets.

Recommendations: Addressing child poverty and disparities

Based on the key findings presented above, relevant stakeholders may consider the following recommendations as action points to accelerate the reduction of child poverty and disparities in Bangladesh.

Recommendations on child well-being

Nutrition

1. Expand nationwide evidence-based and proven nutrition interventions and improve coordination of nutrition programmes, including: use of multiple micronutrients for control and prevention of anaemia; exclusive breastfeeding and timely introduction of appropriate complementary feeding; and iron and folic acid supplementation for pregnant women.

2. Implement interventions at both facility and community levels to manage severe acute malnutrition.

Health

1. Ensure universal access to Zinc and oral rehydration therapy (ORT) to tackle acute childhood diarrhoea.

2. Sustain and further increase immunization coverage in every district.

3. Strengthen programmes to prevent and manage pneumonia through: improving family and community knowledge and care seeking practices; and increasing access to quality of care through strengthening community-based management of pneumonia.

4. Adopt the strategy recommended by WHO and UNICEF (2009) of providing home visits for newborn care in the first week of life by a skilled attendant.

5. Accelerate implementation of existing policies and strategies that are most likely to reduce risks to child well-being, and increase gender and age-sensitive care and support services for Most at Risk Adolescents (MARA) and Especially Vulnerable Adolescents (EVA).

Water and Sanitation

1. Access to safe drinking water and sanitation needs to be consolidated, expanded and sustained. Special emphasis should be given to arsenic affected, flood and disaster prone areas.

2. Arsenic contaminated drinking water is one of the greatest challenges in providing safe water in Bangladesh. Therefore, a new category – "children drink arsenic contaminated tube-well water"– should be added to the list of deprivation indicators under "Safe Drinking Water."

3. Because children are most vulnerable to diseases related to the lack of clean water and proper sanitation, their needs should be prioritized.

Social Protection and Child Protection

1. The Government of Bangladesh should strengthen existing social protection programmes to reduce the vulnerabilities of hard-core poor families and ensure better inter–ministerial coordination in the area. In parallel, the international community should provide harmonized and coordinated support to the Government of Bangladesh in stimulating further development of an effective and efficient safety net in the country. Special attention should be paid to support for families' coping mechanisms to keep their children within a family environment and prevent the separation of children from their families and their institutionalization. Additionally, the expansion of NGO–provided non–formal basic as well as vocational education to street and working children should be incorporated in the social protection system.

2. Alternative care facilities for children deprived of parental care and children in contact with the law

should be increased and developed. The existing network of institutional care should be transformed into a family-type environment and monitoring and supervision mechanisms should be strengthened in order to ensure the quality of care.

3. Appropriate and adequate programmatic interventions should be developed and implemented in phases to support the social reintegration of children who are homeless and living or working on the street.

4. Birth registration interventions should be further strengthened, with a special focus on disadvantaged and vulnerable children.

Education

1. The inclusion of children who are out of school, including those from ethnic minorities, needs the highest level priority.

2. The education of mothers appears to be a crucial contributing factor in improving all the indicators related to child well-being. Therefore, interventions to enhance female education, as well as the adult literacy programme for women, should be given a high priority. The female stipend programme should be continued and made more effective in keeping girls from hard-core poor families in schools.

3. High quality non-formal education opportunities should be provided as alternative modes of learning for the poorest children until the formal system becomes attractive and affordable for such children.

4. Schools need to be made friendly and inclusive for children from the poorest families and education needs to be made relevant to their lives.

5. Financial benefits for teachers in primary schools need to be increased.

Recommendations on laws and policy

1. Child related national legislation should be harmonized with the United Nations Committee on the Rights of the Child Concluding Observations and Recommendations for the Government of Bangladesh 2009. A comprehensive child protection policy, addressing early marriage, child labour and street children issues, should be developed that articulates a clear and structured action plan to ensure preventive and protective measures for children.

2. There should be greater promotion of the implementation of policies that support: improving family and community knowledge and practice related to prevention and care seeking; and increasing access to quality of care through strengthening community-based management of diarrhoea and pneumonia.

3. Social transfers could be linked to education. As more than 80 per cent of children aged 6 to 10 are enrolled in schools, primary schools should be used as a medium to reach the poorest children and their families. Providing social transfers to the poorest families through schools can motivate their parents to enrol, and keep, their children in schools. However, the level of incentives provided should be commensurate to the opportunity cost of sending the child to school.

4. To ensure sustainable human development, child well-being must be considered as the highest priority and recognized in all national policy and planning documents.

5. To address child poverty and deprivation at national policy and programme level, it is necessary to strengthen the capacity of key relevant government officials, and private and public sector research institutions.

6. Increased budgetary allocation and better targeting of the most deprived unions, upazilas and districts is necessary to materialize the relevant policy commitments.

Recommendations on research and advocacy

1. In-depth and rigorous studies should be encouraged on multidimensional issues on child well-being, child poverty and disparities, and an NGO Child Rights Network should be activated and promoted.

2. In all relevant national surveys, data on children should be disaggregated by gender.

3. Workshops should be organised for policy makers and civil society leaders – both at national and regional levels – to obtain their expert opinions and involve them in the process to addressing child poverty and deprivation and put children at the centre of the development agenda.

4. The key findings of this study should be widely disseminated across all 64 districts to ensure the proactive participation of both people at large and local government bodies in the child poverty and deprivation reduction process.

5. Knowledge and awareness on child well-being and the means to draw children out of poverty and deprivation are crucial. Relevant behaviour change communication (BCC) should, therefore, be a high priority.

CHAPTER ONE

CHILDREN AND DEVELOPMENT

Introduction

Bangladesh is a populous country characterized by a young population. Children under 18 years account for 45 per cent of the country's total population of 140.3 million – 63 million children in all (2006).[1] Therefore, child deprivation and vulnerability should be treated as a serious concern for attaining human development in the truest sense of the term. According to the National Child Labour Survey 2002-2003, there were 42.4 million children aged 5-17 – about one-third of the country's total population. One in every six children is a working child, with a total of 7.42 million working children across the country. And children under the age of 15 account for an estimated 10.1 per cent of the total labour force. Across the country, children in poor families face the worst hardship.

Children in Bangladesh, in general, face multidimensional forms of deprivation, violence, abuse and exploitation. This can be seen almost everywhere – in families, on the street, in the community, workplace, school or any state and non-state institutions. A large proportion of this child population is deprived of health care, an acceptable level of nutrition, a hygienic sanitation system, safe drinking water, safety and security. They have limited scope for personal growth through education and, as a result, lack the skills they need to move out of their current state of misery and build a better future. They are victims of various types of vulnerability and exploitation, ranging from that tolerated by the state (arrest, confinement, police torture, the negative attitude of state actors towards children) to societal violence (child marriage, trafficking, sexual abuse, dowry, corporal punishment at home and schools, and abuse and exploitation by employers).

Against this backdrop, this study attempts to sketch the current scenario of child poverty and deprivation that prevails in Bangladesh, based on available statistical data and information, and policy and programme documents from the Government and partner agencies.

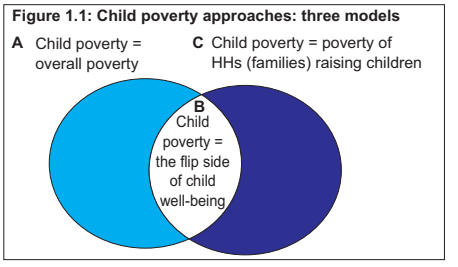
1 The population projection for the year 2006 on the basis of Population Census 2001 has been made by the authors assuming 1.54 per cent growth rate.

Children, poverty and disparities: conceptual framework

"Children living in poverty experience deprivation of the material, spiritual, and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society" (*State of the World's Children Report (SOWC)*, UNICEF, 2005).

UNICEF's Global Study on child poverty and deprivation presents child poverty using a three-model approach as shown in Figure 1.1 and explained in Table 1.1. Model A presents the simplistic way in which much of the world sees child poverty as indistinguishable from overall poverty. This approach starts with a macro view of poverty that must be made more specific (or disaggregated) in order to reveal poverty at the community or household (HH) level. Model B equates child poverty with the poverty of families raising children. The advantage of this model is that it takes a household-level perspective, which is much closer to where children come into focus. Model C combines Models A and B to capture the outcomes for the individual child and brings in non-material aspects of poverty. Model C appears to be the best fit as it considers child well-being and child deprivation to be "different sides of the same coin" (Bradshaw et. al., 2007).[2]

Figure 1.1: Child poverty approaches: three models



2 Cited in the Global Study on Child Poverty and Disparities 2007-2008 Guide, UNICEF. As Bradshaw et. al., note "…from a child rights perspective well-being can be defined as the realization of children's rights and the fulfillment of the opportunity for every child to be all she or he can be in the light of a child's abilities, potential and skills. The degree to which this is achieved can be measured in terms of positive child outcomes, whereas negative outcomes and deprivation point to the neglect of children's rights."

Table 1.1: Three models of child poverty

Model	Implications	Advantage	Disadvantage	Examples
Model A: Child poverty = overall poverty	Focus on material poverty as well as poverty as powerlessness, voicelessness	Seek solutions addressing the underlying or core causes of poverty in the country	Child-specific concerns and/or urge for immediate relief ignored	• Per capita GDP • People living on less than $1 a day (at PPP) or in different wealth/asset quintiles
Model B: Child poverty = the poverty of households (families) raising children	Focus on material poverty	Seek solutions addressing the main underlying or core causes of poverty in the country as well as the inadequate support and services to families raising children	Non-material aspects of child deprivations ignored	• Number of children living in households on less than 50 per cet of the median income or under national poverty threshold (UNICEF IRC Report Card No 6) • Children with two or more severe deprivations (shelter, water, sanitation, information, food, education and health service) ('Bristol concept' in Townsend 2003 or SOWC 2004)
Model C: Child poverty = the flip side of child wellbeing	Strongest focus on child outcomes	Addresses the emotional and spiritual aspects of child deprivation, as well as material poverty, and therefore brings in child protection concerns	Methodological difficulty in producing standard poverty measures (headcount, poverty gap) and/or lack of indicators/statistical data especially in developing country contexts	• Composite indices on child well being in the rich countries (Bradshaw et, al 2006, UNICEF IRC Report Card No 7) • Complex child poverty measures in some OECD countries (e.g. UK)

Recent research has shed more light on child deprivations, family income and the usefulness of composite indicators. The groundbreaking study *'Child Poverty in the Developing World'* (Townsend et. al., 2003)[3] examined child poverty using a model that most closely resembles Model B in Table 1.1. The Bristol study looked through the lens of seven severe deprivations of human needs to estimate the poverty headcount: (i) shelter, (ii) sanitation facilities, (iii) safe drinking water, (iv) information, (v) food, (vi) education, and (vii) health.

A conceptualization of child poverty that includes the income/consumption dimension is valuable from at least two viewpoints: First, looking at incomes brings in the issue of stability and quality of employment – a major concern for care providers, parents and their children, as well as for young adults. Second, income/consumption can be used more readily to capture transient poverty, which is often the target of social protection measures. However, there are important theoretical limitations to, and practical, policy-oriented arguments against, the (sole) use of monetary measures on poverty (Lipton and Ravallion 1995; Ravallion 1992; 1998; Reddy and Pogge, 2002),[4, 5]

UNICEF's 2007 Report Card *'Child poverty in perspective: An overview of child well-being in rich countries'* looked at child outcomes through six dimensions of child well-being: (i) material well-being, (ii) health and safety, (iii) education, (iv) peer and family relationships, (v) subjective well-being, and (vi) behaviour and risk.

Considering the three models presented in Figure 1.1, and the work that has been conducted around deprivations and income based measures, the 'best' model to capture factors that influence child outcomes should, theoretically, consider:

1. Both income and non-income factors of the caretakers or the household, and how these determine whether or not a child enjoys her/his right to survive, grow and develop;
2. How resource scarcity and deprivations impact children directly, and how they are, in general, experienced differently according to gender, age and social status at the family, household or country levels;
3. How childhood is a period that is distinct from adulthood (life cycle approach);
4. How family care and protection enable girls and boys to enjoy other basic rights, i.e., children who are deprived of a safe and caring environment are also more likely to experience other deprivations.

3 Cited in the Global Study on Child Poverty and Disparities 2007-2008 Guide, UNICEF

4 Ibid 2.

5 For details about the limitations of money-metric measures of poverty and possible alternative measures, see also Barkat Abul (2003), "Right to Development and Human Development; Concepts and Status in Bangladesh", in Hameeda Hossain (ed.), Human Rights in Bangladesh 2002, Ain-O-Shalish Kendra, Dhaka 2003.

Nationally, there are no published data on child poverty for Bangladesh. Data are, however, available on household level poverty. This assumes that if a household is poor, all members in that household are also poor. Data are generated using two methods: (i) the Direct Calorie Intake (DCI) method, which measures only food intake, and (ii) the Cost of Basic Needs (CBN) method, which is based on the monetary value of basic consumption needs. The details of these two methods are shown below.

DCI and CBN methods of poverty measurement

Two types of poverty measures commonly used in estimating poverty headcounts are: (i) Direct Calorie Intake (DCI) method, and (ii) Cost of Basic Needs (CBN) method. The DCI method is used to estimate the incidence of poverty by using a threshold food calorie intake. A person having a daily calorie intake of less than 2,122 kilocalories is considered "absolute poor" while one with an intake of less than 1,805 kilocalories is considered "hard-core poor" or "extreme poor". The CBN method stipulates a consumption bundle deemed to be adequate for basic consumption needs and then estimates its cost. The household expenditure on basic need items including food, clothing, housing, health care expenses, and education is considered, and an "upper poverty line" and a "lower poverty line" are estimated. People living below these lines are considered poor

Methodological issues pertinent to the study

There is little documented evidence of any understanding of the different aspects of child deprivations and how these relate to each other, the relationship of child deprivations with family and household deprivations, the implication of weaknesses in public policies on child and family deprivations, or appropriate forms of addressing local or regional constraints. Too often, knowledge and technical capacity grow weaker as discussions move upstream from micro-level, child-oriented programmatic interventions towards the more general and murky waters of policy making.

UNICEF has commissioned this study against this backdrop to help fill the gap in understanding. **At the country level**, the study provides an evidence-based analysis to create better understanding of how policies, programmes and partnerships translate into outcomes for children. **At regional and global levels**, it provides new knowledge of country-level linkages between policies and outcomes to advocate for specific measures to address child poverty and disparities. This study aims, therefore, to raise the policy profile of child poverty and disparities in outcomes related to the Millennium Development Goals (MDGs) and facilitate the steering of development and donor agencies towards a passionate agenda to achieve results for children.

The **purpose of the study** is to generate evidence and insights and identify networks that can be used as leverage to influence national development plans, to inspire and feed into poverty reduction or sector-wide strategies, and to develop common country assessments and other development tools. Nonetheless, it is important to stress that the central focus of the study is on producing quality analytical products at the country level, to support the development of child-sensitive poverty reduction strategies and policy interventions for Bangladesh.

The study has been accomplished by following intensively a standardized methodology i.e., the *UNICEF Guide on Child Poverty and Disparities 2007-2008*. As per the Study Guide, both statistical and policy templates have been completed successfully by the study team. These templates provide a contemporary scenario and analysis of child poverty and disparities prevailing in Bangladesh.

A strong and vibrant **Working Group** consisting of government officials, UNICEF personnel, development organizations and study team members ensured the successful completion of the templates. Both statistical and policy experts were included in the Working Group. To ease and expedite the activities of the Working Group, a Core Group was formed.

There are 45 tables in the statistical templates. Of these, 28 are complete and 12 partially complete. Five tables remain incomplete, as data were not available in the required format.

Sources of data and information for the statistical templates include: the Multiple Indicator Cluster Survey (MICS) 2006; the Child and Mother Nutrition Survey (CMNS) 2005; the Household Income and Expenditure Survey (HIES) 2005; the Bangladesh Population Census 2001 Population Projection Data; the Poverty Monitoring Survey (PMS); the Bangladesh Demographic and Health Survey (BDHS) 2004; the Bangladesh Labour Force Survey 2005-2006; the Child

Table 1.2: Key parameters of national surveys considered in the study

Survey title	Survey year	Total sample size of households		Data collection instruments used
		Original	Successfully interviewed	
Multiple Indicator Cluster Survey (MICS)	2006	68,247	62,463	1. Household questionnaire for mother. 2. Questionnaire for individual women aged 15-49. 3. Questionnaire for under-five children.
Child and Mother Nutrition Survey (CMNS)	2005	8,060	3,069	1. Child and Mother Nutrition Survey questionnaire
Household Income and Expenditure Survey (HIES)	2005	10,080	10,080	1. Household Income and Expenditure Survey
Bangladesh Demographic and Health Survey (BDHS)	2004	10,811	10,500	1. Household questionnaire, 2. Women's questionnaire 3. Men's questionnaire

Labour Survey; the Bangladesh Economic Review the Statistical Year Book; the Statistical Pocket Book; the Public Expenditure Review for the Health Sector; the Health Economics Unit; BANBEIS; the Statistical Department of Bangladesh Bank; and other online sources mentioned in the Study Guide. Completion of the statistical templates required rigorous involvement of the Team Leader, the statistical experts of the study team and the statistical experts of the Bangladesh Bureau of Statistics. In the completion of the statistical templates, in most cases, outputs have been generated from the raw database of the most significant surveys such as MICS, CMNS, BDHS, and HIES (Table 1.2).

The study team faced and overcame a number of diverse constraints in completing the statistical templates. These included: the lack of readily available child poverty-related data/information; the need to generate output from the raw data of various surveys; the fact that most data/information was at the household level; the need for proxy variables/indicators; the lack of year-specific data in the templates; the unavailability of child poverty, deprivation and disparity-related data from a single source (survey, report, documents etc.); problems in disaggregating the national budget for children where expert judgment was the only solution; and the unavailability of data/information on certain indicators.

In addition to the statistical template, the UNICEF Global Study Guide requires completion of eight tables in the policy template. Completion of the policy template required rigorous review of a number of policy documents, such as Laws, Acts and regulations, sector-specific policies, national programmes, key policy statements, Ministerial decrees and directives. The key national programme initiatives to address the goals are set in policies such as: the Poverty Reduction Strategy Paper (PRSP); the National Plan of Action on Nutrition, Education, and Children; the third and fourth periodic reports on the Convention on the Rights of the Child (CRC); MDG outcomes related to child poverty; policies to support family/household income that focus on a wide range of issues such as poverty and disparities; the child nutrition initiative; child health (access, use, equity and efficacy of health services); child protection (ensuring children receive protection from exploitation, exclusion, negligence, abuse and enjoy their right to grow up in a family); child education (access, use, equity and efficacy of education services to ensure all children enjoy right to education); shelter; and access to water and sanitation. Information on financial matters, i.e. national budgetary allocation, is involved in a number of policy templates. Key stakeholders responsible for formulation and implementation of various policies and programme have been consulted for their expert judgment and insights in the policy template completion process.

In addition to the Working Group and the Core Group, the UNICEF Focal Point and designated personnel from a number of Sections (such as education, child protection, water and sanitation, communication and information, and health and nutrition) from the UNICEF Bangladesh Country Office provided data/information and guidance for successful completion of the study.

The participation of the Core Group in the "Regional Technical Workshop on Child Poverty and Disparities", organized by the UNICEF Regional Office for South Asia (ROSA) in Kathmandu, Nepal on 7-9 May, 2008, provided the study team with insights on methodological issues and experiences from other countries. The Study Team Leader, on behalf of the Core Team, presented a progress report on the study conducted by Human Development Research Centre (HDRC) in Bangladesh.

The country analysis has been conducted in line with the chapter outline formulated in the Study Guide and on the basis of completed statistical and policy

templates, aiming to protect child rights more effectively and reduce child poverty and disparities by implementing national policies and programmes to ensure better services and protection for every child in the country.

What this study tells us about children in Bangladesh

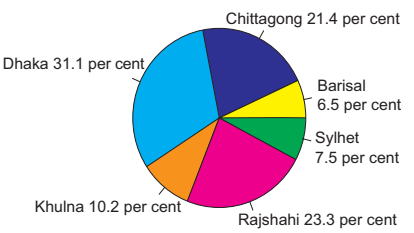
This study reviews child deprivation, well-being and disparities in Bangladesh. Child deprivation has been assessed in terms of health, education, nutrition, information, water, sanitation and shelter. Child well-being has been analyzed in terms of several outcome indicators including: stunting; wasting; underweight; breast-feeding; iodized salt consumption; vitamin A supplementation; prevalence of diarrhoea and pneumonia; knowledge about HIV and AIDS; immunization; birth registration; child labour; early marriage; school enrolment and social protection. Relevant policies and programmes have been reviewed to assess how they address current child poverty, well-being and disparities.

To give the readers a taste of the information in this report, this section presents a set of examples. A snapshot of the report can also be found in the *Executive Summary*.

According to the Population Census of 2001, of the total population of 130 million (67.1 million males, 62.9 million females) children aged 0-17 years account for 45 per cent (23.9 per cent boys and 23.9 per cent girls). Assuming a 1.54 per cent growth rate, the total population in the country in 2006 was estimated to be 140.3 million with 72.4 million males and 67.9 million females, and a child population of 63.2 million – 33.5 million boys and 29.7 million girls.

Of the country's 63.2 million children aged 0-17 years, about 73 per cent live in rural areas and 27 per cent in urban areas. As shown in Figure 1.2, the highest proportion of the country's children live in Dhaka division (31 per cent), followed by Rajshahi (23 per cent), Chittagong (21 per cent), Khulna (10 per cent), Sylhet (8 per cent), and Barisal division (7 per cent).

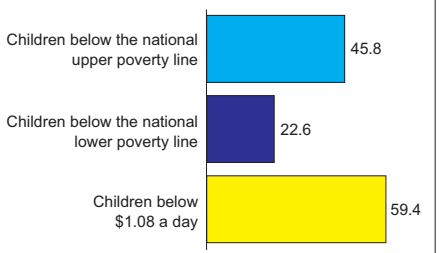
Figure 1.2: Distribution of children (0-17 years) by geographic regions



Source: MICS 2006 [Reference: Annex I: Table 1.1.1]

An analysis of the state of poverty among children reveals that 46 per cent of children in Bangladesh live below the national poverty line; 59 per cent live below the internationally agreed poverty line and 23 per cent live in persistent poverty (Figure 1.3).[6]

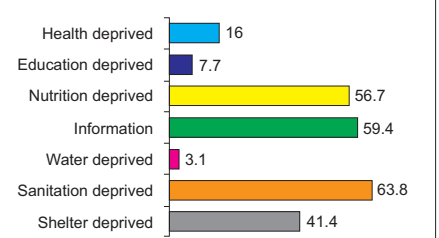
Fiure 1.3: Status of poverty of children (0-17 years, per cent)



Source: HIES 2005, [Reference: Annex I: Table 1.1.2]

In terms of deprivation of materials, goods, and services: 41 per cent of the country's children are deprived of shelter; 64 per cent of sanitation; 59.4 per cent of information; 57 per cent of nutrition; 16 per cent of health; and 8 per cent of education (Figure 1.4). Although it appears that only 3 per cent of children are deprived of drinking water, the real extent of deprivation is much higher when access to arsenic-free water is taken into account.[7]

Figure 1.4: Deprivation status of children (0-17yrs per cent)



Source: MICS 2006, CMNS 2005
[Reference: Annex I: Table 1.1.2]

6 The lower poverty line under the CBN method is considered to be the persistent poverty line.

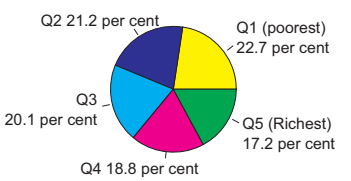
7 Data on people's access to safe drinking water is not available in Bangladesh. However, the most recent study revealed that people's access to safe, clean and arsenic-free drinking water is 65 per cent at best. The study also revealed that poor people are 11 times more likely to suffer from arsenicosis than the rich in rural areas (see Barkat Abul and Abul Hussam, "Provisioning of Arsenic-free Water in Bangladesh; A Human Rights Challenge", prepared as keynote paper, Engineering and Special Vulnerabilities, National Academy of Engineering, Washington D.C.: 2-3 October, 2008).

How is less severe deprivation defined?

1. Shelter deprived	Children living in dwellings with four or more people per room
2. Sanitation deprived	Children using unimproved sanitation facilities, such as pit latrine without slab/open pit, bucket, hanging toilet/hanging latrine, flush to somewhere else, flush to unknown place/not sure/don't know
3. Water deprived	Children using water from an unimproved source. (i.e., unprotected well or spring, surface water etc.) Note: Water deprivation does not include drinking arsenic-contaminated water
4. Information deprived	Children aged 3-17 years with no access to a radio or television (i.e. broadcast or telecast media)
5. Nutrition deprived	Children who are stunted, wasted or underweight
6. Education deprived	Children of school age (aged 7-17) not currently attending school or attended but did not complete their primary education
7. Health deprived	Children aged12-23 months who have not received all vaccinations including BCG, DPT1, DPT2, DPT3, polio0, polio1, polio2, polio3 and measles by the age of twelve months

In terms of household wealth, almost one-quarter of all children live in households from the poorest wealth quintile, while about 17 per cent live in households from the richest quintile (Figure 1.5).

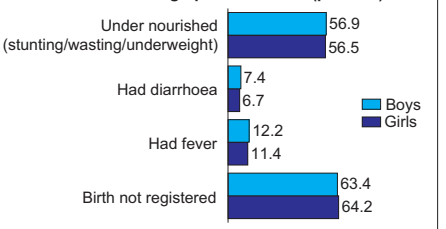
Figure 1.5: Distribution of children according to Wealth Index Quintiles



Source: MICS 2006 [Reference: Annex I: Table 1.1.2]

Among children aged 0-4 years, about 57 per cent of both boys and girls were undernourished (suffering from stunting, wasting, or underweight) in 2005 and about 7 per cent had diarrhoea in 2006. About 12 per cent of boys and 11 per cent of girls had fever in the two weeks preceding the MICS survey. The births of 63 per cent of boys and 64 per cent of girls are not registered (Figure 1.6).

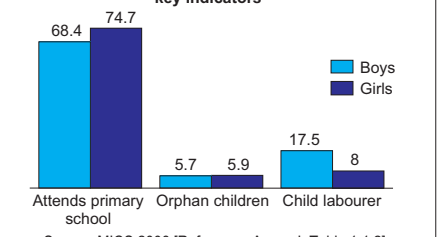
Figure 1.6: Status of children (0-4 years) in terms of key health and demographic indicators (per cent)



Source: MICS 2006, CMNS 2005 [Reference: Annex I: Table 1.1.2]

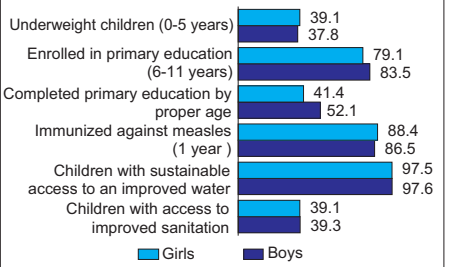
The school attendance rate for children aged 5-14 years is higher for girls (75 per cent) than boys (68 per cent). The prevalence of child labour among this age group is 18 per cent for boys and 8 per cent for girls. Among children of the same age group, orphans constitute about 6 per cent for both boys and girls (Figure 1.7).

Figure 1.7: Status of children (5-14 years) in terms of key indicators



Source: MICS 2006 [Reference: Annex I: Table 1.1.2]

Figure 1.8: Status of children against key MDG indicators (per cent)



Source: MICS 2006, CMNS 2005 [Reference: Annex I: Table 1.1.3]

Children and the Millennium Development Goals (MDGs): progress and disparity

The status of children against key MDG indicators (Figure 1.8) shows that 38 per cent of boys and 39 per cent of girls aged 0-5 years are underweight. The enrolment ratio among children aged 6-11 years is lower for girls (79 per cent) than for boys (84 per cent). The completion rate of primary school at the proper age is also lower for girls (41 per cent) than for boys (52 per cent). In terms of immunization against measles for children aged one, girls seem marginally better off (88 per cent) compared to boys (87 per cent). The rate of access to sustainable drinking water is quite encouraging although the rate may be lower if access to arsenic-free drinking water is considered (see footnote 7).

The reduction of child mortality is one of the eight MDGs. In Bangladesh, the mortality rate for children under the age of five was more than halved between 1993-1994 and 2004 and now stands at 88 deaths per 1,000 live births.

The political, economic and institutional context

The political, geographic and institutional background

Since ancient times, Bangladesh has been famed for its glorious history and culture and its strategic geographical setting on the Bay of Bengal. Surrounded by India in the east, west and north, and by Myanmar in the southeast, it lies in the delta of three mighty rivers – the Ganges (Padma), the Brahmaputra and the Meghna – that curve their way through Bangladesh to the Bay of Bengal.

The People's Republic of Bangladesh became independent in December 1971, after nine months of liberation war. The new State experienced famines, natural disasters and widespread poverty as well as political turmoil and military coups. From the mid 1970s to the early 1990s, the State was ruled by a series of military autocratic regimes and experienced a growth rate of only 3.7 per cent per year throughout the 1980s. Since the restoration of democracy in 1991, it has experienced relative stability and economic progress with a modest annual growth rate of 4.8 per cent in the 1990s, and 5.9 per cent from 2001 to 2005.[8]

8 Barkat A et. al., (2009). Financing Growth and Poverty Reduction: Policy Challenges and Options in Bangladesh, UNDP Bangladesh.

From 1991 to 2006, the Government was a parliamentary democracy with Islam as the State religion. However, political rule has been suspended under emergency law since 11 January 2007. The parliament comprises 345 members including 45 seats reserved for women elected from single-member constituencies. The Prime Minister, as the Head of Government, forms the cabinet and runs the day-to-day affairs of the State. The country is divided into six administrative divisions, each named after their respective divisional headquarters: Barisal, Chittagong, Dhaka, Khulna, Rajshahi, and Sylhet. These divisions are sub-divided into districts. There are 64 districts in Bangladesh, each further sub-divided into upazilas (sub-districts) or thanas ("police stations"). Each upazila, except for those in metropolitan areas, is divided into several unions, with each union consisting of multiple villages. In the metropolitan areas, police stations are divided into wards, which are further divided into mahallas. There are no elected representatives at the divisional, district or upazila levels, and the administration is composed only of Government officials. Direct elections are held for each union (or ward), which elect a chairperson and a number of members.[9]

Population, economic growth, emerging issues and challenges

With a population of 140.3 million and a total area of 157,570 square kilometres, Bangladesh is ranked as the seventh most populous nation in the world, and has the highest population density in the world, excluding a handful of city-states. The current total fertility rate is 2.7 children per woman, compared with 6.2 children 30 years ago.[10] The population is relatively young, with those aged 0 to 25 years accounting for 60 per cent of the entire population, while just 3 per cent are 65 or older. Life expectancy is 63 years for both males and females.[11]

The existing socio-economic situation of Bangladesh presents a peculiar paradox of rich natural resources counterpoised by extreme poverty. Even though the climate, which is changing, is favourable for agriculture (the mainstay of the economy), current agricultural output is far below its potential. However, the potential growth of the fishing industry is vast with innumerable canals, rivers and inshore and off-shore fishing areas across the Bay of Bengal.

9 Banglapedia
10 Bangladesh demographic and Health Survey 2007: Preliminary Report
11 ibid

Table 1.3: The structure of the economy

Sectors	Share (per cent) in total GDP at constant price 2005-2006 (Base 1995-96 = 100)[1]	Share (per cent) in total Employment (2005-2006)[2]
Agriculture, forestry and fishery	21.77	48.1
Mining and quarrying	1.16	0.1
Industry	17.05	11.0
Services[3]	60.02	40.8

Source: 1 Bangladesh Economic Review 2006, pp.27, 34
2 Bangladesh Labour Force Survey 2005-2006 (Provisional)
3 Services = electricity, gas and water + construction + wholesale and retail trade + hotels and restaurants + transport, storage and communication + financial and intermediations + real estate, renting and other business activities + public administration and defence + education + health and social Work + community, social and personal services.

Despite continuous domestic and international efforts to improve economic and demographic prospects, Bangladesh remains a developing country. Its per capita income in 2006 was $2,300 (adjusted by purchasing power parity) compared to the world average of $10,200.[12] The economy of Bangladesh is still largely agro-based, with 22 per cent of the country's GDP and 48 per cent of employment linked to agriculture. While the service sector contributes 60 per cent of GDP, industry contributes less than 20 per cent (Table 1.3).

The PRSP also stated that the analysis of the macro-economic impact of floods in 2004 points out that the growth of per capita income is likely to fall from 4.5 per cent to 3.7 per cent as a result of lost income. The fall in per capita income may be more for poor and non-poor households that are very near the poverty threshold.

Face to face with the grim realities of acute food shortage, natural emergencies and disasters, the

Table 1.4: Comparison of flood situation and issues

Issues related to flood	Year		
	1988	1998	2004
Inundated area (percentage of land)	61 per cent	68 per cent	38 per cent
Duration of flood (number of days)	23	72	21
People affected (in millions)	45	31	36
Total number of deaths	2,335	918	800
Loss of income/Assets (in million $)	330	2,000	2,200

Source: PRSP, Oct-2005, page 19.

Bangladesh is one of the most disaster-prone countries in the world. The country faces multi-dimensional crisis in terms of staple food, natural, environmental and human-induced disasters. Over-flooding, cyclones, tornados, droughts, arsenic contamination in the water and deforestation are quite common. Water, salinity, a drastic fall in the underground water-level, and avian influenza are all matters of grave concern. Above all, climate change could have catastrophic consequences that could jeopardise the very existence of the country. Noted national experts on environment and climate change have viewed the consequences of global warming, the greenhouse effect and the melting of the ice and snow that cap the Himalayas as devastating. With a one-metre rise in sea level, 15-17 per cent of the country will be submerged, with 15-20 million people displaced and trapped in unthinkable misery (Islam, 2007).

In its PRSP, the Government of Bangladesh provides a comparative picture of the flood situation for 1988, 1998 and 2004 (Table 1.4).

Government has adopted a strong Agricultural Development Policy, food security measures, disaster management and risk reduction programmes. Government actions have included the following:

1. In 2007-2008, the Government created an Endowment Fund with Tk. 3,500 million to strengthen research for increased agricultural productivity (Budget Speech, 2008)
2. Cash subsidies worth Tk. 2,500 million have been provided to farmers with a total land holding of 4,563,000 acres across 484 upazilas.
3. Food management and food security measures are now high priority, to mitigate the food crisis. Domestic procurement with incentive pricing for wheat and rice has been introduced to build up an adequate buffer stock. In addition, advance planning to import substantial quantities (about 3 million metric tons) of food grains from external sources has been given top priority.

12 ibid

4. In the 2007-2008 financial year, the contribution of the Fisheries and Livestock sub-sectors to GDP was 4 per cent and 2.9 per cent respectively. To mitigate the food crisis and poverty, the Government is encouraging social fisheries, building fish sanctuaries, releasing fish in ponds, providing microcredit with nominal interest, and trying to enforce responsible fishing so that indiscriminate fishing does not deplete the source and resource.

5. In 2009, the Government provided Tk. 160 million to compensate poultry farmers who were badly affected by bird flu. In addition, facilities such as tax-holding, and the duty exemption on imports of equipment, medicines, and vaccines helped farmers to rebuild their farms, and addressed food shortages and deficient protein supply.

6. The national goal is to achieve "A robust, well-managed, equitable, and disaster risk resilient national food security system" (Corporate Plan, 2005-2009: 15). The vision of the Government is to reduce the risks to the people, especially the poor and disadvantaged, from natural, environmental and human-induced hazards, to a manageable and acceptable humanitarian level. To this end, national experts, civil society members, non-governmental organizations (NGOs), Government functionaries and development partners (donors), have all expressed their commitment. The "Corporate Plan - A Framework for Action 2005-2009" is evidence of the collaborative efforts of government and development partners. It envisages the following key measures:

    i An effective Disaster Information Management and Coordination Centre at the national level, and at integrated district level.

    ii An effective community level hazards warning system.

    iii Greater levels of coordination and information, acquisition and dissemination across Government agencies, NGOs and civil society networks.

    iv Enhanced national and regional cooperation and networks.

    v Coordinated, timely and appropriate response and more effective damage assessment, level and recovery systems.

In-country independent observers and those from outside Bangladesh have suggested that the country's disaster management and response preparedness is better than most countries in the region. This success is the result of strong political will, mass mobilization and people's participation in the process.

Challenges to human development and equity

As shown in the Fact, page 18, the country has made some progress in reducing poverty since the 1990s with the incidence of poverty falling from 57 per cent in 1991/92 to 40 per cent in 2005.[13] Relative inequality, however, has increased during that time with the Gini index for Bangladesh rising from 0.388 in 1991/92 to 0.467 in 2005.[14] Though there has been remarkable progress in increasing primary school enrolment and attaining gender parity in primary and secondary schooling, challenges still remain in reducing dropout rates and improving the quality of education. Around half of the population is far from being literate.[15] Notable progress has been achieved in reducing the total fertility rate; under-five and infant mortality rates; the maternal mortality ratio; increasing immunization coverage against measles; and lowering the prevalence of underweight children under five. However, the proportion of child deliveries handled by skilled birth attendants is still just 20 per cent, and the ratio of doctors to population is still 1:3317.[16]

Challenges remain in: increasing the share of the poorest quintiles in national income/consumption and reducing the prevalence of extreme poverty; reducing the dropout rate in primary and secondary education and increasing the adult literacy rate; ensuring gender parity in tertiary education; reducing maternal mortality and increasing the proportion of births attended by skilled health personnel; addressing the potential threats of HIV/AIDS and developing strong mechanisms to monitor outbreaks of malaria in high-risk districts; and increasing access to sanitary latrines in rural areas and urban slums.[17] Bangladesh continues to suffer high levels of malnutrition in the form of both protein-energy malnutrition and micronutrient deficiencies. Up to 48 per cent children under the age of five (6-59 months) are underweight, 43 per cent are stunted and 13 per cent are wasted.[18]

13 Household Income and Expenditure Survey 2005. Incidence of poverty indicates poverty based on the CBN method and poverty below the upper poverty line.

14 Household Income and Expenditure Survey 2005.

15 Current literacy rate of 7+ year's population is 53 per cent (Statistical Pocket Book, BBS 2007).

16 Millennium Development Goals Mid Term Bangladesh Progress Report 2007; Statistical Pocket Book, BBS 2007.

17 Barkat, A. et. al. (2009). Financing Growth and Poverty Reduction: Policy Challenges and Options in Bangladesh, UNDP Bangladesh.

18 Bangladesh Demographic and Health Survey 2004, National Institute of Population Research and Training (NIPORT), Dhaka, Bangladesh.

Facts: Bangladesh: successes and challenges in human development and equity

Over recent decades, Bangladesh has achieved notable successes in the following areas:

- *reducing the incidence of poverty*
- *increasing primary school enrolment*
- *attaining gender parity in primary and secondary schooling*
- *reducing the total fertility rate*
- *reducing under-five and infant mortality rates*
- *increasing immunization coverage against measles; and*
- *lowering the prevalence of underweight children aged below five*

Challenges to human development and equity remain in the following areas:

- *reducing the prevalence of extreme poverty*
- *increasing the share of the poorest quintiles in national income/consumption*
- *reducing the dropout rates in primary and secondary education*
- *improving the quality of education*
- *increasing the adult literacy rate*
- *ensuring gender parity in tertiary education*
- *reducing the ratio of doctors per head of population*
- *reducing maternal mortality*
- *increasing the proportion of births attended by skilled health personnel*
- *addressing the potential threats of HIV/AIDS*
- *developing strong mechanisms to monitor outbreaks of malaria in high-risk districts*
- *increasing access to sanitary latrines in rural areas and urban slums*
- *reducing the prevalence of child malnutrition*
- *improving dietary intakes of both children and adults in vitamin A, iron, iodine and zinc; and*
- *reducing iron-deficiency anaemia among children and pregnant women*

These rates are unacceptably high, even when considered in the context of Bangladesh's low per capita income. Child malnutrition, especially in the earliest years, is associated with increased rates and severity of infectious diseases and contributes to more than half of all child deaths.[19] The dietary intakes of both children and adults are severely deficient in multiple micronutrients, particularly vitamin A, iron, iodine and zinc. Although there has been significant progress in reducing vitamin A deficiency among pre-school children, the consumption of vitamin A enriched foods is still low. Iron deficiency anaemia, which is also highly prevalent, affects one-third of adolescent girls and non-pregnant women and is even higher in pregnant women (51 per cent). More than half of all children aged 6-59 months are anaemic.[20] The immediate causes of malnutrition in women and children are inadequate dietary intake and high infectious disease burden, resulting from household food insecurity and inappropriate household practices in feeding, personal hygiene and caring for adolescent girls, pregnant women, mothers and their young children. These are exacerbated by a lack of knowledge and awareness about what constitutes a healthy way of life.

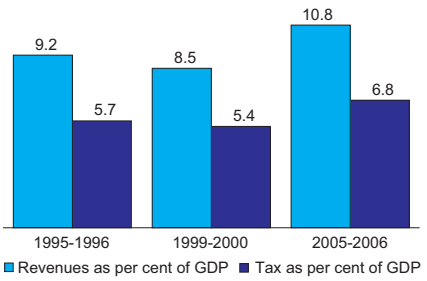
19 Health, Nutrition and Population Sector Programme (HNPSP) July 2003-June 2010, Preliminary document, January 2005, MOHFW Website (http//.www.mohfw.gov.bd).
20 Ibid.

Macro-economic strategies and resource allocation

Policies for macro-economic stabilization and structural adjustment were implemented in Bangladesh in the early to mid 1980s and were pursued more vigorously in the early 1990s. These policies aimed primarily to reduce fiscal and external deficits in the face of declining foreign aid. Fiscal measures included reduction or elimination of agricultural and food subsidies in the early 1980s, introduction of Value-Added Tax (VAT) in the early 1990s, and curtailing the role of the government in direct investment in productive sectors. The Government's role in development activities was redefined in terms of investment in the people – education, healthcare, public utilities, and physical infrastructure. The recent fiscal policies of the Government aim to strengthen the tax administration and include the creation of a Large Taxpayers Unit and a Central Intelligence Unit to

monitor tax compliance of large taxpayers, expand the income tax and VAT net, strengthen customs administration, rationalize non-tax revenue, and develop the professional skills of National Board of Revenue officials.

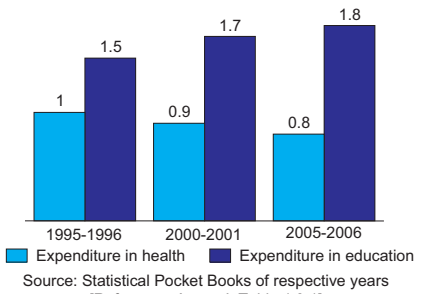
Figure 1.9: Total revenue and taxes as percentage of GDP



Source: Statistical Year Books of respective years
[Reference: Annex I: Table 1.3.1]

Although the revenue-GDP ratio has increased, particularly since the 1990s, as shown in figure 1.9, it is still very low even by the standard of the developing countries.[21] During this period, while the Government expenditure in education has increased, the expenditure in health has decreased (Figure 1.10).

Figure 1.10: Total Government Expenditure in health and education as percentage of GDP



Source: Statistical Pocket Books of respective years
[Reference: Annex I: Table 1.3.1]

External sources were once the main source of financing, but the dependence on external sources has gradually declined.

In the face of declining foreign assistance, the Government's reliance on domestic borrowing has increased in recent years. However, this increases the risk of rising inflation or crowding the private sector out of the credit market.

21 The average revenue-GDP ratio of OECD countries is 37 per cent. The ratio is 17 per cent in India, 20 per cent in Pakistan and 16 per cent in Thailand (Ahmed, S. (ed.) 2005)

Against the backdrop of recent inflationary pressure on the economy, and particularly on energy and food grain prices, the Bangladesh Bank (BB) has formulated a new credit policy focusing on selective credit control measures. The broad monetary policy of the country has been expansionary, in favour of credit to essential sectors such as agriculture, small and medium enterprises (SMEs), house building, renewable energy, etc. At the same time, it restricts the expansion of credit to less essential or luxury items such as cosmetics, expensive cars, cigarettes, the import of superior quality ceramic products, etc. Bangladesh is now following a policy of 'free float currency', which appears to be a mere luxury for such an economy, at a time when both the export and import sectors of the country are suffering from structural rigidities.

The current wave of inflation has been eroding the purchasing power of low and middle income people in Bangladesh, as they need to pay much higher bills for food grains and other commodities. The national Exchequer has been under constant pressure as a result of the world petroleum price hike, although the pressure has been eased to some extent with the recent fall in prices resulting from the worldwide economic recession. According to the Bangladesh Bank, overall inflation in Bangladesh was 10 per cent on both a 12-month annual average and on a point-to-point basis in August 2008, while food price inflation was 12.6 per cent on a 12-month average basis and 12.4 per cent on a point-to-point basis.[22] In addition to such external factors, some internal factors such as crop-loss as a result of natural disasters, the Bank's exchange rate policies, and the expansion of broad money (M3) and credit have exacerbated the price hike of primary commodities in Bangladesh.[23] A recent World Bank report estimated that the food price hikes have pushed more than four million Bangladeshis into poverty. It has been estimated that the food price shock raised the poverty rate in 2008 by around 3 percentage points from the baseline poverty rate of 2005.[24]

Since joining the World Trade Organization (WTO) in the mid-1990s, Bangladesh has been adopting vigorous trade liberalization measures. Whereas in the 1980s piecemeal and partial reforms were undertaken, liberalization of Bangladesh's trade regime since 1991 is generally considered to have been more systematic and comprehensive. Trade liberalization measures have opened the economy to the world market

22 Economic Trends, Bangladesh Bank (http://www.bangladesh-bank.org/).

23 Islam M. Shahidul, "Commodity Boom and Inflation Challenges for Bangladesh", Institute of South Asian Studies (ISAS) Working Paper, March 2008.

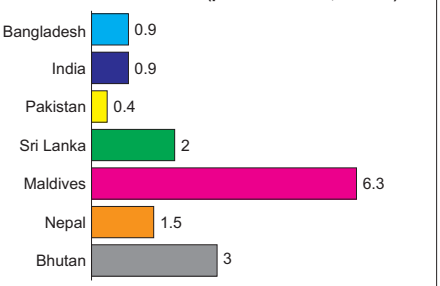
24 BangladeshNews.com.bd (http://www.bangladeshnews.com.bd/2008/08/27/food-price-hike-pushed-40-lakh-into-poverty).

significantly, and involved a process of redirecting incentives away from import substitution towards export competition. The main components of import liberalization in Bangladesh in the 1990s were the removal of quantitative restrictions (QRs), reductions in nominal and effective tariffs, and the adoption of a unified and moderately flexible exchange rate regime. The expanding global economy and WTO agreements have created new opportunities and challenges for Bangladesh, which faces the severe constraints of underdeveloped technology and a low capital base. The domestic import substitute industries have been facing increasingly tough competition following the gradual reduction of duty rates. Export industries, on the other hand, have to survive and expand by competing with other countries.[25]

Until the mid-1970s, the input management system in agriculture was Government-dominated and the State was responsible for the procurement and allotment of all inputs to farmers. About one-third of the development budget was absorbed by agricultural subsidies. These policies had a major part in the initial adoption of the contemporary HYV (high yielding variety) rice technology. The market-based reforms moved gradually away from the centrally-based input management system to a liberal market system. Liberalization in the agricultural sector includes privatization of imports and distribution of pesticides and chemical fertilizers, irrigation equipment, agriculture machinery, seeds and agricultural trade. Policy reforms have played a crucial role in increased food grain production and paved the way for easy access to, and increased use of, agricultural inputs by farmers, improved food security, and increased budgetary savings as a result of the withdrawal of subsidies. However, since the privatization of the fertilizer distribution system, Bangladesh has been experiencing a fertilizer crisis of varying degrees almost every year. According to the second PRSP, one of the main challenges identified for the Government is the provisioning of subsidies on agricultural inputs, including the right type and mix of support programmes and prioritization of the implementing strategy. Other broad based support is needed to ensure access to quality seeds (HYV, hybrid), fertilizer, electricity, diesel and other inputs at the right price and time. Another strategy to implement the policy of agricultural growth in this phase is that the ongoing programme will continue to develop market places and market outlets. The Government will continue to support agro-entrepreneurs through infrastructure development, concession on import duties, export bonus and income tax exemption. One priority is minor irrigation for the efficient use of surface water. Suggested interventions include facilitating tubewells and surface water irrigation, micro-irrigation, and the revival of rivers and the Ganges Barrage.[26]

Public expenditure has increased over the years with the increase in population. In the year 2006-2007, total public expenditure was Tk. 817,749 million with development expenditure amounting to Tk. 218,832 million and revenue expenditure to Tk. 598,916 million. Over last two decades, revenue expenditure has been increasing relative to development expenditure. The composition of public expenditure in the year 2006-2007 shows that the highest allocation (14.5 per cent) went to education followed by debt repayment (13.5 per cent). In addition, 6.6 per cent of total public expenditure was allocated to health, 5.8 per cent to defence, and 4.8 per cent to social security and welfare. But when it comes to the percentage of total GDP that goes to key services for children, budgetary allocation is less encouraging, with health and education expenditure accounting jointly for less than four per cent of GDP and lagging behind neighbouring countries, as shown in Figures 1.11 and 1.12 below.

Figure 1.11: Public health expenditure in selected South Asian Countries (per cent of GDP, in 2004)*



Source: Human Development Report, UNDP 2007/2008

For the last two decades, the Government has been pursuing a number of social safety net programmes (SSNP) that include cash transfers, food transfers, micro-credit, and special poverty alleviation programmes. Available information show that there are 47 well recognized SSNPs that address both income poverty and human poverty. Although the extent of such programmes has been increasing over time, investment in safety nets as a share of public expenditure has been declining. Regional targeting has been one of the main approaches of social safety net programmes of Bangladesh, but there is little evidence

25 Barkat et. al.,(2009), Financing Growth and Poverty Reduction: Policy Challenges and Options in Bangladesh, UNDP Bangladesh.

26 Ibid.

Figure 1.12: Public expenditure on education in selected South Asian Countries (per cent of GDP, in 2002-2005)*

Source: Human Development Report, UNDP 2007/2008

* Note: The reported percentages of public expenditure differ from those shown in Figure 1.10, which draws on a different reference year.

of effective approaches on regional issues in the overall SSNP design. According to HIES 2005, the percentage of households reached by such programmes is lower in regions with high poverty incidence, relative to regions with low poverty incidence. Government safety net programmes have been inadequate in covering the needs of the poor; and the benefits of the programmes are shrinking as a result of the high price of essentials. The present SSNP coverage is not sufficient, given the high prevalence of poverty.[27]

27 Barkat A et. al (2009), Financing Growth and Poverty Reduction: Policy Challenges and Options in Bangladesh, UNDP Bangladesh.

CHAPTER TWO

POVERTY AND CHILDREN

Introduction

This chapter provides an analysis of various poverty and deprivation aspects that are related to children. It begins with a brief introduction, followed by a core poverty analysis, presented in three sections: income poverty and deprivation; the status of child survival and equity aspects; and the causal analysis for the same. The secondary analysis presented below has been prepared on the basis of available national surveys such as the HIES, DHS, and CMNS. It may be noted that data in these surveys are not child segregated, so households with children (0-17 years) have been considered as the proxy for child data. The study team had to rely on only the latest raw data sets of the aforementioned surveys, and, therefore, has been unable to generate relevant data that is comparable over time in some areas. This information gap has been one limitation of the analysis.

Children affected by income poverty and deprivations

Estimate of total number of children affected

Despite the unavailability of child-segregated data in national surveys, attempts have been made to ascertain the absolute size of the child population living in poverty and deprived of basic amenities. The methodology used to estimate the absolute numbers is based on per household child population of various age brackets, which is, in turn, based on the estimates drawn from MICS 2005 and CMNS 2005 data (Table 2.1). The average number of children by respective age bracket has been applied on the projected total number of households for the year 2005. Absolute figures on specific types of child poverty and/or deprivation have, therefore, been estimated on the basis of stated calculations. These will serve as indicative figures for policy makers.

Table 2.1: Estimated number of children per household (HH)

Age bracket	Children/all HHs	Children/HHs with children
0-17 years	2.04	2.39
3-17 years	1.72	2.01
7-17 years	1.26	1.48
<5 years	0.5	0.58
0-2 years	0.1	0.12

Source: MICS 2006, CMNS 2005

Child poverty: income consumption approach

In this section, child poverty has been measured using the following three approaches: (i) the Cost of Basic Needs (CBN); (ii) Direct Calorie Intake (DCI), and (iii) the international poverty line for developing countries. Regardless of the approach used, the study finds that households with children aged 0 to 17 years are more likely to be poor compared to households without children.

The study finds that in terms of both CBN and DCI approaches (Figure 2.1), about 42 per cent of households – home to about 25 million children across Bangladesh – are living below the upper and/or absolute poverty lines (HIES 2005). The same is true

Figure 2.1: Poverty in Bangladesh over time (in per cent) CBN Method

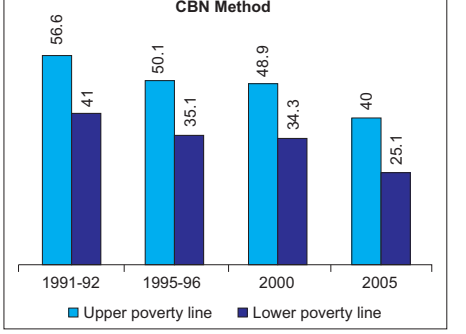
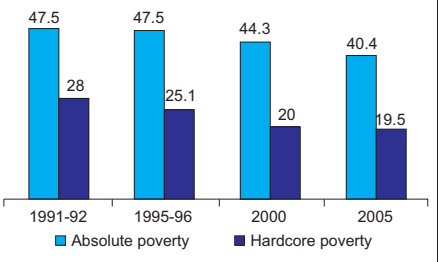


Figure 2.1: Poverty in Bangladesh over time (in per cent) DCI Method

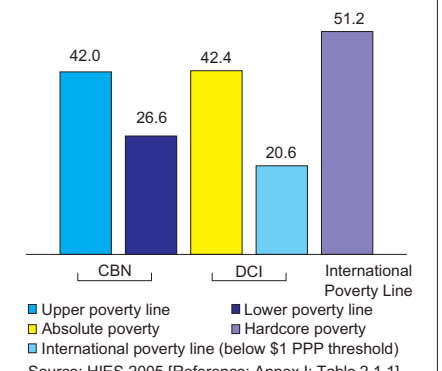


Source: HIES 2005 [Reference: Annex I: Table 2.1.1]

for about 40 per cent of all households, whether there are children present or not. Likewise, around 27 per cent of households with children (i.e. 25 per cent of all households) fall below the lower poverty line and 21 per cent (i.e., 20 per cent of all households) of such households live below the hardcore poverty line. About 46 per cent of all children in Bangladesh live below the upper poverty line, and about 30 per cent are below the lower poverty line (i.e., around 16 per cent between the 'above lower poverty' and 'below upper poverty' lines). Furthermore, about 56 per cent of all children are living below the international poverty line (Annex I: Table 2.1.1).

More than half of all households (51 per cent) with children are poor in terms of the international poverty line (below the $1 PPP threshold) and about 49 per cent of all households fall below the $1 PPP threshold (Figure 2.2).

Figure 2.2: Poverty among households with children: 2005



Source: HIES 2005 [Reference: Annex I: Table 2.1.1]

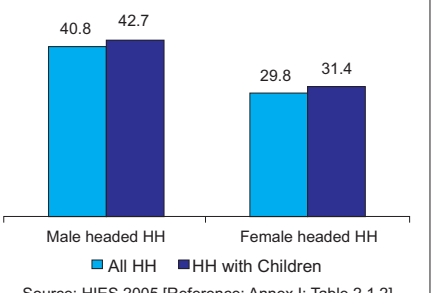
Although similar data for households with children over different time periods (1991/1992 to 2000) could not be generated because of lack of access to HIES raw data sets,[28] the incidences of poverty among all households have declined irrespective of the poverty measurement approach used. For example, in 1991-1992, about 57 per cent of all households had lived under the upper poverty line and 48 per cent were defined as absolute poor. Likewise, 41 per cent of all households during that time lived below the lower poverty line and 28 per cent of all households were hardcore poor in terms of their per capita calorie intake (Figure 2.1).

Analysis reveals that, regardless of the poverty measurement used, (CBN, DCI, or international poverty line) the incidence of poverty increases with the increasing number of children in households (Annex II: Table 2.1.2). Moreover, poverty among households with children is more pronounced among non-Muslims than among Muslims (e.g. 63 per cent of Buddhists are living below the upper poverty line, compared to 41 per cent of Muslims).

The extent of poverty declines according to the educational level of the parents. For example, 53 per cent of households that have a household head with no education live below the upper poverty line, compared to only 19 per cent of households where the head has completed secondary education as a minimum.

Analysis reveals that male-headed households with children are more likely to live in poverty than comparable female-headed households. In general, however, households with children are more poverty prone compared to all households, and in male-headed households, the likelihood of living below the upper poverty line is relatively higher (Figure 2.3).

Figure 2.3: Child poverty status by HH head's gender: 2005 (in per cent)

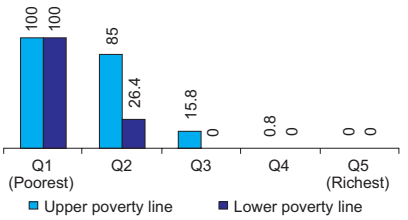


Source: HIES 2005 [Reference: Annex I: Table 2.1.2]

28 Those who are familiar with HIES 2000, 1995-96, and 1991-92 were occupied with other assignments and were unable to provide inputs.

The study also finds that almost all children from the lower wealth quintiles are likely to be suffering from poverty; while very few among richer quintiles (Q5, Q4, Q3 respectively) are poor. All households with children from the poorest quintile (Q1) and four in every five from Q2 fall below the upper poverty line (Figure 2.4).

Figure 2.4: Child poverty in Bangladesh among income quintiles: 2005 (CBN Method) (per cent)



Source: HIES 2005 [Reference: Annex I: Table 2.1.2]

The magnitude of child poverty is evident from findings that about 48 per cent of households with children are living in poverty (below the upper poverty line) although both parents are working. Similarly, about 56 per cent of households with children send at least one child under 15 to work and still live in poverty – about 39 per cent of such households are living below the lower poverty line. Therefore, although very poor households send their children to work as a poverty coping strategy, their poverty continues. The implication is that child labour is of such little value that it does not work as a poverty coping strategy in the short-term, let alone the long-term.

Facts:

- *Child poverty in the lowest quintile remains high, regardless of the thresholds applied*
- *Child labour is under valued in Bangladesh and does not work as a poverty coping strategy*

Land ownership and/or access to operational land in Bangladesh is often related to the poverty status of a household. Around 46 per cent of households with children have fallen below the upper poverty line in spite of the fact that they own some land and/or have some operational land, and about 30 per cent are living below the lower poverty line.

About 49 per cent of households with children have at least one adult member suffering from chronic illness and living below the upper poverty line. Similarly, larger proportions of such households (about 37 per cent) have children with chronic illness and have fallen below the upper poverty line.

For households who are living below the upper poverty line and have children, the analysis indicates some other common characteristics: (i) about one in three have an orphan child, (ii) 36 per cent have a high dependency ratio, and (iii) 36 per cent have at least one older person (70+ years).

Facts: Child poverty: some socio-economic features

Among household with children living below the poverty line:

- *33 per cent have an orphan child*
- *36 per cent have a high dependency ratio*
- *36 per cent have at least one person over 70 years of age*

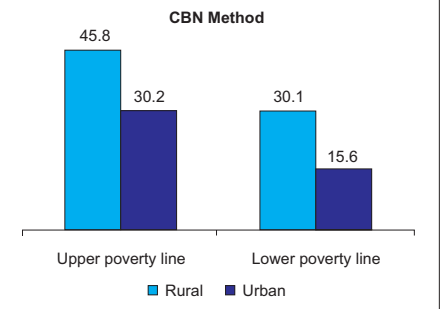
Table 2.2: Odds ratios for the probability of income and consumption poverty for selected indicators: 2005

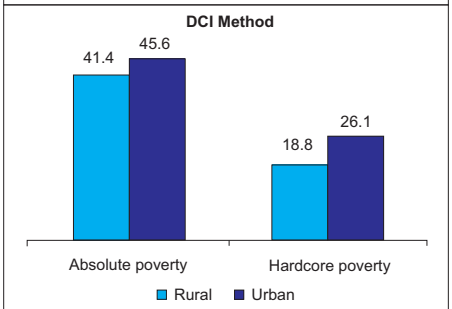
Indicator	Upper poverty line (CBN)	Absolute poverty (DCI)
Barisal Region	1.17	1.24
Rajshahi Region	1.16	0.69
Wealth index quintiles (Q1)	NA	3.10
Wealth index quintiles (Q2)	5.67	1.13
No education of household head	1.14	0.92
Buddhist	1.17	0.48
Christian	1.32	0.67
Hindu	0.79	0.68
At least one child<15 working	1.28	0.76
Household does not own land	2.21	2.32
Household has own land	0.83	0.70
Household has no own operational land	1.93	1.84
Household has own operational land	0.84	0.70

Source: HIES 2005, Annex I: Table 2.1.3

The study has found (Figure 2.5) that households with children in rural areas are more likely to be living in poverty than their urban counterparts if poverty is measured using the CBN method. For example, 46 per cent of those in rural areas are below the upper poverty line, compared to 30 per cent in urban areas, while the reverse is true if the DCI method is used: absolute poor in the rural vs. urban contexts are 41 per cent and 46 per cent respectively.

Figure 2.5: Regional dimension of child poverty 2005: CBN and DCI Methods





Source: HIES 2005 [Reference: Annex I: Table 2.1.2]

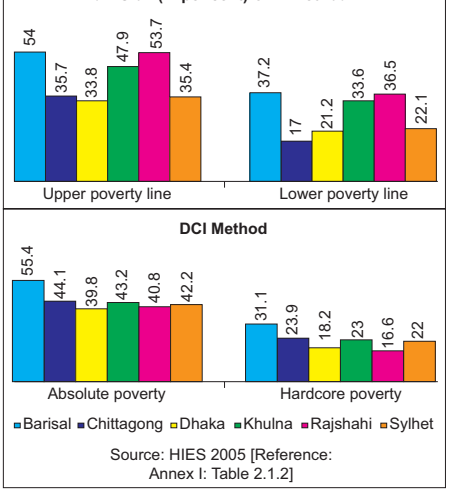
The regional dimensions of child poverty are analyzed by all six administrative divisions. Among all divisions, Barisal is the most child poverty prone region in the country irrespective of poverty measures; around 55 per cent live below the upper poverty and/or absolute poverty lines, 37 per cent below the lower poverty and 31 per cent below the hard-core poverty lines. While Rajshahi appears to follow closely behind Barisal as the second most poverty prone region in terms of the CBN method, Chittagong is in second place when poverty is measured using the DCI method (Figure 2.6).

The analysis based on estimated odds ratios for the probability of income and consumption poverty confirms these findings for the most part.

Status of child deprivation

Child deprivation has been measured using seven indicators: (i) shelter; (ii) sanitation; (iii) water; (iv) information; (v) food; (vi) education; and (vii) health. For each of these indicators, the criteria for assessing severe and less severe deprivation has been used as suggested in the Global Study Guide (Table 2.3).

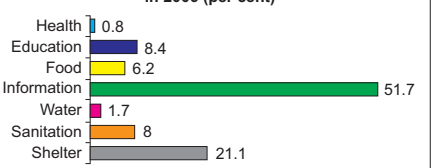
Figure: 2.6: Distribution of child poverty by division (in per cent) CBN Method



Source: HIES 2005 [Reference: Annex I: Table 2.1.2]

Child deprivation status has been measured by two types of deprivation estimations given in Table 2.3, which considers "severe deprivation and less severe deprivation". Deprivation status, both severe and less severe, varies with the indicators of deprivation. The deprivation analysis shows (Figure 2.7) that among children aged 3-17 years, 52 per cent are severely deprived of information, 21 per cent of households of shelter and around 8 per cent of education and sanitation.

Figure 2.7: Severe deprivation of children in 2006 (per cent)



Source: MICS 2006, CMNS 2005 [Reference: Annex I: Table 2.1.4]

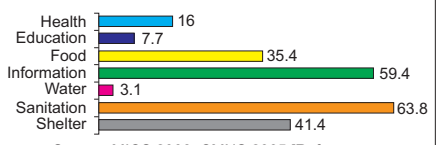
The study reveals that children from about 59 per cent of households are less-severely deprived of information, whereas 64 per cent and 41 per cent of households respectively face similar levels of deprivation of sanitation and shelter (Figure 2.8). Although the proportion of households with children severely deprived of food is 6 per cent, the proportion of such households facing less severe food deprivation is about 35 per cent.

Table 2.3: Deprivation assessment matrix

Indicator	Deprivation criteria	
	Severe	Less severe
Shelter (Sh)	Children living in a dwelling with five or more people per room	Children living in dwellings with four or more people per room
Sanitation (S)	Children with no access to a toilet facility of any kind	Children using unimproved sanitation facilities. Unimproved sanitation facilities are: pit latrine without slab/open pit, bucket, hanging toilet/hanging latrine, flush to somewhere else, flush to unknown place/not sure/don't know
Water (W)	Children using surface water such as rivers, ponds, streams and dams,	Children using water from an unimproved source such as unprotected well, unprotected spring, surface water
Information (I)	Children (aged 3-17 years) with no access to a radio or television or telephone (mobile and non mobile) or computer (i.e. all forms of media)	Children (aged 3-17 years) and adults with no access to a radio or television (i.e. broadcast or telecast media).
Food (F)	Children who are more than three standard deviations below the international reference population for stunting (height for age) or wasting (height for weight) or underweight (weight for age). This is also known as severe anthropometric failure	Children who are more than two standard deviations below the international reference population for stunting (height for age) or wasting (height for weight) or underweight (weight for age).
Education (E)	Children (aged 7-17) of school age who have never been to school i.e., who are not currently attending school.	Children (aged 7-17) of school age who are not currently attending school but attended and did not complete their primary education.
Health (H)	Children who have not been immunized against the main vaccine-preventable diseases.	Children who have not been immunized against all vaccines by two years of age (If the child has not received the nine following vaccinations, they are defined as deprived: BCG, DPT1, DPT2, DPT3, Polio 0, Polio1, Polio2, Polio3 and Measles) or did not receive treatment for a recent illness involving an acute respiratory infection or diarrhoea.

Source: Annex 1: Detailed layout for the statistical tables, pp. 18-19, Global Study on Child Poverty and Disparities 2007-2008 Guide. New York: Global Policy Section, Division of Policy and Planning, UNICEF.

Figure 2.8: Less severe deprivation of children in 2006 (per cent)



Source: MICS 2006, CMNS 2005 [Reference: Annex I: Table 2.1.4]

In terms of the most frequent case of deprivation, over 52 per cent of children aged 3-17 years do not have access to all forms of media (i.e., no radio or television, ground or mobile phone, or computer). Shelter and information have appeared as the two most frequent aspects of child deprivation. About 7 million children are deprived of these two amenities. The three most frequent combinations of amenities of which children are deprived are shelter, information and education. Over 750,000 children are deprived of these three amenities combined.

Estimates show that about 22,000 children aged 0-2 years (of the country's 2.8 million) did not receive immunization against any diseases in 2005. Around 450,000 children of the same age group have not received all the required immunization or have received no treatment for recent illness as a result of acute respiratory infections (ARI) or diarrhoea.

Attempts to compare child deprivation status over time have not been possible as relevant deprivation data had not been collected in earlier MICS.

Correlation of poverty measures and combined poverty incidence

Analysis of correlates of severe child deprivation reveals that around 58 per cent of children are severely deprived of any one of the following six indicators: shelter; sanitation; water; information; education; and health. Moreover, around 20 per cent children are suffering from at least two severe deprivations.

The extent of child deprivation has an almost identical pattern irrespective of gender as shown in Figure 2.9. Examination of male-female differentials in this regard

disaggregated by five years of age brackets shows similar patterns of deprivation for each of the age brackets irrespective of gender.

The proportion of households facing at least one deprivation has not been seen to be dependent on household size. The same is also true for households suffering at least two deprivations. For example, a higher proportion of children living in households with less than three members and/or in households with 5-6 members are likely to face at least one severe deprivation, compared to households with 3-4 members and/or 7+ members.

The more education the head of household has, the less likely it is that children from that household will face at least one severe deprivation. The same observation is true for children facing at least two severe deprivations. For example, in 74 per cent of households where the household head has no education, children are likely to suffer from at least one deprivation. However, children are likely to suffer from at least one deprivation in 29 per cent of households where the household head has secondary plus education.

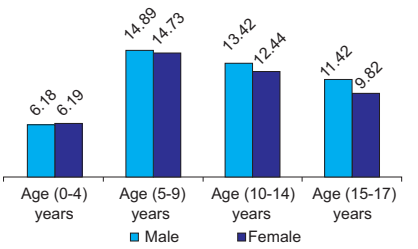
The poorer households in terms of wealth are likely to face more deprivations (at least one or two) compared to those in richer quintiles. For example, only 7 per cent of households belonging to the poorest quintile do not face any severe deprivation at all. In contrast, about 83 per cent of households in the richest quintiles enjoy this situation.

Analysis disaggregated by religion and ethnicity shows that children from among religious and/or ethnic minorities are more prone to deprivations. An estimated 63 per cent of children from Buddhist communities and 67 per cent of children from Christian communities face at least one type of severe deprivation, compared to about 58 per cent among Muslims. Children from particular ethnic groups are also more likely to experience at least one deprivation: 93 per cent of *Saontal*, 81 per cent of *Tripuras* and 68 per cent of *Marmas* children. In contrast, the proportion for *Bangalee* children is about 58 per cent.

About three in four households with children with less than three members and living below the international poverty line are facing at least one severe deprivation. More than one in five of such households are facing at least two severe deprivations. Similarly, more than half of households with children that have seven or more members are also facing at least one severe deprivation, whereas nearly one in five such households are facing at least two severe deprivations.

The variation by place of residence shows that, overall, children living in rural areas are more vulnerable to deprivations than their urban counterparts. The regional analysis has shown that, despite the high risk that children across the country will face at least one severe deprivation (more than one in two), children living in Rajshahi are the most vulnerable, with 63 per cent in this position, closely followed by Barisal and Sylhet (61 per cent each).

Figure 2.9: At least one less severe deprivation by boys and girls (per cent)

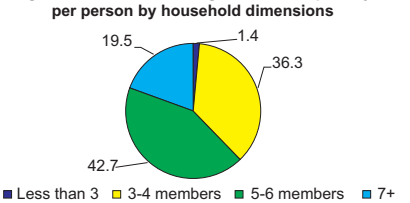


Source: MICS 2006 [Reference: Annex I: Table 2.1.7]

More than one in every two children (51 per cent) are from families who live in households under the threshold of $1 purchasing power parity (PPP) per person per day. Looking at children in various five-year age groupings, the proportion of children under the international poverty threshold for developing countries varies by around 15 percentage points and ranges between 45 per cent and 60 per cent. About 7 per cent of children from households above the threshold level are experiencing at least one or other type of severe deprivation of human needs, and 12 per cent experience at least one kind of less severe human deprivation.

It may be noted that gender disaggregations among these categories do not reveal any major difference between boys and girls from the different five year age groups (Figure 2.9).

Figure 2.10: Children living on under $1 per day per person by household dimensions



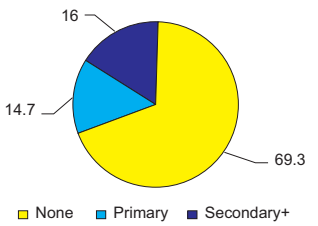
Source: MICS 2006 [Reference: Annex I: Table 2.5]

Facts:

About 33 per cent of children living below the upper poverty line are either orphans and 36 per cent of them belong to households having one or more members aged 70+

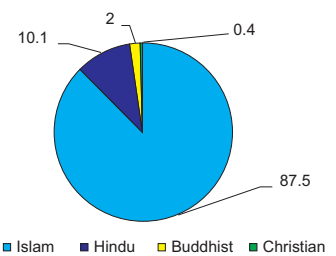
The study has explored child poverty against the international poverty line threshold based on the size of household, education of household head, religion and wealth dimensions (Figure 2.10 – 2.13); and pertinent deprivation issues. Analysis by household size reveals that a large proportion of children (about 65 per cent) from households with 5-6 members households face at least one severe deprivation and around 29 per cent face two deprivations.

Figure 2.11: Children living on under $1 per day per person by education of household head



Source: Table 2.5

Figure 2.12: Children living on under $1 per day/person by religion



Source: MICS 2006 [Table 2.5]

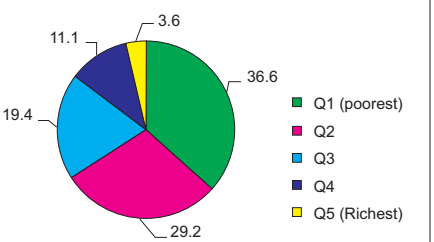
The study finds that 69 per cent of children living below the poverty line are from households whose heads do not have any schooling. (Figure 2.11)

Moreover, of the children from households above the international poverty line and experiencing severe deprivation and/or less severe deprivation, about 71 per cent and 44 per cent respectively are from households where the heads have no education (Table 2.5).

Dimension of child deprivation.

- *Three in four households with children that have fewer than three members and live below $1 PPP per person per day are facing at least one severe deprivation while one in five such households are facing at least two severe deprivations*
- *One in two households with children that have seven or more members are facing at least one severe deprivation and one in five such households are facing at least two severe deprivations*

Figure 2.13: Children living on under $1 per day per person by wealth quintile



Source: MICS 2006 [Table 2.5]

About 77 per cent of children living under the international poverty line are either orphaned or belong to households having one or more members aged 70+.

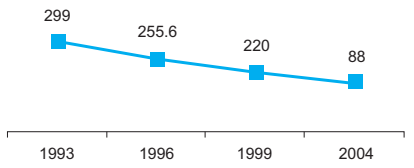
The geographic dimensions show that most children living below the international poverty threshold are from rural areas. Regional analysis shows that nearly two-thirds of such children are either from Dhaka (28 per cent) or from Rajshahi (29 per cent).

Child survival and equity

Change in the under-five mortality rate over time

The under five mortality rate (U5MR) was more than halved between 1993-1994 and 2004 and now stands at 88 deaths per 1,000 live births (Figure 2.14). The U5MR among households in the poorest quintile is much higher compared to those in the richest quintile -121 deaths per 1,000 live births vs. 72 deaths per 1,000 live births (for details, see Statistical Template 2.2.1). The U5MR among girls in 1993-1994 and 1999-2000 was close to that for boys. However,

Figure 2.14: Change in U5MR (over time)



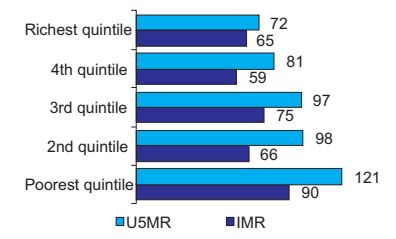
Source: BDHS 2004 [Reference: Annex I: Table 2.2.1]

BDHS 2004 has reported that the U5MR for girls has fallen at a faster pace than for boys.

U5MR by main social strata

In 2004, both the infant mortality rate (IMR) and U5MR among boys was higher than that for girls. The higher the mother's educational status, the lower the IMR and U5MR. The infant and under-five mortality scenario show a similar tendency according to social level: the higher the wealth status the lower the IMR and U5MR (Figure 2.15).

Figure 2.15: IMR and U5MR by wealth quintile (per cent)



Source: BDHS 2004 [Reference: Annex I: Table 2.2.2]

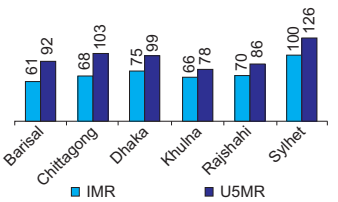
The BDHS 2004 found that IMR in rural and urban areas was similar (72 per 1,000 live births each), but that U5MR in rural areas was slightly higher than in urban areas (98 per 1,000 live births vs. 92 per 1,000 live births).

Across the divisions, both IMR and U5MR are highest in Sylhet. However, Barisal has the lowest IMR (61 per 1,000 live births) and Khulna has the lowest U5MR (78 per 1,000 live births) (Figure 2.16).

Links between child mortality and poverty

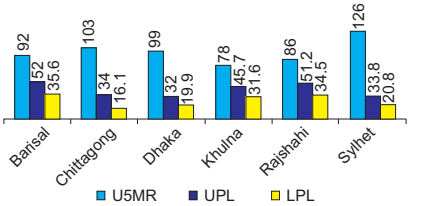
Attempts to establish links between the poverty situation and U5MR do not show a relationship that can be explained easily (Figure 2.17).

Figure 2.16: IMR and U5MR by division



Source: BDHS 2004 [Reference: Annex I: Table 2.2.2]

Figure 2.17: U5MR and poverty lines by divisions



Source: BDHS 2004 [Reference: Annex I: Table 2.2.3]

Causal analysis: underlying factors in poverty levels and trends

Correlations among child poverty measures and combined poverty incidence

In order to assess how child poverty outcomes are affected by various factors, simple linear correlation coefficients have been computed and these are presented in Table 2.4. Though the computation process was severely constrained by data shortage, an analysis of the results obtained is presented in Table 2.5. There is a positive correlation between possession (or lack) of assets and types of deprivations. A similar correlation is seen between asset holding, shelter, and sanitation. Most of the correlation coefficients are highly significant statistically, even at the level of 1 per cent.

Such correlations provoke thinking on other aspects of child poverty. If we consider the results shown in Table 2.5, we see clearly that the percentage of children aged 0-4 years with household income below $1 per person per day is over 58 per cent. The situation for children aged 5 to 9 years is even more precarious. If we consider severe deprivation and less severe deprivation, it is clear that such deprivation status increases by age group. Household size also has an impact on deprivation.

Table 2.4: Correlation between different indicators for child poverty/disparity

	Bottom asset quintile (Q1)	Two deprivations (H,Sh)	First four deprivations (Sh, S, W, I)	Last three deprivations (F,E, H)	Shelter	Sanitation	Water	Information	Education	Health
Asset Q1.	1.000	.056*	.024*	.010*	.273*	.312*	.050*	.009*	.070*	.018*
Two deprivations.	.056*	1.000	-.002*	-.002	.161*	.017*	-.001	-.187*	-.019*	.487*
First four	.024*	-.002	1.000	.261*	.047*	.079*	.157*	.010*	.021*	-.004
Last three	.010*	-.002	.261*	1.000	.045*	.016*	.150*	.010*	.099*	-.004
Shelter	273*	.161*	.047*	.045*	1.000	.070*	.010*	.003	.071*	.015*
Sanitation	.312*	.017*	.079*	.016*	.070*	1.000	.004	-.003*	.055*	.011*
Water	-.050*	-.001	.157*	.150*	.010*	.004	1.000	.003	.014*	.004
Information	-.009*	-.187*	.010*	.010*	.003	..003	..003	1.000	.101*	-383*
Education	.070*	.-019*	.021*	.096*	..071*	.055*	.014*	.101	1.000	-.040
Health	.018*	.487*	-.004	-.004	.015*	.011*	.004	-.383*	-.040	1.000

Source: MICS 2006
*Correlation is significant at the 0.01 level (2-tailed).

Note: Information for household income ($1.08 PPP per person, per day) and food are not available in MICS 2006.
H = Health, Sh = Shelter, I = Information, F = food, W = Water, S = Sanitation, E = Education

Table 2.5: Combined child poverty incidence

Indicator	Percentage of children in relevant category		
	who live in households under the $1 day/person PPPs threshold	who are experiencing severe deprivation of human needs	who are experiencing less severe deprivation of human needs
		while their households live above the $1 day/person PPPs threshold	
All children (0-17)	51.14	7.42	12.30
Individual dimension			
Sex and age			
Male			
0-4 years	58.43	5.14	10.99
5-9 years	59.60	7.12	1.81
10-14 years	54.10	9.58	11.79
15-17 years	44.47	11.88	14.46
Female			
0-4 years	58.46	6.33	11.32
5-9 years	60.91	6.86	10.25
10-14 years	53.86	7.36	12.14
15-17 years	45.12	6.54	14.63
Household dimension			
Household size			
Less than 3	1.4	3.5	2.1
3-4 members	36.3	44.8	46.1
5-6 members	42.7	35.4	34.7
7+	19.5	16.3	17.1

Indicator	Percentage of children in relevant category		
	who live in households under the $1 day/person PPPs threshold	who are experiencing severe deprivation of human needs	who are experiencing less severe deprivation of human needs
		while their households live above the $1 day/person PPPs threshold	
Education of household head			
None	69.3	71.3	
Primary	14.7	14.2	44.6
Secondary+	16.0	14.5	19.6
Gender of the head of the household			35.8
Male	92.8	90.1	
Female	7.2	9.9	90.7
Wealth index quintiles			9.3
Q1 (poorest)	36.6	13.4	
Q2	29.2	25.4	3.8
Q3	19.4	32.2	13.0
Q4	11.1	20.2	26.4
Q5 (Richest)	3.6	8.8	31.6
Religion			25.1
Islam	87.5	87.3	
Hindu	10.1	10.5	91.4
Buddhist	2.0	1.3	7.8
Christian	0.4	0.6	0.4
Work (among households with children)			0.3
Both parents working	3.9	6.6	3.7
Neither parent working	3.3	3.3	5.1
No adult of working age (18-54)	22.5	39.0	27.4
At least one child under 15 working	3.8	8.5	4.3
Illness and disability in the household			
Adult(s) with chronic illness	38.4	42.5	42.6
Child/children with chronic illness[1]	7.9	8.3	6.3
Family vulnerability (not mutually exclusive categories)			
Orphan child in household	38.4	42.5	42.6
High dependency ratio (4+ children per adult)	7.9	8.3	6.3
Elder (70+) person in household	38.4	42.5	42.6
Geographic dimension			
Region			
Barisal	6.9	3.1	8.1
Chittagong	16.3	18.0	16.7
Dhaka	28.3	22.6	37.1
Khulna	13.8	10.2	11.0
Rajshahi	29.2	39.0	21.7
Sylhet	5.6	7.1	5.4
Residence			
Urban	16.1	11.0	26.4
Rural	83.9	89.0	73.6

Source: HIES 2005.

Methodological notes 1

i Child/children with disability are replaced by Child/Children with chronic illness.
ii Information on children, specifically, is not available in HIES 2005, but information on households with children is presented.
iii Here we assume that if a household with children lives under the $1 day/person PPP threshold, then the children of these households are living under the $1 day/person PPPs threshold. If a household with children lives above the $1 day/person PPPs threshold then the children of these households are living above the $1 day/person PPPs threshold.
iv Children are assumed to experience severe or less severe deprivation of human needs if they live in households that are experiencing such deprivation.

Regression analysis

Regression Analysis is a strong statistical tool for the investigation of relationships between variables. In order to assess the relative importance of factors affecting deprivation status of children, four regressions in logistic regression formats have been run in this study. The results are discussed in this section.

What is regression analysis and why it is used?

Regression analysis is a technique for studying the dependence of one variable (called a 'dependent variable') on one or more variables (called 'explanatory' or 'independent' variables). This makes it possible to estimate or predict the average value of the dependent variable in terms of the known or fixed value of the independent variables. Regression analysis is used, in general, to:

- *estimate the relationship that exists, on average, between the dependent variable and independent variables*
- *determine the effect of each explanatory variable on the dependent variable, controlling the effects of all other explanatory variables; and*
- *predict the value of the dependent variable for a given value of the explanatory variable*

Logistic regression is a technique for analyzing problems and is used when the dependent (response) variable is a dichotomous variable (i.e. it takes only two categorical values, like yes or no, male or female, defective or non-defective, occurrence or non-occurrence, etc. usually coded as 0 or 1) and the independent (input) variables are continuous, categorical, or both. In the situation of a dichotomous dependent variable, a logistic or probit regression model should be used

In this study, we have a situation where dependent variables indicate whether something belongs to the category of 'at least one severe deprivation' or not; to the category of 'at least two severe deprivations' or not; to the category of at least one less severe deprivation or not, etc. Therefore, a binary logistic regression has been adopted and each dichotomous dependent variable is explained by a set of independent variables

First regression: being in the 'At least one severe deprivation' = Dependent Variable category[29]

Logistic regression results show that child poverty is related to several factors. The results from the regression analysis show the following:

1 The likelihood of being in the group of at least one severe deprivation decreases with increase in wealth.

2 Movement towards a higher wealth group decreases the chance of being in the category of at least one severe deprivation.

3 The education of a mother reduces the likelihood of being in the category of at least one severe deprivation, proving that a mother's education has a positive impact in reducing deprivation. At least one severe deprivation decreases with an increase in the mother's level of education.

4 The severity of at least one deprivation rises with a rise in female-headed households. This shows that children in such households have fewer opportunities and, as a result, deprivations of different types increase.

5 Regional differences in terms of deprivations could not be ascertained.

6 All the regression coefficients turned out to be statistically significant at a level of 5 per cent.

How to read the relevant annex tables on regression analysis

*In the Annex Tables there are four relevant tables [Annex I: Table 3.5.4 (a), (b), (c), and (d)]. An example from one of the four tables aids an understanding of the results of regression. To avoid multi co-linearity, one dummy in every category is not shown in the table [for example, the wealthiest quintile – quintile 5 – is not shown]. In this calculation, **'wealth (1)'** is the poorest quintile, and **'wealth (4)'** is the wealthiest. The coefficient of wealth index, **'B'**, declines as the wealth index moves from poor to rich. That is, where the coefficient of poorest is 4.683, the coefficient of **wealth (4)** is 1.408. So, when wealth increases, at least one severe deprivation declines. 'S.E.' indicates **'Standard Error'**, which measures the standard deviation of the statistic/estimate. The **Wald Statistic** is equal to the square of the ratio of logistic coefficient 'B' to its **'S.E.'**. The **Wald** Statistic tests the significance of each of the covariate and dummy independents in the model. If the Wald Statistic is significant, then the parameter is significant in the model. The **'Exp (B)'** column is SPSS's (Statistical Package for Social Sciences) level for the odds ratio of the row independent with the dependent. It is the predicted change in odds for a unit increase in the corresponding independent variable. An odds ratio below 1 corresponds to decreases and an odds ratio above 1 corresponds to an increase in odds. Odds ratios close to 1.0 indicate that unit changes in that independent variable do not affect the dependant variable*

29 Dependent variable = at least one severe deprivation (W)
At least one severe deprivation = 1, otherwise = 0
Independent variables: R = Region, W = Wealth index, M = Mother's education level, Ar = Area of residence H = Household head sex, Hs = Household size.
Regression Equation: $W = ß_0+ß_1R+ ß_2W+ ß_3M+ ß_4Ar+ ß_5H+ ß_6Hs+ξ$
Estimated Regression Equation: W = -3.141+ [.037, .162, -.242, .042, -.245]R+ [4.683, 4.157, 2.818, 1.408] W+[.997, .880, .505]M+[-.340, -.423]Ar+.251H+-.123Hs
The logistic regression has been run in binary form, and results are presented in Annex I: Table 3.5.4 (a).

			B	S.E.	Wald	df	Sig.	Exp (B)
1	2	Meaning	3	4	5	6	7	8
Household Size	hh size	= Household size	-.123	.010	155.769	1	.000	.885
Household head	gender(1)	= Male	.251	.030	68.038	1	.000	1.285
Mother's educational level	melevel3(1)	= No education	.997	.040	635.932	1	.000	2.710
	melevel3(2)	= Primary level	.880	.021	1,710.341	1	.000	2.411
	melevel3(3)	= Secondary level	.505	.023	497.860	1	.000	1.657
Wealth quintile	wealth(1)	= Poorest: wealth(1) and fourth wealth group: wealth(4)	4.683	.044	11,363.679	1	.000	108.069
	wealth(2)		4.157	.043	9,468.162	1	.000	63.908
	wealth(3)		2.818	.042	4,541.488	1	.000	16.741
	wealth(4)		1.408	.043	1,077.062	1	.000	4.087
Place of residence	area(1)	= Rural	-.340	.040	71.539	1	.000	.712
	area(2)	= Urban	-.423	.019	478.536	1	.000	.655
Region	HH7(1)	= Barisal	.037	.034	1.173	1	.279	1.038
	HH7(2)	= Chittagong	.162	.030	29.761	1	.000	1.176
	HH7(3)	= Dhaka	-.242	.029	68.976	1	.000	.785
	HH7(4)	= Khulna	.042	.033	1.658	1	.198	1.043
	HH7(5)	= Rajshahi	-.245	.030	66.063	1	.000	.783
	Constant		-3.141	.056	3,131.957	1	.000	.043

Second regression: being in the 'At least two severe deprivations' = Dependent variable category[30]

1. When at least two severe deprivations are considered as Dependant Variables, then it seems to be more pronounced by (than for at least one severe deprivation) the set of independent variables.
2. Most of the regressions have results that could be expected, and the amount of change is substantial.
3. The higher the mother's education level, the lower the chance of belonging to the category of at least two deprivations. Similarly, the higher the wealth index, the lower the chance of belonging to this category.
4. When household size increases, the chance of belonging to the category of at least two severe deprivations also increases.
5. Households in this category can be found in all the regions, but variations among the regions could not be ascertained due to lack of data.
6. It should be noted that all the regression coefficients turned out to be highly significant at the 5 per cent level.

Third regression: being in the 'At least one less severe deprivation = Dependent variable' category[31]

1. Being in the category of at least one less severe deprivation decreases with an increase in wealth. Movement towards a higher wealth group reduces the chances of experiencing at least one less severe deprivation.
2. The more education a mother has, the lower the chances of at least one less severe deprivation.
3. In this case, regional differences are relatively more pronounced.
4. Each regression coefficient is highly significant.

Fourth regression: being in the 'No severe deprivation' = dependent variable category[32]

1. When no severe deprivation is considered as a dependant variable, it seems to be more pronounced by the set of independent variables.

30 Dependent Variable = At least two severe deprivations (X)
At least two severe deprivations = 1, Otherwise = 0
Independent variables: R = Region, W = Wealth index, M = Mother's education level, Ar = Area of residence, H = Household head sex, Hs = Household size.
Regression Equation: $X = ß0+ß_1R+ ß_2W+ ß_3M+ ß_4Ar+ ß_5H+ ß_6Hs+ξ$
Estimated Regression Equation is given below: X = -7.123 + [-.771,-.341, .153,-.070,-.192]R+ [4.387, 3.183, 2.081, 1.374] W+[-.047,.839, .531]M+[-.996, -.875]Ar+-.143H+-.739Hs
The logistic regression has been run in binary form, and results are presented in Annex I: Table 3.5.4 (b).

31 Dependent Variable = At least one less severe deprivation (Y)
At least one less severe deprivation = 1
Otherwise = 0
Independent variables: R = Region, W = Wealth index, M = Mother's education level, Ar = Area of residence,
H = Household head sex, Hs = Household size.
Regression Equation: $Y = ß_0+ß_1R+ ß_2W+ ß_3M+ ß_4Ar+ ß_5H+ ß_6Hs+ξ$
Estimated Regression Equation: Y = .536 + [-.353, -.053, .087, .190, -.220]R+ [4.488, 3.308, 2.944, 1.166] W+[.924,1.317, .718]M+[-.256, -.455] Ar+-.207H+-.066Hs
The logistic regression has been run in binary form, and results are presented in Annex I: Table 3.5.4 (c).

32 Dependent Variable = No severe deprivation (Z)
No severe deprivation = 1
Otherwise = 0
Independent variables: R = Region, W = Wealth index, M = Mother's education level, Ar = Area of residence
H = Household head sex, Hs = Household size.
Regression Equation: $Z = ß_0+ß_1R+ ß_2W+ ß_3M+ ß_4Ar+ ß_5H+ ß_6Hs+ξ$
Estimated Regression Equation: Z = 3.141 + [-.037, -.162, 0.242, -0.042, 0.245] R+ [-4.683, -4.157,-2.818, -1.408] W+ [-.997, -.880, -.505]M +[.340, .423] Ar+-.251H+0.123Hs
The Logistic regression has been run in binary form, and results are presented in Annex I: Table 3.5.4 (d).

2. Most of the regression coefficients have results that could be expected and the amount of change is substantial.
3. The higher the mother's education level, the lower the chance of children belonging to the category of no deprivations. Similarly, the higher the wealth index, the lower the chance of belonging to the category of no deprivations.
4. Children in the category of 'no severe deprivation' can be found in all regions, but regional differences could not be ascertained.

Combined child poverty incidence

Of all children in the age group 0-17 years, over 51 per cent belong to households living on $1 PPP per person, per day. Above this threshold, 7.4 per cent of children experience severe deprivation and 12.3 per cent experience less severe deprivation. The scenario is worse for females, and household size is also important. Conditions are more precarious for households with three or four members, compared to households with more. This may be because households with more members have more earnings, overall.

Household education status plays an important role in shaping household deprivation status. For example, deprivation is very high when the household head has no education, compared to households with an educated head. The proportion of children facing severe and less severe deprivation is very high (43 per cent for each) among households where adults suffer chronic illness. A similar scenario exists among households with an orphaned child and a high dependency ratio of old aged people.

All of these scenarios are found more intensively among rural households than among urban households where children appear to be a little better off.

Odds analysis and odds ratio analysis

In order to make a sound statement about the extent of child deprivation, the odds ratio has been computed (as seen in Annex I: Table 2.1.7). The key findings from the analysis are as follows:

1. For every 10 children facing less severe deprivation, there is one child who is not.
2. For every four children there is one child with at least two severe deprivations.
3. The severity of these deprivations is similar for boys and girls.
4. Households where the head has no education face severity in child deprivation more than other households.
5. Child deprivation is very acute among the poorest quintile (Q1) in the wealth index.
6. For every child in the poorest quintile (Q1) without at least two severe deprivations, there is more than one (1.06) child who has at least two deprivations. Interestingly, this ratio declines as the wealth index rises.
7. Among indigenous people, the proportion of children with at least two severe deprivations is very high among the Saontals (1.66 against 1), compared to other ethnic groups. This ratio is lowest among the Chakma (0.18 against 1).
8. There are some regional differences, with the lowest proportion of children with at least two severe deprivations found in Chittagong (0.17 against 1) and in Rajshahi (0.35 against 1).
9. Similar types of differences are also seen between rural and urban residents. In urban areas, the ratio of children with at least two severe deprivations against those who do not is 0.15 against 1. This ratio is 0.29 against 1 in rural areas.

Households have been segmented by characteristics such as male-headed and female-headed households, rural and urban households in order to compute odd ratios for severity [as seen in Annex I: Tables 2.1.7a - 2.1.7d]. In this analysis, the key findings are:

1. For every child with at least two severe deprivations in a female-headed household, there is more than one (1.3) such child in a male-headed household.
2. This distinction is more pronounced for rural households compared to urban (1.9 against 1). When one considers less severity in deprivation, the situation is even worse.
3. For every child with at least one indicator of less severe deprivation among urban children, there are twice as many rural children (2.4 against 1).
4. Male and female-headed households with at least one less severe deprivation show similar scenarios (1.3 against 1) as in the case of at least two severe deprivations.

What are odds and the odds ratio?

Odds: *A ratio of the number of people affected by something, to the number of people who are not.*

Odds ratio: *The odds ratio is defined as the ratio of the odds of an event occurring in one group to the odds of it occurring in another group, or to a sample-based estimate of that ratio. These groups might be men and women, an experimental group and a control group, or any other dichotomous classification. If the probabilities of the event in each of the groups are p (first group) and q (second group), then the odds ratio is:*

$$\frac{p/(1-p)}{q/(1-q)} = \frac{p(1-q)}{q(1-p)}$$

How to read the relevant annex table

Annex I: Table 2.1.7 shows the odds for the probability that children will or will not experience deprivations. An example from the table is helpful in understanding the odds analysis. In the poorest quintile (Q1) wealth index, 14,924 children belong to the category of at least two severe deprivations and 14,062 children do not belong to that category. It indicates that there is more than one child who falls into the category of at least two severe deprivations against every single child belonging to the category of less than two severe deprivations. Again 28,115 children of the poorest quintile belong to the category of at least one less severe deprivations, while 135 children do not belong to that category.

Indicator	Odds of children having			
Wealth index quintiles	'At least one less severe' deprivation		'At least two severe' deprivations	
Q1 (poorest)	28,115/135	208.26	14,924/14,062	1.06
Q2	27,835/496	56.12	6,553/20,526	0.32
Q3	26,336/715	36.83	2,815/22,780	0.12
Q4	24,361/3,697	6.59	1,111/22,810	0.05
Q5 (Richest)	206,011/7,722	26.68	443/21,485	0.02

CHAPTER THREE

THE PILLARS OF CHILD WELL-BEING

Introduction

The scenario of child well-being in Bangladesh has been sketched with a focus on five major components: **nutrition; health; child protection; education;** and **social protection**. These have been referred to by UNICEF as the *Pillars of Child Well-being*. This section deals not only with well-being outcomes or context, but also with the national policies that drive outcomes. The analysis of each pillar of well-being involves laws, policies, outcomes, causality, and strategy and includes data and information collected in the Policy Template of the Study as well as in tables in Part 3 of the Statistical Template. Analyses of the *Pillars of Child Well-being* provide crucial insights and underpin the 'building blocks' for a comprehensive strategy to address child poverty and disparities.

Nutrition

National laws, policies and key programmes

The Government's concern for nutritional initiatives can be traced to the 1972 **Constitution**, which recognizes the improvement of the nutritional level of citizens as one of the state's prime duties. The Constitution says: "*The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties,...*".[33] During the1980s, however, nutrition programmes were a low priority. The public sector, private sector and NGOs did not see nutrition as an issue of national importance. Bangladesh is a signatory to the 1992 *World Declaration on Nutrition* agreed at the International Conference on Nutrition (ICN).[34] As per the ICN Declaration, the Bangladesh **National Food and Nutrition Policy**[35] of 1997 aims to increase the production and availability of both staple and non-staple nutritious food to improve the nutritional status of the population, but especially children. It also emphasizes the provision of formal and non-formal nutrition education - once again, with an emphasis on children. **The National Plan of Action for Nutrition (NPAN)**[36] of 1997 sets specific targets to reduce: the prevalence of low birthweight; severe and moderate Protein-Energy Malnutrition (PEM); micronutrient deficiencies including nutritional anaemia, Vitamin A deficiency, and Iodine Deficiency Disorders (IDD); and night-blindness; and restore the growth rate of infants and children of different ages – some of these targets to be achieved by 2010, and some by 2010. It also sets goals to protect, promote and support breastfeeding, empowering all women to breastfeed their children by the same timeline. **The National Food Policy**[37] of 2006, with its goal to ensure a dependable food security system for all people of the country at all times, also emphasizes adequate nutrition for all (especially women and children).

The Poverty Reduction Strategy Paper (PRSP-I)[38] covering the period 2004-2007, aims to reduce the proportion of malnourished under-five children by 50 per cent and eliminate gender disparity in child malnutrition. The specific targets set for the PRSP period are shown in the box below.

- *Reduce severe Under-two Protein-Energy Malnutrition (U2PEM) from 12.6 per cent in 1995 to less than 5 per cent in 2006*
- *Reduce moderate U2PEM from 36 per cent in 1995 to 25 per cent in 2006*
- *Reduce incidence of low birthweight (LBW) from 50 per cent in 1995 to 15 per cent in 2006*
- *Reduce stunting from 43 per cent in 1995 to 35 per cent in 2006*

33 The Constitution of Bangladesh, Part II, Fundamental Principles of State Policy, Article 18 (1): Public health and morality.

34 International Conference on Nutrition (ICN), held in Rome, Italy in December 1992.

35 Bangladesh National Food and Nutrition Policy 1997, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh

36 National Plan of Action for Nutrition (NPAN) 1997, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh in Collaboration with Bangladesh National Nutrition Council 1997.

37 National Food Policy 2006, Ministry of Food and Disaster Management, Government of the People's Republic of Bangladesh.

38 Unlocking the Potential: National Strategy for Accelerated Poverty Reduction (PRSP-I), General Economic Division, Planning Commission, Government of the People's Republic of Bangladesh, October 16, 2005. The PRSP was adopted in October 2005 to cover the period 2004-2007. The NEC meeting of 30 April 2007 agreed to extend the PRSP to June 2008.

- *Reduce Body Mass Index (BMI) from 60 in 1995 to 40 in 2006*
- *Reduce female under-five (U5) underweight, moderate or severe, as percentage of male figure from 8 in 1990 to 0 in 2006*
- *Reduce female U5 severe underweight as percentage of male figure from 26 in 1990 to 10 in 2006*
- *Reduce night blindness from 0.6 per cent of children (1-5 years) in 2003 to 0.2 per cent in 2006*
- *Reduce geographical disparity in child malnutrition*
- *Reduce prevalence of child malnutrition among the poor*
- *Reduce prevalence of anaemia in pregnant women from 70 per cent to 45 per cent in 2006 and in adolescent girls from 65 per cent to 25 per cent*
- *Reduce prevalence of iodine deficiency from 69 per cent of the population in 2003 to 25 per cent in 2006*

The National Plan of Action (NPA) for Children[39] (2005-2010) was developed in accordance with the commitments made at the 1990 World Summit for Children. It is consistent with the UN Convention on the Rights of the Child (CRC) and the 'follow on', A World Fit for Children Plan of Action (2002), as well as with other international instruments, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). It is also consistent with the MDGs, the National Children Policy (1994) and the Government of Bangladesh PRSP. The NPA seeks to achieve the relevant food and nutrition related MDG goals and targets (Targets 2, 4 and 5). Goals set by the NPA to be achieved by 2010 are to: increase food security of food insecure households; reduce the prevalence of low birth weight; reduce the prevalence of micronutrient deficiencies (including vitamin A deficiency, iodine deficiency disorders and iron deficiency anaemia amongst children, adolescent girls, and women of childbearing age); reduce the prevalence of malnutrition among children under the age of five, with a particular focus on children under two; improve infant and child feeding practices, including the initiation of breastfeeding immediately after delivery and exclusive breastfeeding for six months.

The National Health Policy of Bangladesh 2000 has 15 goals and objectives, 10 policy principles, and 32 strategies.[40] A number are related to improving the nutritional status of children. To make necessary basic medical utilities accessible to people of all strata as per Article 15(A) of the Bangladesh Constitution, and to develop the health and nutrition status of the people as per Section 18(1) of the Bangladesh Constitution, the Policy has the following objectives related to child nutrition:

- *To reduce the intensity of malnutrition among people, especially children and mothers; and implement effective and integrated programmes to improve the nutrition status of all segments of the population (Objective 4)*
- *To undertake programmes for reducing the rates of child and maternal mortality within the next five years and reduce these rates to be an acceptable level (Objective 5)*
- *Nutrition and health education will be emphasized, as they are the major driving forces of health and Family Planning (FP) activities. There will be one nutrition and one health education unit in each upazila, so that they can reach every village (Strategy 17)*

A brief review of the key programmes to improve the nutritional status of the people, especially of children, conveys an idea of how far they have been able to address nutrition issues.

Programme against Vitamin A Deficiency Disorder/ Vitamin A Supplementation (VAS) Programme is being implemented nationwide by the Institute of Public Health Nutrition (IPHN) under the Ministry of Health and Family Welfare (MOHFW) with the help of the Expanded Programme on Immunization (EPI), different sub-national health departments, Bangladesh Television and Betar (Radio), and the Department of Mass Communication (DMC). The VAS Programme is being financed by the Canadian International Development Agency (CIDA) and the Micronutrient Initiative (MI). The key objective is to reduce child mortality and morbidity rates and to keep the prevalence of night blindness among under-five children below 1 per cent. To reduce the micronutrient deficiencies of the target group the Programme addresses the following:

- *Children under one year of age: High potency Vitamin A capsules (0.1 million I.U) supplementation during measles vaccination under the Expanded Programme on Immunization (EPI)*
- *Children aged 1-5 years: High potency Vitamin A capsules (0.2 million I.U) supplementation through national events twice a year, at 4-6 month intervals'*
- *Lactating mothers: High potency Vitamin A capsules (0.2 million I.U) supplementation during postpartum period (within six weeks of delivery)*

39 National Plan of Action for Children (2005-2010), Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh. July 2006.

40 Bangladesh National Health Policy 2000, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh

Recent studies show that the VAS Programme resulted in the following key improvements changes in child health:

1. Coverage of Vitamin A Capsules (children aged 1-5 years): 96 per cent in November 2007;[41]
2. Deworming table (Albendazole): 97 per cent in November 2007;[42]
3. Postpartum coverage: 29 per cent in 2006[43]; and
4. >1 year coverage: 73 per cent in 2006[44].

Control of Iodine Deficiency Disorders (CIDD) through Universal Salt Iodization (USI): To combat iodine deficiency disorders, the Government of Bangladesh passed the Iodine Deficiency Disease Prevalence Act in 1989, which proclaims universal iodization of edible salt for human and animal consumption and includes prevention, enforcement, and education efforts. Through the Universal Salt Iodization Programme, the CIDD is being implemented across the country by the Bangladesh Small and Cottage Industries Corporation (BSCIC) with the support of the Ministry of Industries and the Institute of Public Health Nutrition under the Ministry of Health and Family Welfare. The objective is to improve coverage of household consumption of adequately iodized salt by more than 90 per cent by 2015. UNICEF is providing financial and technical assistance, including the free supply of the iodizing agent, potassium iodide. Programme activities include monitoring iodized salt; educating the field workers of the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) on control of iodine deficiency disorder, training on the testing of iodized salt, surveillance of salt for iodization, and so on. The second phase of the Programme for the period July 2000 to June 2010 is now being implemented at a cost of Tk. 619.30 million, with the Government and UNICEF contributing Tk. 302.40 and Tk. 316.90 million respectively.[45] According to MICS 2006, household consumption of iodized salt stands at 84 per cent. But the coverage of adequately iodized salt is only 51 per cent (IDD/USI Survey, 2004-2005).

A campaign to promote and protect breastfeeding is being implemented by IPHN and the Bangladesh Breastfeeding Foundation, and supported by the National Nutrition Programme.

41 Year Book 2007. Management Information System, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, May 2008, page 85.

42 ibid.

43 ibid.

44 ibid.

45 Annual Development Programme 2008-2009, Planning Commission, Government of the People's Republic of Bangladesh, page-128.

The Comprehensive Public Health Nutrition Programme (1991-1996) was a large nutrition intervention programme supported by UNICEF, and implemented by IPHN. This was the first big national nutrition programme, with a philosophy based on national coverage. It addressed micronutrient malnutrition problems, human resources development, mass health and nutrition education and the promotion of breastfeeding.

Community Nutrition Programme (1996-2000): This programme, under IPHN, was not fully approved and implemented.[46] However, its activities were brought together under a joint agreement between the Government of Bangladesh and UNICEF and were implemented by IPHN as per the Agreement and the Operational Plan of the then Health and Population Sector Programme (HPSP) of the Ministry of Health and Family Welfare.

Bangladesh Integrated Nutrition Programme (1995-2001): this programme was implemented by the MOHFW and included three major components: (1) National level nutrition activities; (2) Community-based nutrition; and (3) Inter-sectoral Programme Development. The Programme ended in June 2002.[47]

In 1995, the **Bangladesh National Nutrition Project** was launched with the World Bank as the main funder. As a pilot project, the initiative had been deemed the largest community-based nutrition programme in any developing country.[48] In July 2004, the National Nutrition Project became the **National Nutrition Programme (NNP)** – successor of earlier Government nutrition initiatives, especially for children and women. This programme is supported primarily by international development partners such as the International Development Association (IDA), the Netherlands, and CIDA and is being implemented by the NNP's Programme Management Unit (PMU) under the MOHFW. The total cost of the NNP for the current phase (2004-2010) is Tk. 13,472 million with the Government of Bangladesh and the Donors Consortium contributing Tk. 1,132 million and Tk. 12,340 million respectively. The major objectives of the Programme are as follows:

46 Source Book, Health Nutrition and Population Sector, Human Resources Management, Planning and Development Unit, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, February 2005, page-269

47 National Plan of Action for Children 2005-2010 Bangladesh, Ministry of Women and Children Affairs, Government of the People's republic of Bangladesh, July 2006, page-29.

48 http://www.worldbank.org.bd/external/default/main? menu PK = 295791 & page PK = 141155 & piPK = 141124 & the Site PK = 295760

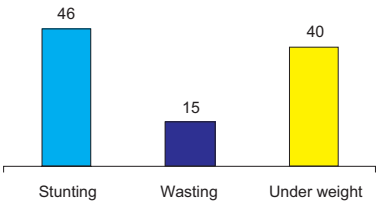
- *Reduce the severe malnutrition rate in under-two children to below 5 per cent (current rate:12.9 per cent)*
- *Reduce the moderate malnutrition rate in under-two children to below 30 per cent (current rate:36.3 per cent)*
- *Increase the weight of at least half of all the pregnant women by 9kg or more*
- *Reduce the percentage of children born with low birthweight (LBW) to below 30 per cent*
- *Reduce the prevalence of anaemia in adolescent girls and pregnant women to one-third of the current rate*
- *Reduce and limit the prevalence of night-blindness in under-five children to 0.5 per cent*
- *Halve the current prevalence (43.1 Per cent) of iodine deficiency*

The activities and strategies of the programme consist of two components: (i) Service and (ii) Programme Support and Institutional Development. The Service component is comprised of two sub-components: first, area-based community nutrition services to improve behavioural practices in critical areas such as breastfeeding, timely introduction of solid foods, and increased food intake during pregnancy. This component also increases awareness and treatment of malnutrition in the primary care health system and provides food security and income-generating activities to the poorest households in the community. The second Service sub-component funds a foundation to promote and protect breastfeeding; funds a programme for national micro-nutrient supplements; and provides technical assistance to draft legislation on fortification and food quality standards. The Programme Support and Institutional Development component has three sub-components: (i) programme management and institutional development; (ii) monitoring, evaluation, and operations research; and (iii) training and behavioural change communications. These components strengthen the management capacities of communities and NGOs.

Four different Government Ministries, including the Ministry of Health and Family Welfare play a key role in implementation of the programme. To date, the NNP has reached about 30 million beneficiaries across 34 Districts of six Divisions.

The total public expenditure on nutrition interventions in 2005-2006 was Tk. 1,670 million, falling to Tk. 1,200 million in the following year (see Table 3.1). In 2005-2006, the lion's share of total nutrition expenditure – Tk. 1,536 million – was allocated to child nutrition interventions, falling to Tk. 927 million in 2006-2007. The major share of the budgetary allocation was channelled through three projects and institutions: IPHN, NNP, and Bangladesh National Nutrition Council (BNNC). Of total public expenditure, nutrition expenditure accounted for 0.19 per cent and 0.11 per cent in the years 2005-2006 and 2006-2007 respectively (for details, see Annex II: Table 2).

Figure 3.1: Child nutrition status in Bangladesh (in per cent)



Source: CMNS 2005 [Reference: Annex I: Table 3.1.1]

For breastfeeding counselling, about Tk. 14 million and Tk. 9.7 million were spent in the years 2005-2006 and 2006-2007 respectively. A total of Tk. 141 million was spent on micronutrient supplementation in the year 2005-2006, rising to Tk. 198 million in the following year. Public expenditure for primary health care facilities was Tk. 1,122 million in 2005-2006, falling to Tk. 797 million the following year.

Table 3.1: Total public expenditure on nutrition interventions (in million Tk.)

Expenditure Head	2005-2006			2006-2007		
	Revenue	Development	Total	Revenue	Development	Total
Public expenditure on nutrition	33.163	1636.483	1669.646	24.614	1175.256	1199.87
Public expenditure on child nutrition	30.163	1506.282	1536.445	21.414	905.256	926.67

Child outcomes, disparities and gender inequality: causality and correlation

Nutritional status has been considered a major indicator of child well-being, as the future physical and intellectual development of children is affected significantly by the nutritional status that prevailed during their childhood (see figure 3.1). Nutritional status has been measured by three well-recognized parameters or anthropometrics indices: stunting, wasting, and underweight. According to the Child and Mother Nutrition Survey (CMNS) 2005, almost half of all children under-five (46 per cent) in Bangladesh are stunted and 40 per cent are underweight. Compared to

stunting and underweight, a relatively small section of children (about 15 per cent) were suffering from the wasting that indicates acute malnutrition – the result of more recent food deprivation and/or illness. There were no remarkable disparities between boys and girls on any of the three parameters of nutritional status. However, there was a significant disparity in the levels of stunting and underweight between the children living in rural and urban areas (49 per cent vs. 36 per cent, and 42 per cent vs. 30 per cent respectively).

Facts: Huge numbers of children are malnourished

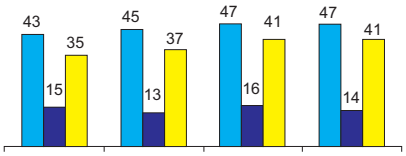
Of all children under five in Bangladesh, 46 per cent are stunted and 40 per cent are underweight. Stunting is a primary manifestation of malnutrition in early childhood, including malnutrition during foetal development as a result of the malnutrition of the mother, while underweight is the result of inadequacies in the intake of calories and vital nutrients such as vitamins and minerals. The prevalence of stunting is 13 per cent higher among children in rural areas than among their urban counterparts, and the prevalence of underweight is 12 per cent higher

Age-specific analysis shows that male infants have a notably lower prevalence of wasting compared to female infants (19 per cent vs. 24 per cent). In contrast, the prevalence of stunting and underweight is much higher among male infants compared to their female counterparts (22 per cent vs. 15 per cent, and 31 per cent vs. 26 per cent respectively). Regardless of gender, all key parameters for malnutrition (stunting, wasting and underweight) rise abruptly at the age of 12 months and then decrease gradually until the age of five. In terms of weight for age, female children aged 0-59 months are relatively better off than their male counterparts by one percentage point (for detail sees Annex I: Table 3.1.1).

There is a slight negative relationship between the nutritional status of children and the size of the household (see Figure 3.2). Household size does not have a direct impact on child wasting. Stunting, however, is found in about 47 per cent of children living in households with 5-6 members, compared to about 43 per cent of children living in a household with less than three members. In households with more than five members, the prevalence of underweight children is 41 per cent, falling by 4-5 percentage points in small households.

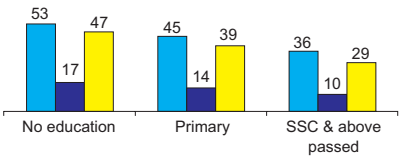
The nutritional status of children has a significant connection to the educational status of the women in the household (see Figure 3.3). The study finds a strong relationship between malnutrition and the status of women's education in Bangladesh. As the level of women's education rises, the level of child malnutrition decreases. More than half of all children in households where mothers have no education have been found to be stunted, compared to children in households where mothers have primary education (45 per cent). The prevalence of stunting falls to 36 per cent in households where a mother has completed the secondary level or above. In other words, the prevalence of stunting is 17 per cent higher in households where mothers have no education, compared to households where mothers have completed their school education.

Figure 3.2: Child nutrition status by household size (in per cent)



Source: CMNS 2005 [Reference: Annex I: Table 3.1.1]

Figure 3.3: Child nutritional status by women's education (in per cent)



Source: CMNS 2005 [Reference: Annex I: Table 3.1.1]

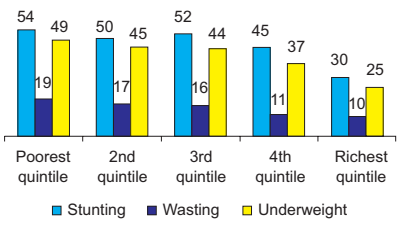
Facts: Maternal education reduces child malnutrition

Prevalence rates of stunting, wasting and underweight among children from households where the mother has no education are 53 per cent, 17 per cent and 47 per cent respectively. These are lower (45 per cent, 14 per cent and 39 per cent respectively) among children where mothers have at least primary level education. And the figures are even lower (36 per cent, 10 per cent and 29 per cent respectively) among the children of mothers who have at least secondary education

Similarly, the occurrence of wasting is 3 per cent higher among households where the mother has no education compared to households where mothers have completed primary education, and 7 per cent higher than in households where mothers have completed secondary education. In addition, the proportion of underweight children (47 per cent) is much higher in households with uneducated mothers, compared to households with mothers educated up to secondary level and above (29 per cent), indicating a disparity of 1 per cent.

A direct relationship is obvious between child nutrition and household wealth (see Figure 3.4). Child nutrition status in terms of three parameters stunting, wasting, and underweight, has been found to be worst in households in the poorest quintiles – almost double that found in the wealthiest.

Figure 3.4: Child nutrition status by household wealth quintile (in per cent)

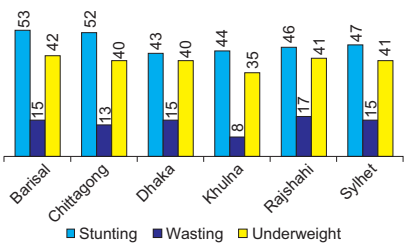


Source: CMNS 2005
[Reference: Annex I: Table 3.1.1]

Child nutrition status is better in urban areas than in rural areas. About 49 per cent of children are stunted in rural areas, compared to 36 per cent in urban areas -- a disparity of 13 percentage points. The rural-urban disparity on the prevalence of underweight among children is also high – 42 per cent vs. 30 per cent. For details, see Annex I: Table 3.1.1.

Spatial analysis indicates that child nutritional status is not similar all over the country (Figure 3.5). Among the six administrative divisions, the nutritional status of children is relatively better in Khulna compared to other divisions. About 53 per cent of children are found to be stunted in Barisal, followed by 52 per cent in Chittagong and 46 per cent in Rajshahi. Wasting among children is much higher (17 per cent) in Rajshahi than in Khulna (8 per cent). Underweight is less prevalent among children in Khulna (35 per cent) than in Sylhet and Barisal, at 41 per cent and 42 per cent respectively. Under any circumstances, breast milk is the ideal food for the newborn. The proportion of mothers who

Figure 3.5: Child nutrition status by region (in per cent)



Source: CMNS 2005
[Reference: Annex I: Table 3.1.1]

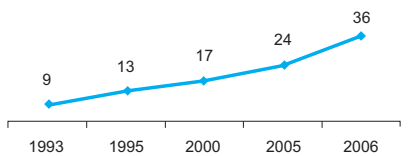
breastfed their baby within one hour of birth and within one day of birth was 36 per cent and 81 per cent

Facts: The rural-urban disparity in child nutrition reveals a surprising scenario in national poverty

Although household level national poverty estimates (in terms of calorie intake) are higher in urban areas than in rural Bangladesh, children in rural areas have been found to be more stunted and underweight than children in urban areas by 13 per cent and 12 per cent respectively

respectively according to MICS 2006. In the accompanying analysis, 'initial' breastfeeding is breastfeeding within one hour of birth. The scenario of breastfeeding is almost the same in rural and urban areas. However, regional variations in initial breastfeeding practice have been found across the administrative divisions. Initial breastfeeding is higher in Barisal and Sylhet divisions (42 per cent) compared to Chittagong division (32 per cent). Encouragingly, an increase in breastfeeding is visible among mothers in Bangladesh (Figure 3.6).

Figure 3.6: Initial breastfeeding practice within one hour of birth: 1993-2006 (per cent)



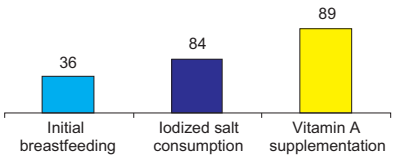
Source: MICS 2006, BDHS 1993, 1996, 2000 & 2003
[Reference: Annex I: Table 3.1.2]

Facts: A good scenario on initial breastfeeding, but no room for complacency

More than 80 per cent children were breastfed within one day of birth – a satisfactory scenario. But there is still some way to go: only around one-third of newborns are breastfed within one hour of birth

Iodized salt consumption is at a satisfactory level, with 84 per cent of households consuming iodized salt, with no rural-urban disparity (Figure 3.7). The consumption of iodized salt is highest (94 per cent) in Khulna and lowest (78 per cent) in Chittagong. In Sylhet, 92 per cent of households are consuming iodized salt, followed by Barisal (90 per cent), Dhaka (84 per cent), and Rajshahi (82 per cent). There has been remarkable progress in the Vitamin A Supplementation programme in Bangladesh. Almost 89 per cent of children have received Vitamin A supplementation - 92 per cent in urban areas and 88 per cent in rural areas. Spatial analysis does not show any significant variation among the administrative divisions. More children who had received Vitamin A supplements were found in Chittagong and Khulna divisions than in Barisal, Dhaka, Rajshahi and Sylhet (for details see Annex I: Table 3.1.2).

Figure 3.7: Child nutrition: supply side and uptake variables (in per cent)



Source: MICS 2006, [Reference: Annex I: Table 3.1.2]

Building blocks and strategy partners

The Government's policy, strategies and programmes on nutrition to improve child well-being have evolved gradually and are robust. Increased programme efforts, backed by substantial allocations and a community-based pro-poor strategy to raise the nutritional level of children, has provided clear evidence and insights about children's well-being across the country.

As the lead agency and chief coordinator of the National Nutrition Programme, the Ministry of Health and Family Welfare is in the driving seat and guides the onward movement of the programme.

The other Ministries participating actively in the NNP and providing support, are the Ministry of Agriculture, the Ministry of Food and Disaster Management, the Ministry of Fisheries and Livestock, and the Ministry of Women and Children Affairs. The four cornerstones of the programme are: the Directorate General of Health Services; the Directorate General of Family Welfare; IPHN; and NNP. The NNP, with the mandate to provide nationwide coverage, has already brought 34 districts of six divisions under the umbrella of the programme and is expanding its network to the remaining 30 districts to ensure total coverage. This Programme is one of the strongest initiatives with NGOs and private-public partnership in meeting the nutritional needs of children. The VAS and USI Programmes, with high levels of acceptance, have also been working well, making a big difference in child welfare. All of these programmes provide a great opportunity for NGO-Private-Public partnerships following the policy of 'NGO-led and Government-supported', and 'Government-led and NGO/Private Parties supported' programmes.

For functional convenience, the Ministries mentioned above act as independent bodies to ensure smooth implementation of nutrition programmes. However, in matters of policy and strategy formulation they stand together to provide momentum for child well-being by raising the level of child nutrition and by reducing poverty and disparities. United Nations (UN) agencies, particularly UNICEF and the World Bank, have been providing both technical and financial support to the NNP from the very beginning, and the World Bank also coordinates the inputs of donor agencies into the NNP.

The most important policy lesson learnt to date is that nutrition – a national, multi-dimensional issue and a State responsibility fixed by the 1972 Constitution – should be dealt with multisectorally and coordinated at the highest level of the government.

Health

National laws, policies and key programmes

The **Constitution of Bangladesh** as per Article 15(A)[49] seeks to ensure that people of all strata have access to necessary basic medical utilities, and as per Article 18 (1),[50] the improvement of public health is recognised as one of the primary duties of the State.

The National Children Policy, 1994 (NCP) seeks to "ensure the rights of safe birth and survival to all children" through pre-natal and post-natal healthcare,

49 The Constitution of Bangladesh, Part II, Fundamental Principles of State Policy, Article 15 (A): Provision of basic necessities.

50 The Constitution of Bangladesh, Part II, Fundamental Principles of State Policy, Article 18 (1): Public health and morality.

essential obstetric services, and extended maternity leave for working mothers. Encouraging breastfeeding and supporting breastfeeding in the workplace also form a part of the NCP. Other elements of the NCP include: ensuring the health of all children through the Expanded Programme on Immunization against six fatal diseases; prevention of diarrhoea and Acute Respiratory Infection (ARI); access to integrated healthcare for all children; raising awareness on personal hygiene; and educating mothers on child nutrition and development.

In August 2000, the Government of Bangladesh approved the **National Health Policy**.[51] In line with constitutional obligations, the overall goal of the Policy is to ensure that people of all strata have access to necessary basic medical utilities and to improve the health and nutrition status of the people of Bangladesh. And in line with constitutional requirements, the Health Policy has 15 goals and objectives, 10 policy principles and 32 strategies. Most are related directly or indirectly to the improvement of children's health status and aim to:

1. undertake programmes to reduce the rates of child and maternal mortality within the next five years to an 'acceptable' level (Objective 5);
2. adopt satisfactory measures to ensure improved maternal and child health at the union level and install facilities for safe and clean births in each village (Objective 6); and
3. create awareness through the media and other channels to enable every citizen, irrespective of caste, creed, religion, income and gender, and especially children and women in any part of the country, to obtain health, nutrition and reproductive health services on the basis of social justice and equality through ensuring everyone's constitutional rights (Principle 1).

Another milestone was the introduction of the revised **Population Policy of Bangladesh** in 2004. Its principal objective was to ensure planned parenthood, maternal and child healthcare, and reproductive healthcare to pursue MDG1 for poverty eradication, and raise living standards by improving health. The Health and Population policies of the Government are two 'wings' of an integrated programme as reflected in PRSP I.

In line with a Constitutional obligation to develop and sustain a society in which the basic needs of all people are met and every person can prosper in freedom, and to cherish the ideals and values of a free society, the vision of Bangladesh's PRSP-I[52] is to reduce poverty substantially within the shortest possible time. The PRSP also takes into consideration Bangladesh's previous official commitment to achieve the MDGs, as well as its social targets. One of the MDG health targets is to reduce infant and under-five mortality rates by 65 per cent and eliminate gender disparity in child mortality.[53] The strategic goal in this area, therefore, is to improve the health of children and mothers. The targets are as follows:

- *Reduce the Neonatal Mortality Rate (NMR) per 1,000 live births from 41 in 2004 to 32 in 2006*
- *Reduce the Infant Mortality Rate (IMR) per 1,000 live births from 65 in 2004 to 47.9 in 2006*
- *Reduce the Under-five Mortality Rate (U5MR) per 1,000 live births from 88 in 2004 to 70 in 2006*
- *Reduce the Maternal Mortality Rate (MMR) per 100,000 live births from 320 in 2001 to 275 in 2006*
- *Reduce female U5MR as percentage of male U5MR from 107 in 2000 to 102 in 2006*
- *Reduce incidence of child mortality among the poor (poor-rich ratio 1.86)*
- *Reduce rural child mortality as a percentage of urban child mortality from 140 in 2000 to 120 in 2006*
- *Increase Ante-Natal Care (ANC) coverage from 48.7 per cent in 2004 to 60 per cent in 2006*
- *Increase Post-Natal Care (PNC) coverage from 17.8 per cent in 2004 to 30 per cent in 2006*
- *Increase utilization of Essential Obstetric Care services from 26.5 per cent (risk group) in 2003 to 40 per cent in 2006*
- *Ensure access to Emergency Obstetric Care (EmOC) in case of complications to all women*
- *Increase skilled birth attendance (SBA) at birth from 13.4 per cent in 2004 to 25 per cent in 2006*

National health and population policies, and PRSP-I, all seek to reduce adolescent pregnancy, provide reproductive health awareness and services to all adolescents, prevent transmission of sexually-transmitted diseases (STDs) including HIV/AIDS, and reduce the negative health consequences of sexual abuse and exploitation.

51 Bangladesh National Health Policy 2000, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.

52 Unlocking the Potential: National Strategy for Accelerated Poverty Reduction (PRSP-I), General Economic Division, Planning Commission, Government of the People's Republic of Bangladesh, October 16, 2005. The PRSP was adopted in October 2005 to cover the period 2004-2007. The NEC meeting of 30 April 2007 agreed to extend the PRSP to June 2008.

53 Unlocking the Potential: National Strategy for Accelerated Poverty Reduction (PRSP-I), General Economic Division, Planning Commission, Government of the People's Republic of Bangladesh, October 16, 2005. page-139

The National Plan of Action for Children,[54] (2005-2010) seeks to achieve the relevant health goals and targets of the MDGs (i.e. MDGs 4, 5, and 7). Within the framework of Government policies and programmes, the overall goal of the NPA is to improve the health of children and women. The major objectives are as follows:

- *Reduce the infant mortality rate to 48, neonatal mortality rate to 32, under-five child mortality rate to 70, and maternal mortality rate to 2.75 per 1,000 live births by 2006*
- *Maintain polio eradication to achieve polio eradication certification by 2008*
- *Achieve elimination of neonatal tetanus nationally and in all districts by 2005 and reduce measles morbidity by 50 per cent by 2005 compared to 1999*
- *Reduce the prevalence of Hepatitis-B infection (HbsAg) among children aged 3-5 years by 80 per cent by 2010 compared to the prevalence level of the pre-vaccination era*
- *Maintain a high level of immunization coverage (85 per cent of children under one year of age), 85 per cent for DPT, 80 per cent for measles and 85 per cent for polio by 2006*
- *Control diarrhoeal diseases by increasing the use of oral rehydration therapy (ORT) to 56 per cent*
- *Improve service provider management of severe and very severe ARI cases from 60 per cent to 100 per cent by 2006*
- *Increase the met need of emergency obstetric care to 40 per cent from 27 per cent*
- *Increase the uptake of neonatal care (three visits) to 60 per cent*
- *Increase skilled attendance at birth to 25 per cent from 12 per cent*
- *Increase postnatal care to 30 per cent from 16 per cent by 2006*

Policies and strategic plans on HIV/AIDS

Today, more than 33 million people are living with HIV/AIDS worldwide.[55] Over 96 per cent of them live in low- and middle-income countries,[56] demonstrating the high correlation between HIV/AIDS and poverty. Half of new HIV infections are among young people aged 15-24.[57] If this situation is left unchecked or inadequately addressed, the epidemic has the potential to drive communities deeper into poverty. MDG6[58] calls on all nations to halt and reverse the spread of HIV by 2015.

HIV in Bangladesh remains at relatively low levels in most at-risk population groups, with the exception of injecting/intravenous drug users (IDUs) among whom prevalence continues to grow. UNAIDS estimates show that about 12,000 Bangladeshis were living with HIV at the end of 2007.[59] Although overall HIV prevalence remains under 0.1 per cent among the general population in Bangladesh, the country is vulnerable to an expanded HIV epidemic as a result of the prevalence of behaviour patterns and risk factors that facilitate the rapid spread of HIV. Bangladesh's seventh round of serological surveillance (2006) showed that HIV prevalence among all high-risk groups remained below one per cent with the exception of injecting drug users.[60]

To prevent HIV/AIDS, and in line with MDG6, the Government of Bangladesh has prepared several policies and strategic plans.

The National Policy on HIV/AIDS: In 1997, the Cabinet endorsed the National Policy on HIV/AIDS that was developed by the Directorate of Health Services in the Ministry of Health and Family Welfare (MoHFW). The Policy acknowledges the challenge that HIV/AIDS poses and provides guidance on how to respond to it. The Government has established the National AIDS Committee (NAC) – a high level body on HIV/AIDS that is chaired by the Minister MOHFW with the State President as its Chief Patron. In addition, Bangladesh has ratified international and regional conventions on HIV/AIDS, such as the Declaration of Commitment on HIV/AIDS of the UN Special Session of the General Assembly (June 2001); the Kathmandu call for Action Against HIV and AIDS (2003); the MDGs; the Islamabad Declaration of the 12th SAARC Summit (January 2004); and the Joint Ministerial Statement of the second Asia-Pacific Ministerial Meeting on HIV/AIDS (July 2004), etc.

National Strategic Plan on HIV/AIDS (NSP): Through the Ministry of Health and Family Welfare, the Government of Bangladesh prepared the National Strategic Plan for HIV/AIDS 2004-2010 under the guidance of the NAC and with the involvement and support of different stakeholders. The NSP has

54 National Plan of Action for Children: 2005-2010 Bangladesh, Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh, July 2006

55 UNFPA. Online. http://www.unfpa.org/aids_clock/, 16 September 2008.

56 UNFPA. Online. http://www.unfpa.org/aids_clock/, 16 September 2008.

57 UNFPA, Bangladesh. Online. http://www.unfpa-bangladesh.org/php/thematic_hiv.php

58 Combat HIV/AIDS, Malaria and other disease

59 The World Bank, HIV/AIDS in Bangladesh. Online Material. http://siteresources.worldbank.org/INTSAREGTOPHIVAIDS/Resources/ 496350-1217345766462/HIV-AIDS-brief-Aug08-BD.pdf, August 2008.

60 The World Bank, HIV/AIDS in Bangladesh. Online Material. http://siteresources.worldbank.org/INTSAREGTOPHIVAIDS/Resources/496350-1217345766462/HIV-AIDS-brief-Aug08-BD.pdf, August 2008.

identified five strategic programmes as follows:

- *Provide support and services to priority groups*
- *Prevent vulnerability to HIV infection*
- *Promote safe practices in the health care system*
- *Provide care and support services to people living with HIV and AIDS*
- *Minimize the impact of the HIV epidemic*

Poverty Reduction Strategy Paper (PRSP-I): The 2005 Poverty Reduction Strategy Paper of the Government highlighted HIV/AIDS in the health section. With an emphasis on the explicit implementation of the national strategy plan on HIV/AIDS, the PRSP seeks to reduce HIV/STD infections so that they do not affect more than 5 per cent of the at risk population.[61]

The Government of Bangladesh has been implementing different programmes in the health sector to address health-related issues. Many have a particular focus on child health, and a few of these key programmes are reviewed here.

Health, Nutrition and Population Sector Programme (HNPSP): The sector-wide HNPSP (2003-2010) is an umbrella under which health, nutrition, population interventions have been gathered.[62] Although launched for a period of five years (July 1998 to June 2003), it was revised in 2003 to incorporate nutrition as one of the major components, and its name was changed accordingly. The goal of the HNPSP is to modernize the country's health sector and facilitate progress towards the health-related MDGs. Its aim is to ensure sustainable development of health, nutrition, and reproductive health for all citizens of Bangladesh, and especially for children, women and vulnerable groups. The HNPSP is being implemented from 2003 to 2010 at a cost of Tk. 324,503 million. The contributions of the Government of Bangladesh and the donor consortium are Tk. 216,568 and Tk. 107,935 million respectively.[63] The Programme is implemented jointly by the Government of Bangladesh and a multi-donor Trust Fund and led, on the donor side, by the World Bank. The other donor agencies are the UK Department for International Development (DFID), the European Union (EU), RNE (Embassy of the Kingdom of the Netherlands), Swedish International Development Cooperation Agency (SIDA), the United Nations Population Fund (UNFPA), the Canadian International Development Agency (CIDA) and KfW (Germany).

Within the context of the PRSP, the health, nutrition and population sectors intend to emphasize the reduction of severe malnutrition, high mortality, and fertility; the promotion of healthy life styles; and the reduction of risk factors to human health from environmental, economic, social and behavioural factors, with a sharp focus on improving the health of the poor. In line with the MDGs and the PRSPs, some targets have been set for achievement between 2006-2007 and June 2010 through the programmes under the HNPSP. These targets are as follows:

- *Reduce the Neonatal Mortality Rate from 32 to 21 per 1,000 live births*
- *Reduce the Infant Mortality Rate (IMR) from 48 to 37 per 1,000 live births*
- *Reduce the Maternal Mortality Rate (MMR) from 2.75 to 2.40 per 1,000 live births*
- *Reduce the Total Fertility Rate (TFR) from 2.80 per cent to 2.20 per cent*
- *Reduce drop out of contraceptive methods from 49.4 per cent to 20 per cent*
- *Increase the Contraceptive Prevalence Rate (CPR) from 58 per cent to 72 per cent*
- *Reduce the population growth rate from 1.40 per cent to 1.20 per cent*
- *Increase the number of Nursing Institutes from 44 to 50*
- *Increase the average life expectancy of women from 65 to 70 years*
- *Sustain the cure rate of Tuberculosis at 85 per cent and above*
- *Prevent the spread of HIV/AIDS*
- *Reduce malnutrition among children under-five from 42 per cent to 30 per cent*
- *Reduce the anaemia of pregnant women from 45 to 30 per cent*[64]

The Operational Plans of the HNPSP that deal with child health include: Essential Service Delivery; Expanded Programme on Immunization; Integrated Management of Childhood Illness; School Health Programme; and Micronutrient Supplementation, among others.

61 Unlocking the Potential: National Strategy for Accelerated Poverty Reduction (PRSP-I), General Economic Division, Planning Commission, Government of the People's Republic of Bangladesh, October 16, 2005. Page-142. The PRSP was adopted in October 2005 to cover the period 2004-2007. The NEC meeting of 30 April 2007 agreed to extend the PRSP to June 2008.

62 Health, Nutrition and Population Sector Programme (HNPSP), MOHFW, Government of Bangladesh.

63 Bangladesh Economic Review 2008 (Bangalee Version), Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-152.

64 Annual Development Programme: 2007-2008, Planning Commission, Government of the People's Republic of Bangladesh, page-281.

The Expanded Programme on Immunization (EPI): Immunization plays a vital role in reducing infant and child morbidity and mortality. EPI is a priority programme for the Government of Bangladesh and a success story. It is a programme of vaccination against six childhood diseases – diphtheria, pertussis (whooping cough), tetanus, tuberculosis, polio and measles – all of them preventable. In Bangladesh, the Programme was undertaken under the mandate and auspices of the World Health Organization's mandate of 'universal child immunization' in the early 1980s. The Programme actually became fully operational in 1985.[65] Its objectives include the following:

- *To increase the percentage of children receiving the full series of routine EPI vaccines to 90 per cent by 2010*
- *To maintain polio free status certification*
- *To achieve Neonatal Tetanus (NT) elimination in all districts by 2008*
- *To reduce the prevalence of HepB chronic infection among children aged 3-5 by 80 per cent by 2010, compared to the level of the pre-vaccination era*
- *To reduce measles mortality by 90 per cent by 2010, compared to 1999 estimates*
- *To introduce new and under-used vaccines; and*
- *To improve immunization and vaccine safety*[66]

The major activities of the Programme include: ensuring 100 per cent registration of the EPI target population; effective annual micro planning at implementation levels with involvement of the Government of Bangladesh, NGOs and other stakeholders; decreasing the dropout rate for DPT3 and measles through effective supervision and monitoring, following the Reach Every District strategy; ensuring effective vaccine and other logistics at all levels; and identifying hard-to-reach areas to ensure coverage of every child with EPI vaccines.[67] Under this Programme, two days each year are declared National Immunization Days (NIDs), usually during the dry winter months to facilitate wide participation. At present, EPI is being implemented by the DGHS under the Ministry of Health and Family Welfare. IPHN, Bangladesh Television and Betar (radio), and the Department of Mass Communication also assist in programme implementation, while UNICEF, WHO and the Global Alliance for Vaccines and Immunization (the GAVI Alliance) provide financial and technical assistance.

65 BANGLAPEDIA. Online. http://banglapedia.search.com.bd/HT/E_0086.htm

66 YEAR BOOK 2007. Management Information System, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, May 2008, pag-.11.

67 YEAR BOOK 2007. Management Information System, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, May 2008, pp.11-12.

Integrated Management of Childhood Illness (IMCI) and Newborn Health: The IMCI strategy encompasses a range of interventions and incorporates elements of diarrhoeal and Acute Respiratory Infection (ARI) control programmes, child-related aspects of malaria control, nutrition, immunization, and essential drugs programme to prevent and manage major childhood illness, both in health facilities and in the home.

The IMCI objectives include reducing morbidity and mortality associated with the major causes of disease in children under five, promoting healthy growth and development through disease prevention, and promoting healthy practices. Programme activities under Community Based Integrated Management of Childhood Illness (C-IMCI) include: improving the five key care practices: essential newborn care; infant and young child feeding and nutrition (micronutrients); early childhood development; prevention of drowning; and caring and care-seeking at family level. It also strengthens community case management by basic health workers, trains informal health providers, and supports counselling, community mobilization and participation. Other activities include increasing local government involvement; the selection of low performing areas to ensure a particular focus on the poor; and Pre-Service Education (PSE) to introduce IMCI in the medical, paramedical and nursing curriculum. Facility-based IMCI (F-IMCI), on the other hand, focuses on: increasing the skills of health providers in case management and counselling in an integrated way; and improving health systems in terms of regular supplies of drugs, supportive supervision, regular reporting and effective referral and management information systems (MIS). Its other activities include referral care introduction in district and sub-district hospitals. To date, F-IMCI has been implemented in 274 upazilas and 41 districts of six divisions[68] with the support of UNICEF, WHO, AusAid and CIDA. There is an urgent need to expand this programme within the broader framework of the HNPSP.

National AIDS/STD Programme (NASP): NASP provides the oversight to guide, lead and coordinate the national response to the HIV epidemic.[69] Strategic action plans for the National AIDS/STD Programme set out fundamental principles, with specific guidelines on a range of HIV issues including: testing; care; blood safety; prevention among youth, women, migrant workers and sex workers; and sexually transmitted

68 Health and Nutrition Section, UNICEF Bangladesh, August 2008.

69 UNFPA, Bangladesh. Online. http://www.unfpa-bangladesh.org/php/thematic_hiv.php

infections (STIs). While earlier commitment was limited and implementation of HIV control activities was slow, Bangladesh has now strengthened its programmes to improve its response.

HIV/AIDS Prevention Project: UNFPA is providing technical assistance to the National AIDS/STD Programme to strengthen its institutional capacities. The areas of technical assistance are: coordination; monitoring and evaluation; safer sex promotion; drug user intervention; STI management; advocacy and Behaviour Change Communication (BCC), and financial management.

Mainstreaming HIV/AIDS into Sectoral Plans at National and District Levels in Selected Ministries of the Government of Bangladesh: UNFPA has implemented this project through access to the UNAIDS Programme Accelerated Fund (PAF). Focal points in 16 selected ministries were identified and oriented on HIV/AIDS prevention activities, and HIV/AIDS activities have been identified for inclusion into the Sectoral Plans of these Ministries. UNFPA is also providing support to strengthen the understanding of parliamentarians, policy makers and civil society on their role in the prevention of HIV/AIDS.

The HIV/AIDS Prevention Project (HAPP 2000-2007) is financed jointly by the World Bank and DFID, which provided $27 million to support the scaling up of interventions among groups at high risk in a rapid and focused manner, while strengthening overall programme management. Three UN agencies assisted the Government in the implementation of key project components: UNICEF managed the NGO service delivery component; WHO managed blood safety activities, and UNFPA managed capacity building. With the closure of the project, HIV interventions are being integrated into the Government's multi-donor supported Health, Nutrition and Population Sector Programme. The World Bank is supporting the Government's two-pronged strategy: (i) increasing advocacy, prevention, and treatment of HIV/AIDS within the Government's existing health programmes, and (ii) scaling up interventions among high risk groups.

School Health Education (Teachers and Students): According to MICS 2006, 60 per cent of adolescent boys (aged 10-19) and 57 per cent of adolescent girls had heard of HIV and AIDS. Among these, only 52 per cent of boys and 34 per cent of girls knew that they could protect themselves from HIV by using a condom. As Bangladesh is a country that has low HIV prevalence and interventions for highly vulnerable populations supported by other agencies, WHO sees creating awareness on HIV/AIDS in schools as a priority intervention. As a first step, WHO is supporting the National STD/AIDS Programme to orientate teachers on HIV/AIDS, and a series of programmes started nationwide in 2003. In this project, teachers learn about: the basic facts on HIV and AIDS; the HIV/AIDS situation in Bangladesh; how HIV and AIDS are spread (and, importantly, how they are not spread); the window period; the difference between being HIV positive and having AIDS; and how to protect oneself from infection (including the use of condoms and the need to respect the human rights of those affected by HIV/AIDS and other vulnerable populations). Teachers still feel uncomfortable in talking about these issues, but in reality, their students are curious and have many questions about the physiological and emotional changes during adolescence. If parents and teachers fail to answer these questions, students will get the information elsewhere, perhaps from their friends, and that information may well be wrong. As family life education has not gained the desired momentum through the formal education system, WHO is supporting awareness programmes for students on HIV/AIDS.

In the health sector, a total of Tk. 41,114 million was allocated in the year 2005-2006, rising to Tk. 49,700 million in the year 2006-2007. During the same period, revenue spending on health increased to Tk. 26,948 million from Tk. 20,142 million – a 33 per cent increase on the base year. Within the total expenditure on health, development expenditure increased at a lower rate than the revenue budget (for details see Policy Template 2 in the Annex).

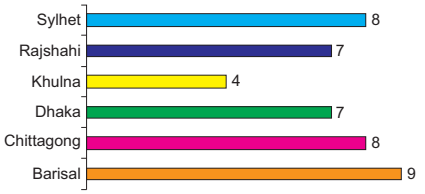
Child outcomes, disparities and gender inequality: causality and correlation

Prevalence of Diarrhoea: A large proportion of deaths among children under five worldwide are caused by a single disease – diarrhoea. Bangladesh is no exception. WHO statistics (2006) shows that diarrhoea contributes to 45 per cent of child deaths during the neo-natal period. Diarrhoea alone is entirely responsible for an additional 20 per cent of such deaths.[70]

According to MICS 2006, the occurrence of diarrhoea among children under the age of five was 7 per cent, with an insignificant gender variation: 7.4 per cent for boys, and 6.9 per cent for girls. Age specific analysis shows that the highest incidence of diarrhoea (11 per cent) has been found among children aged 6-11

70 World Health Organization, Mortality Country Fact Sheet 2006: Bangladesh. World Health Statistics 2006.

Figure 3.8: Prevalence of childhood diarrhoea, 2006 (in per cent)



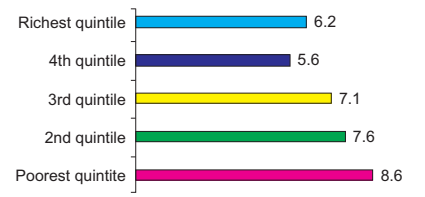
Source: MICS 2006 [Reference: Annex I: Table 3.2.1]

months. The regional picture shows a wide variation among the divisions, (Figure 3.8). The highest occurrence of diarrhoea among children under five has been found in Barisal (9 per cent) and the lowest in Khulna (4 per cent). The prevalence of diarrhoea in Chittagong and Dhaka has been found to be identical, at 7 per cent. There is no significant rural-urban disparity in the occurrence rates among children under five.

The prevalence of diarrhoea among children under five children is correlated with household size. As household size rises, the prevalence of diarrhoea increases. In households with 5-6 members, the prevalence of under-five diarrhoea is 8 per cent, compared to 5 per cent in households with less than three members.

As we have seen, a mother's education has a major impact on child health outcomes and it has been proved that the more education a mother has, the better those outcomes are. The prevalence of diarrhoea among under-five children is lower in households where the mother has been educated to secondary level and above, compared to other categories i.e., no education or educated under non-standard curriculum. The prevalence for diarroheal disease has been found to be two percentage points higher among households where mothers have no education, compared to households where mothers completed secondary or post secondary education.

Figure 3.9: Prevalence of diarrhoea by HH wealth status (in per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.2.1]

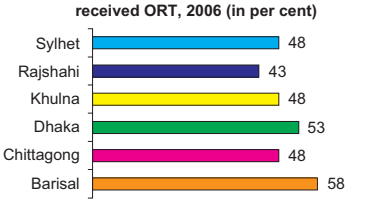
Facts: High prevalence of diarrhoea

More than 7 out of every 100 children under the age of five still suffer from diarrhoea, which is one of the major causes of child mortality. The highest prevalence is found among children aged 6-11 months (11 per cent). The occurrence rate of diarrhoeal disease in children under five correlates with household size – the larger the household, the greater the prevalence rate of diarrhoea. For a household with 5-6 members it is 8 per cent, falling to 5 per cent when there are less than three household members

The incidence of diarrhoea among children vary according to the wealth of the household. There is a remarkable disparity between the rich and the poor regarding incidence of diarrhoea. In the poorest quintile, 9 per cent of children suffered from diarrhoea while those in the 4th quintile registered the lowest rate at 6 per cent. The prevalence of diarrhoea shows a clear downward trend as one moves towards the richer wealth quintile (Figure 3.9).

Analysis on the prevalence of diarrhoea also shows the highest incidence in households that are Christian (9 per cent) and the lowest among Buddhist households (5.6 per cent). Among ethnic minorities, the highest proportion of under-five children suffering from diarrhoea was reported by Saontals (12 per cent) followed by Tripuras (8 per cent), Bangalees (7 per cent) Garos (6 per cent) and Marmas (6 per cent). The incidence of diarrhoea in the Chakma community has been registered as low as 4 per cent.

Figure 3.10: Under-5 children with diarrhoea who had received ORT, 2006 (in per cent)



Source: MICS 2006

Children under the age of five living in vulnerable families, such as those with a single parent, orphaned children, or with a high dependency ratio (more than four children per adult), have been found to suffer more from diarrhoea. The prevalence of diarrhoea among households with orphaned children is 7.4 per cent, which is slightly higher than the national prevalence rate (7.1 per cent). Details on the prevalence of diarrhoea are presented in Annex I: Table 3.2.1.

Oral Rehydration Therapy (ORT): The deaths of children under five as a result of diarrhoea could be prevented, for the most part, by taking existing interventions to scale and increasing coverage to reach those who need them. The solution lies, to some extent, in our knowledge about when and why these children die. This huge death toll could be reduced by, for example, the knowledge that diarrhoea is a major cause of death for thousands of newborns and under-five children in Bangladesh and that ORT is the simplest, cheapest and most effective treatment.

ORT, or the intake of increased fluids and continued feeding is a widely recognized medical treatment for children under five who are affected by diarrhoea. However, reported findings show that less than half of all under-five children affected by diarrhoea in Bangladesh received ORT (MICS 2006). Children in urban areas received 4 per cent more ORT than their rural counterparts. A wide geographic disparity was also been found, with 58 per cent of children affected by diarrhoea reported as having received ORT in Barisal, compared to 43 per cent in Rajshahi (Figure 3.10).

Facts: Oral Rehydration Treatment (ORT) is still too low

Almost half of all children under the age of five who suffer from diarrhoea in Bangladesh do not receive Oral Rehydration Treatment - the simple, cheap but effective treatment for diarrhoea. The treatment rate is 4 per cent higher in urban areas than in rural areas. Spatial analysis shows that, in Rajshahi, the highest number of children (57 per cent) do not receive ORT when they get diarrhoea

The proportion of children under five who receive ORT varies with the educational status of the mother in the household. About 52 per cent of children living in households where the mother had completed secondary or post secondary education received ORT, compared to 47 per cent of those in households where the mother had no education – a clear indication of the significant impact of a mother's education on the prevalence of diarrhoea and on the use of ORT.

Facts: Mothers' education, prevalence of diarrhoea and ORT

About 52 per cent of children living in households where the mother had completed secondary or post secondary education received ORT, compared to 47 per cent of those in households where the mother had no education

Household wealth is a determining factor in the prevalence of diarrhoea and for the use of ORT. The analysis on receipt of ORT according to household wealth levels reveals that children under five in rich households took ORT at a higher rate than those in poor households, with a difference of 10 percentage points between the richest quintile and the poorest quintile. For details, see Annex I: Table 3.2.1.

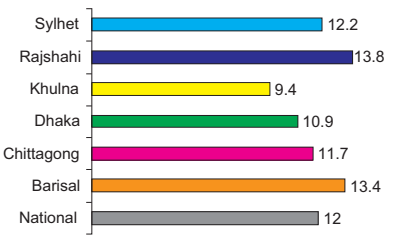
Prevalence of pneumonia: WHO estimates show that 18 per cent of all under-five deaths in Bangladesh are caused by one single disease - pneumonia. It is a major cause of under-five mortality, followed by diarrhoea.[71]

Facts: Pneumonia and child mortality

An estimated 12 per cent of children under five suffer from pneumonia, which is responsible for 18 per cent of all under-five deaths in Bangladesh. Almost 80 per cent of those who suffer from pneumonia do not receive antibiotic treatment. The rate of antibiotic treatment for children with pneumonia is very low (13 per cent) in Barisal compared to other administrative divisions

In the Statistical Template of the Study Guide, the working definition of *Child Fever is described as "when the child had an illness with a cough, breathing faster than usual with short, quick breaths or difficulties in breathing"*. In the MICS 2006 for Bangladesh, this type of fever among children under the age of five has been considered as pneumonia. Pneumonia is, therefore, regarded as synonymous with the child fever definition given in the Annex I: Table 3.2.1.

Figure 3.11: Prevalence of pneumonia (in per cent)



Source: MICS 2006
[Reference: Annex I: Table 3.2.1]

Pneumonia is regarded as the most serious type of acute respiratory infection, and causes a vast number of child deaths worldwide each year. In Bangladesh, about 12 per cent of children under five

71 World Health Organization, Mortality Country Fact Sheet 2006: Bangladesh. World Health Statistics 2006.

had pneumonia in 2006, with little disparity between rural and urban areas. As shown in Figure 3.11, among the six divisions, the highest prevalence of pneumonia has been reported in Rajshahi (14 per cent) and the lowest in Khulna (9 per cent). The prevalence of pneumonia was higher in Barisal division (13 per cent) than in Sylhet (12 per cent). The prevalence of pneumonia among children under five in the richest quintile is 9 per cent, compared to about 13 per cent in the poorest quintiles (for details, see Annex I: Table 3.2.1).

Antibiotic treatment of pneumonia: One-fifth of children under five were reported to have received antibiotic treatment, with insignificant variations between rural and urban areas. Treating pneumonia with antibiotics is more common in Khulna and Dhaka (24 per cent and 25 per cent respectively), compared to other divisions. Barisal has the lowest reported use of antibiotic treatment for under-five pneumonia at just 13 per cent. The proportion of children treated for pneumonia with antibiotics increases with an increase in mother's education as well as the household's economic status. Attitudes towards treatment of under-five pneumonia with antibiotics show a remarkable variation between male-headed and female-headed households. A far higher proportion (34 per cent) of pneumonia-affected children receive antibiotic treatment in female-headed households, compared to those in male-headed households where the percentage is 21 per cent (for details, see Annex I: Table 3.2.1).

Adolescent health outcomes: comprehensive knowledge about HIV prevention

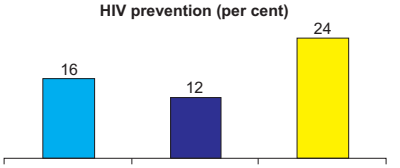
A comprehensive knowledge about HIV prevention means having accurate knowledge about HIV transmission and the measures that will prevent its transmission. Such knowledge is crucial to reduce HIV infection by half by 2015 and to combat the spread of HIV/AIDS (MDG6). Comprehensive knowledge about HIV has been used as a key indicator to measure national responses to the HIV epidemic among young people aged 15-24 years. Comprehensive knowledge includes, firstly, knowledge of two methods of preventing HIV transmission, i.e. having only one faithful uninfected sex partner and always using a condom during sex; and secondly, rejection of two misconceptions, i.e. that HIV can be transmitted by sharing food or by mosquito bites; and thirdly, understanding that a healthy looking person can have HIV.

Facts: Poor knowledge about HIV/AIDS

Bangladesh shares a border with India, which has a high prevalence of HIV/AIDS. This, coupled with lack of knowledge about HIV/AIDS, makes Bangladesh vulnerable to increased infections. Only 16 per cent of young women aged 15-24 years had comprehensive knowledge about HIV prevention. While 24 per cent of women in urban areas know how to prevent HIV infection, in rural areas only 12 per cent of women have this knowledge, and the percentage is particularly low (8 per cent) in Sylhet division. Knowledge of HIV prevention is highly correlated with women's education: illiterate women have very poor knowledge (3 per cent), followed by women with at least primary education (7 per cent). Such knowledge is relatively high (23 per cent) among women with secondary and or post secondary education

According to MICS 2006, only 16 per cent of young women aged 15-24 have comprehensive knowledge about HIV prevention. There is a huge knowledge gap (two-fold) between urban and rural young women (24 per cent compared to 12 per cent) (Figure 3.12). The highest proportions (20 per cent) of young women with comprehensive knowledge are found in Khulna and Dhaka divisions, while in Sylhet, only 8 per cent of young women have such knowledge about HIV prevention.

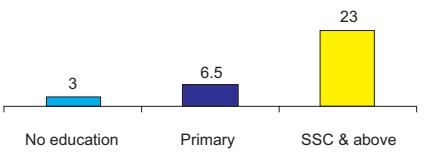
Figure 3.12: Comprehensive knowledge about HIV prevention (per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.2.2]

The level of education and wealth is closely linked to the level of knowledge on HIV. About one-quarter of educated young women who have been educated to secondary level or above have comprehensive knowledge on HIV, compared to just 3 per cent of young women with no education (Figure 3.13). The status of comprehensive knowledge about HIV prevention among young women has been found to be remarkably higher among the richest quintile (31 per cent) than among the poorest quintile, where comprehensive knowledge about HIV prevention stands at just 5 per cent.

Figure 3.13: Comprehensive knowledge about HIV prevention by educational status (in per cent)

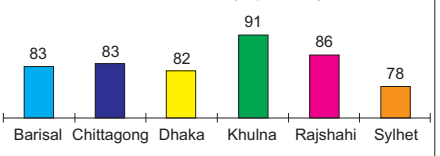


Source: MICS 2006
[Reference: Annex I: Table 3.2.2]

Child immunization: Realizing the MDG4 of "reducing child mortality by two-thirds by 2015" depends very largely on immunization. The Expanded Programme on Immunization has been functioning in Bangladesh since 1974, with six vaccines to prevent six diseases that are still the major causes of child death after diarrhoeal disease and pneumonia. According to UNICEF and WHO guidelines, a child should receive a BCG vaccination to protect against tuberculosis, three doses of DPT to protect against diphtheria, pertussis and tetanus, four doses of polio vaccine, and a measles vaccination by the age of twelve months.

MICS 2006 shows that, nationally, 84 per cent of children under 24 months have received vaccination against specific diseases with insignificant variation between boys and girls (85 per cent compared to 83 per cent). Vaccination coverage is a little higher in urban areas (86 per cent) than in rural areas (83 per cent). Spatial analysis shows that the highest proportion of children under 12 months who have been immunized against all six preventable diseases is found in Khulna (91 per cent) followed by Rajshahi (86 per cent). The lowest proportion of immunized children, compared to other divisions, is found in Sylhet (78 per cent) (Figure 3.14).

Figure 3.14: Vaccination coverage by administrative divisions in 2006 (in per cent)



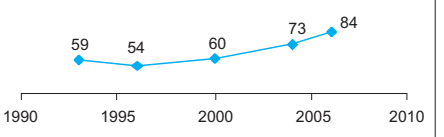
Source: MICS 2006
[Reference: Annex I: Table 3.2.3]

Facts: Spatial disparity in immunization

The child immunization programme has been recognized as the most successful health intervention in Bangladesh. However, regional disparities show that immunization for children under 24 months is relatively low (78 per cent) in Sylhet, compared to the national figure (84 per cent). The coverage is three percentage points higher in urban than in rural Bangladesh

Immunization coverage varies among the six vaccinations (nine doses for six vaccines) against six diseases. The highest coverage has been for polio vaccination. However, some variations between the doses are quite apparent. The coverage is 99 per cent for Polio 1, but falls to 96 per cent for Polio 3. The second highest coverage is for BCG vaccination (97 per cent), followed closely by DPT vaccinations with some variations between the three scheduled doses. As for polio, the coverage is highest for DPT1 (97 per cent) and the lowest for DPT3 (90 per cent). Immunization against measles does not show satisfactory coverage with relatively lower proportions of children (88 per cent) immunized. Immunization coverage has, however, been increasing over time. Overall vaccination coverage for children aged 12-23 months stood at 59 per cent in 1993, and increased to 84 per cent in 2006 (Figure 3.15). A small gap of 3-4 per cent has been found in immunization coverage between the richest and poorest quintiles. The level of education is seen to have a positive impact on receiving vaccination against specific diseases (for detail see Annex I: Table 3.2.3).

Figure 3.15: National vaccination coverage, 1993-2006



Source: MICS 2006, BDHS 1993, 1996, 2000 & 2004
[Reference: Annex I: Table 3.2.3]

Facts: Immunization coverage for measles is low

Among six different types of vaccinations (nine doses for six vaccines) against six fatal diseases, immunization coverage does differ. Immunization coverage against measles, for example, is not high enough, with only 88 per cent of children immunized against this killer disease

Building blocks and strategy partners

The Ministry of Health and Family Welfare and the Ministry of Women and Children Affairs work hand in hand on health, and especially on child health and well-being. Although these two Government Ministries have different mandates and distinct functions and responsibilities, they have a common goal under the MDG – to achieve improvements in infant and child health and well-being.

As defined by WHO "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In Bangladesh, overall responsibility for health services and health care rests with the Government. With the Ministry of Health and Family Welfare as lead agency, the major partners and role-players are: the Ministries of Women and Children Affairs; Social Welfare; Food and Disaster Management; Industry and Labour; Education; Primary and Mass Education; and the UN agencies and NGOs that provide support and guidance for policies, programmes and resource mobilization. The responsibilities for the National Health Programme and child well-being are being undertaken by major implementing agencies including the Directorate General of Health Services, Directorate General of Family Planning, and the NNP, along with their field offices, grassroots level workers, and a large number of NGOs. The Government of Bangladesh, with the support of local NGO partners, is opening new windows of opportunity at the programme implementation level and, alongside donors and UN agencies, is working in a collaborative spirit to implement a nationwide health service network. While Government Ministries provide the overall umbrella, the implementing agencies (DGHS, DGFP, NNP and NGOs) are the cornerstones of the national health programme. The MOHFW has established close linkages between partners and collaborative agencies.

The HNPSP (2003-2010), and the National Plan of Action, 2005-2010, should be fully supported by multisectoral agencies, NGOs and donor agencies to strengthen the cause of child health in particular, and health for all in general, as these plans and programmes contain cross-cutting issues and interventions.

The policy recommendations emerging from the study are as follows:

1 Strengthen coordination and monitoring mechanisms;

2 Strengthen the mothers' education programme through new initiatives;

3 Meet resource needs locally as much as possible in collaboration with development partners (donors and UN agencies) within the given timeframe.

Child Protection

National laws, policies and key programmes

The Constitution of Bangladesh reiterates the State's responsibility to promote children's well-being and protect their rights. It recognizes equality before the law for all citizens' and at the same time, their entitlement to equal protection under the law.[72] The constitution also preserves opportunities for the State to make special provision in favour of children.[73]

On the legal front, **The Children Act 1974 and the Children Rules 1976** are the principal legislative instruments governing the protection of children and the administration of juvenile justice in Bangladesh. They deal with children in conflict with the law and children in need of protection. The Children Act of 1974 is the principal law on children, consolidating and amending the law relating to the custody, protection and treatment of children and trial and punishment of youthful offenders. This Act, along with numerous provisions for custody, protection and treatment of children, also provides for 'Juvenile Justice' when they come into conflict with the law. Defining the age of a child the Act says, *"Child means a person under the age of sixteen years, and when used with reference to a child sent to a certified institute or approved home or committed by a Court to the custody of a relative or other fit person means that child during the whole period of his detention notwithstanding that he may have attained the age of sixteen years during that period".*[74] The Act, therefore, defines a 'child' and 'youthful offender' as a person under the age of 16.

The **National Children Policy**[75] of 1994 enunciates the commitments made by Bangladesh at global conventions and also reflects the domestic initiatives for children. The Ministry of Women and Children Affairs formulated the Policy in December 1994 to protect the interests, rights and welfare of juveniles. To safeguard the interests of children and implement child-related policy directives, the National Children Council has been formed under the National Children Policy.

72 Constitution of Bangladesh, PART-III: FUNDAMENTAL RIGHTS, Article 27: Equality before law.

73 Constitution of Bangladesh, PART-III: FUNDAMENTAL RIGHTS, Article 28: Discrimination on grounds of religion, etc.

74 The Children Act 1974 and the Children Rules 1974 (Act no 39 of 1974), Government of the People's Republic of Bangladesh, June 22, 1974

75 National Children Policy 1994, Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh, December 1994.

The policy states that it is essential to adopt an appropriate programme of action for child welfare in the interest of the overall development of the country, and that everyone should participate in the task of helping every child grow into an able citizen. It defines a child as someone under the age of 14. Its objectives are as follows:

- *Ensure a child's right to live and to ensure his/her overall mental growth*
- *Help develop a child's sense of moral, cultural and social values*
- *Take necessary steps to help develop his/her family environment*
- *Ensure special support for children with disabilites*
- *Adopt policies to ensure maximum protection of children's rights at national, social, family and personal levels*
- *Ensure the legal rights of children in national, social and family activities*

The vision and long-term goal of the **Poverty Reduction Strategy (PRSP-I)**[76] for children's advancement and protection of their rights is encapsulated in the slogan "A World Fit for Children". The vision is to attain pro-poor growth and economic development that is child-centered and ensures both the basic rights and the livelihood needs of children. The PRSP adopted the following key targets to be achieved by 2007 in relation to protection of children:

- *Analyse trends of child abuse, exploitation and violence*
- *Increase coverage of programmes for vulnerable children*
- *Increase rate of under-five birth registration from 8 per cent (in 2000) to 40 per cent in 2007*
- *Reduce the percentage of early marriage by 70 per cent between 2005 and 2007*
- *Ensure juvenile justice reforms*
- *Increase awareness about safe migration, all forms of illegal trafficking and abduction*
- *Reduce all forms of ill-treatment and violence against children*
- *Protect street children from all forms of abuse and exploitation*
- *Ensure safeguards for indigenous children*
- *Increase protection of children deprived of parental care*
- *Increase necessary support services for child victims*
- *Prevent the transmission of HIV/AIDS*
- *Ensure the strict enforcement of the law*

76 Unlocking the Potential: National Strategy for Accelerated Poverty Reduction (PRSP-I), General Economic Division, Planning Commission, Government of the People's Republic of Bangladesh, October 16, 2005.

In response to Article 7 of the Convention on the Rights of the Child, **the 2004 Births and Deaths Registration Act**[77] came into force on 3 July 2006. Birth registration helps to prevent early marriage; ensure all children enrol in school at the right age; protects underage children from working, and ensures special treatment for children in the juvenile justice system.The Act provides for birth registration that adopts a cross-sectoral approach by linking it to the health and education sector. The Act requires birth certificates to serve as proof of age and identity for services such as enrolment in educational institutions, issuance of passports, and transfer of property. Certificates will be required for voter registration, issuance of driving licenses and passports, as well as for employment in government or non-government organizations. In addition, the Government of Bangladesh adopted a Universal Birth Registration strategy that provided free registration for the two years after the Act came into force. The strategy aimed to register all children by the end of 2008.

The **National Plan of Action for Children**[78] (2005-2010) sets goals to protect children from abuse, violence, discrimination and sexual exploitation, including trafficking, within the framework of government policies and programmes in this area. While this NPA covers the main aspects of child protection, it also utilizes the policies of the existing NPA against the sexual abuse and exploitation of children including trafficking. The specific goals of the NPA are to: ensure protection of children from all forms of abuse, violence, discrimination and exploitation including trafficking; build an enabling environment to secure the well-being of children, including those who are vulnerable; and ensure the provision of recovery and reintegration into society for child victims and children of adult victims of abuse, violence, discrimination and exploitation.

The Orphanages and Widows Home Act-1944[79] defines an orphan as a boy or girl, under 18 years of age, who has lost their father or has been abandoned by their parents or guardians. In the light of the **Bangladesh Abandoned Children (Special Provision) Order-1972**,[80] the Government's Department of Social Services cares for these children. In addition to these Acts, laws and policies the

77 Birth and Death Registration Act (Act no 29 of 2004), Government of the People's Republic of Bangladesh, December 7, 2004

78 National Plan of Action for Children: 2005-2010 Bangladesh, Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh, July 2006. page-77

79 Bengal Act No. III OF 1944, The Orphanages and Widows' Homes Act, 1944 (An Act to provide for the better control and supervision of orphanages, widows' homes and marriage bureaux, in Bangladesh)

80 Bangladesh Abandoned Children (Special Provisions) Order, 1972 (P.O No. 124 of 1972); the Abandoned Children (Special Provisions) (Repeal) Ordinance, 1982, Bangladesh (Ordinance No. V of 1982).

Government has enacted several laws to address violence against children such as: The Suppression of Violence against Women and Children Act of 2000; The Disability Welfare Act of 2001; The Acid Control Act of 2002; The Acid Crimes Prevention Act of 2002; The Law and Order Disruption Crimes (Speedy Trial) Act of 2002; and The Prevention of Women and Children Repression (Amendment) Act of 2003. The Government also declared 1991-2000 as the Decade of the Girl Child and an Action Plan for the Girl Child[81] was adopted during that period. In February 2002, the Cabinet approved a National Plan of Action against the Sexual Abuse and Exploitation of Children including Trafficking (NPA-SEACT) with seven themes: prevention; protection; recovery and reintegration; perpetrators; child participation, HIV/AIDS, STIs and substance abuse; plus coordination and monitoring. This policy was developed through a participatory process. The government has finalized the draft of the National Child Labour Elimination Policy 2008, seeking to phase out child labour and rehabilitate over one million children engaged in hazardous labour. The policy will provide guidelines to curb child labour and rehabilitate those involved in risky and hazardous jobs.

To address the array of abuse and violence facing children effectively, i.e., to protect them from all forms of violence and exploitation, different programmes are being implemented solely by the government with the support of many international development partners. Some key programmes are reviewed here.

Birth Registration Project: As a requirement of the 2004 Birth and Death Registration Act, the government's Local Government Division, with technical and financial assistance from UNICEF Bangladesh, is implementing the Birth Registration Project across the country. The goal of the programme is to support the establishment of a functional universal birth registration system in Bangladesh. The key specific objectives are: to ensure birth registration for all citizens of Bangladesh by 2008, and to ensure that birth certificates are used as proof of age, as a protection tool and as a means to access other relevant rights and services. The programme is focused on the children under the age of 18 who constitute 56 per cent of the population (78.4 million children):[82] as well as adults and elderly people of all ages. The total cost of the programme is Tk. 4,460.05 million (GOB Tk. 242.41 million and Partner Agencies (PA) Tk. 4,217.64 million).[83] To date, 40 per cent of the population has been registered.[84] The Government and UNICEF had hoped to achieve universal birth registration by the end of 2008, but believe that this will now be achieved by 2010.[85]

To protect street children and children without parental care from abuse, exploitation and violence and improve their lives by promoting a protective environment and child protection mechanisms, the Department of Social Services (DSS) is implementing the **Protection of Children at Risk** [Street Children and Children without Parental Care (orphaned and vulnerable children)] programme with support from UNICEF and five National and local NGOs in selected areas. The programme costs Tk. 194.18 million (GOB Tk. 44.81 million and PA Tk.149.37 million)[86] and is intended to cover vulnerable children living on the street (those who live and work on the street with or without parents or family; those who work on the street and return to a family other than their own; and those who work on the street and return to their family); and children without parental care living in institutions. A total of 389,892 street children without parental care have benefited from the programme.[87]

Empowerment of Adolescents: The overall objective of this Project is to create a culture of respect for children's protection rights. It aims to do so through the development of child rights-based and gender appropriate policies, advocacy, and changes in societal attitudes, strengthened capacity in government and civil society responses to protection issues, and the establishment of protective mechanisms against abuse, exploitation and violence. The specific objectives of the project are: to support adolescents to access peer education for life skills, including HIV/AIDS and livelihood options to protect themselves from exploitation, violence, and abusive practices, including dowry and child marriage; to establish support mechanisms for adolescents in selected areas involving their community members and community leaders; to advocate for adolescent rights; and to conduct research studies to enhance the knowledge base on adolescent-related issues, including the situation of adolescents from ethnic groups, such as those from the Chittagong Hill Tracts. The project is being implemented in 27 districts of six divisions across the country at a cost of approximately Tk. 44

81 Samata, Bangladesh Decade Action Plan for the SAARC Decade of the Girl Child 1991-2000, Ministry of Social Welfare, Government of the People's Republic of Bangladesh.

82 Child Protection Section, UNICEF, Dhaka, Bangladesh, August 2008

83 Local Government Division, Ministry of LGRD and Cooperatives, Government of the People's Republic of Bangladesh

84 Child Protection Section, UNICEF, Dhaka, Bangladesh, August 2008

85 UNICEF, Bangladesh, online>> 6 September 2008>> http://www.unicef.org/bangladesh/protection_4541.htm

86 Child Protection Section, UNICEF, Dhaka, Bangladesh, August 2008

87 Child Protection Section, UNICEF, Dhaka, Bangladesh, August 2008

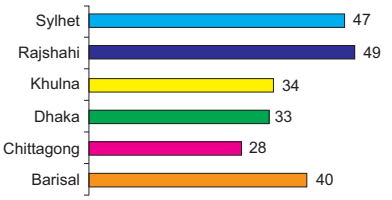
million, with UNICEF providing 90 per cent of the funding with EC support. Around 70,000 adolescents from rural areas – 70 per cent of them girls – are being reached via 2,680 adolescent centres.[88]

Sarkari Sishu Sadan/Sishu Paribar (State Orphanages).[89] This programme is being implemented by the Department of Social Services under the Ministry of Social Welfare. There are 74 state-run orphanages in the country where orphaned children aged five to nine are admitted through an admission committee. The objective of this programme is to provide the necessary education, training and other facilities to orphaned children in a family environment so that they can become active citizens in the future. At the centres they are provided with education, training, and healthcare facilities free of charge. At present, there are about 10,000 orphaned children being brought up in those orphanages and nine more orphanages are being established to accommodate an additional 900 children. Since the 2001-2002 financial year, a total of 30,100 orphaned children have been rehabilitated through this programme. Another programme – Baby Homes[90] – has been implemented by the same ministry since 1981. In six Baby Homes in the country's six divisional cities, abandoned children and children without parental identity aged 0-5 are brought up and later sent to the State orphanages. These homes house about 560 orphaned babies.There are three integrated Juvenile Corrections Centres[91] in Bangladesh, each including a permanent Juvenile Court. They are known as Kishore Unnayan Kendra (KUK) and have a combined capacity of 500 children. In the last five years about 3,000 adolescents have been rehabilitated from these centres. Plans to establish two more centres for girls have been approved.

Child outcomes, disparities and gender inequality: causality and correlation

Birth Registration: Universal birth registration is essential to the protection of children's rights, either protecting them from adverse situations and activities that might harm them, or allowing them to enjoy such rights as education and health, and other child-friendly benefits and treatments. The MICS 2006 found a low level of birth registration (36 per cent) for children aged 0-4, but no substantial disparities between boys (37 per cent) and girls (36 per cent) or between rural and urban locations (36 per cent vs 35 per cent). However, sharp disparities were seen in birth registration of under-five children across the administrative divisions. Birth registration is relatively higher in Rajshahi and Sylhet (49 per cent and 47 per cent respectively), lower in Khulna and Dhaka (34 per cent and 33 per cent), and lowest in Chittagong (28 per cent) (Figure 3.16). This low level of birth registration indicates the system has yet to be as effective as was expected.

Figure 3.16: Birth registration of under-5 children by divisions, 2006 (in per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.3.1]

When it comes to household size, there are no significant differences in the percentage of children aged 0-4 living in households with any number of members above three. The lowest percentage of birth registration (30 per cent) is found in households with fewer than three members. Similarly, there is no appreciable difference in childbirth registration between households where women have no education and households where they do, or across the different levels of education. However, a discernible gap of 6 percentage points is found between the households having women with education, and women without education. Birth registration is higher in female-headed households (66 per cent) than in male-headed households (64 per cent).

Surprisingly, birth registration of children aged 0-4 appears higher among households in the poorest quintile compared to households in the wealthiest quintiles (39 per cent compared to 36 per cent). Birth registration maintains an inverse relationship with the

Facts: Birth registration – a long way to go

As of 2006, only 36 per cent of all children in Bangladesh were covered by the birth registration programme. Birth registration of under-five children is highest (49 per cent) in Rajshahi division and lowest (28 per cent) in Chittagong division

88 Child Protection Section, UNICEF, Dhaka, Bangladesh

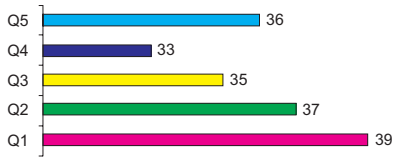
89 Ministry of Social Welfare, Government of the People's Republic of Bangladesh>> http://www.msw.gov.bd/pdf/Program_Protection_Integration.pdf

90 Ministry of Social Welfare, Government of the People's Republic of Bangladesh>> http://www.msw.gov.bd/pdf/Program_Protection_Integration.pdf

91 Third and Fourth Periodic Report of the Government of Bangladesh under the CRC, MOWCA, Government of the People's Republic of Bangladesh, August, 2007, page-84.

socio-economic condition of the households. In other words, birth registration declines as the household wealth quintile rises (Figure 3.17).

Figure 3.17: Birth registration of under-5 children across the wealth quintile, 2006 (in per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.3.1]

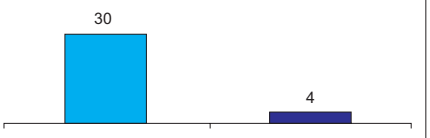
A closer look, and particularly at birth registration documents, reveals a different picture, however. At the time of survey, only about 10 per cent of households were able to show birth registration cards. If such cards are not considered as part of the equation, birth registration rises to 36 per cent. Birth registration seems to rise alongside household wealth if measured by the ability to produce an actual registration card.[92]

Child birth registration was higher among indigenous communities than in the Bangalee population 48 per cent compared to 36 per cent respectively. Among the indigenous communities, it was the highest in the Garo community (59 per cent) and lowest for the Saontals (40 per cent). On the other hand, in terms of religious communities, child birth-registration was higher among the Christians (51 per cent) followed by Buddhists (47 per cent) and lowest among the Hindus (34 per cent). Among households experiencing illness and disability, birth registration stood at 40 per cent. In terms of family vulnerability, no substantial variations are seen among households where there are single parents, orphaned children or older people aged 70 or above. The detailed data on birth registration can be seen in Annex I: Table 3.3.1.

Orphanhood and child vulnerability: Orphaned children are considered to be more vulnerable than other children because they may lack proper care, nourishment, and security. About 6 per cent of children aged 0-17 in Bangladesh have been orphaned with more girls in this position than boys. An analysis of the age specific distribution of orphaned children (boys and girls) shows that a higher proportion are aged 10 to 17, compared to those aged 0 to 9.

A higher proportion of orphaned children live in urban areas, where 6.4 per cent of children are in this position, compared to 5.6 per cent in rural areas. The largest numbers of orphaned children live in Sylhet division followed by Chittagong and Dhaka. The concentration of orphaned children is much higher in female-headed households (30 per cent) than in male-headed households (4 per cent) (Figure 3.18). There does not seem to be any significant relationship between the educational status of women, household wealth and orphanhood of the children (for more details see Annex I: Table 3.3.2). MICS did not collect data on child vulnerability in Bangladesh, and it is not, therefore, possible to sketch the child vulnerability scenario at present.

Figure 3.18: Distribution of orphaned children by HH type, 2006 (in per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.3.2]

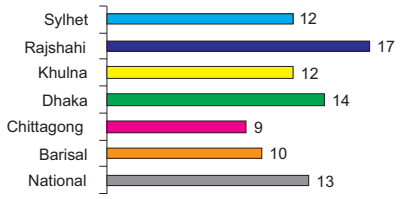
Facts: Large numbers of orphaned children

Six per cent of all children under the age of 17 are orphans. More orphaned children (30 per cent) are found in female-headed households, compared to just 4 per cent in male-headed households. Most orphaned children are aged 10 to 17, and a higher proportion live in urban, rather than rural, areas

Child Labour: MICS data shows that around 13 per cent of children aged 5-14 in Bangladesh are involved in child labour and, of these, only 2.5 per cent receive any pay for that labour. The vast majority are unpaid. About 13 per cent of children are involved in child labour in rural areas, compared to 11 per cent in urban areas. There are major disparities in the distribution of child labour across the administrative divisions. The highest proportion of child labour is found in Rajshahi (where 17 per cent of children are labouring), followed by Dhaka (14 per cent), and is lowest in Chittagong (9 per cent). Almost twice as many boys are working than girls (Figure 3.19). Regardless of sex, the prevalence of child labour among children aged 13 to 14 is twice as high as among those aged 5 to 11.

92 Multiple Indicator Cluster Survey (MICS) 2006, p99-100

Figure 3.19: Prevalence of child labour in Bangladesh (in per cent)



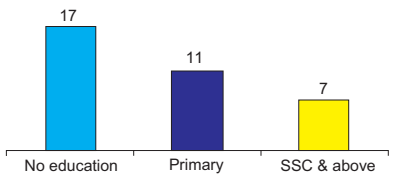
Source: MICS 2006 [Reference: Annex I: Table 3.3.3]

Facts: Child labour in Bangladesh – 2006

About 13 per cent of children aged 4 to 14 are engaged in child labour and 97.5 per cent of them are unpaid. The percentage of children in child labour is highest in Rajshahi division (17 per cent) followed by Dhaka division (14 per cent). The proportion is lower in Chittagong division (9 per cent). Child labour is twice as high among boys than girls in every age group, and twice as high among those aged 13 to 14 as among those aged 5 to 11

No direct relationship is shown between household size and prevalence of child labour. The prevalence of child labour is almost twice as high in households with fewer than three members, compared to higher household sizes. There are no apparent differences in the prevalence of child labour between households that are headed by men or women. However, there is a distinct correlation between child labour and the educational attainment of the mother. The prevalence of child labour is perceptibly higher in households where the mother is not educated or does not have formal education, compared to households where the mother has primary education (17 per cent vs. 11 per cent). As the level of the mother's education rises to secondary level and above, child labour falls by an even greater extent (17 per cent vs. 7 per cent) (Figure 3.20). A strong correlation is evident between child labour and the poverty status of households, with child labour falling as household affluence rises. The occurrence of child labour is twice as high in the poorest households as it is in the wealthiest (16 per cent vs. 8 per cent).

Figure 3.20: Prevalence of child labour by womens' education (in per cent)

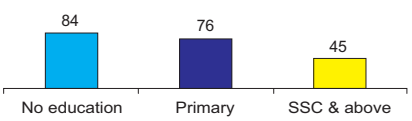


Source: MICS 2006 [Reference: Annex I: Table 3.3.3]

A diverse relationship is observed between child labour and the religion and ethnicity of the households where children live. Child labour is high in Christian households (18 per cent), less so in Buddhist households (9 per cent). Likewise child labour is high in the Garo community (21 per cent), and lowest in the Marma community (9 per cent). Moreover, 14 per cent of children living in households where there is disability or illness are involved in child labour, with a similar figure for children in households with a single parent, an orphaned child or a person aged over 70 (for details, please see Statistical Template 3.3.3).

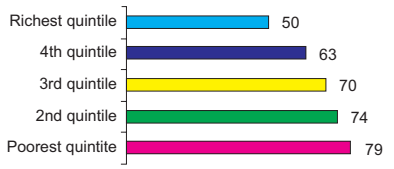
Child marriage: The legal age for marriage in Bangladesh is 18 years for girls and 21 years for boys, but a large proportion of marriages take place earlier. MICS 2006 data indicate that 39 per cent of the young women aged 15-19 years at the time of survey were married and 64 per cent of women aged 20-24 had been married before the legal age of 18 years. However, the proportion of women aged 15-49 years marrying before the age of 15 has declined more than three-fold, from 56 per cent to 16 per cent over the last decade, and the proportion of women marrying before 18 has declined more than two-fold from 85 per cent to 39 per cent. The prevalence of child marriage is higher among rural inhabitants compared to their urban counterparts (36 per cent vs. 27 per cent before the age of 15 and 71 per cent vs. 58 per cent before the age of 18). There are also variations in age at first marriage across the administrative divisions. Child marriage is highest in Rajshahi (75 per cent) and Khulna (74 per cent) divisions and lower in Chittagong (57 per cent) and Sylhet (49 per cent).

Figure 3.21: Incidence of early marriage by mothers' education (in per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.3.4]

Figure 3.22: Incidence of early marriage by economic status (in per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.3.4]

Facts: The scale of child marriage remains alarming

About 39 per cent girls between the age of 15 and 19 years were married before the minimum legal age of 18 years. Another 64 per cent of women aged 20-24 years were married before the legal age limit. More girls in rural areas are married before the age of 15 (36 per cent) than in urban areas (27 per cent). And 71 per cent of girls in rural areas are married before the legal age limit, compared to 58 per cent of girls in urban areas. Child marriage is high (75 per cent) in Rajshahi division, falling to 57 per cent in Chittagong division, and 49 per cent in Sylhet division

Age at first marriage varies by household size, mother's education (Figure 3.21), the gender of the head of the households, the wealth of the households (Figure 3.22), religion, ethnicity and so on. In general, child marriage rises as the size of the household increases. But this trend does not apply for two categories of households: those with fewer than three members and those with more than seven. In households with fewer than three members, up to 43 per cent of girls are married before the age of 15, and 75 per cent before the age of 18. In households of at least seven members, these figures fall to 27 per cent and 59 per cent respectively.

This seems to contradict the patriarchal nature of society of Bangladesh. As the present study was carried out on the basis of secondary data/information, it is imperative that further research is undertaken to help us understand this puzzle.

There is a little variation in age at first marriage among households where the mother has no education, or only the lower level of education. However, fewer girls are married before the age of 18 in households where the mother has been educated up to secondary level and beyond (45 per cent). Child marriage is relatively higher in male-headed households than in female-headed households (67 per cent vs. 62 per cent). A direct correlation is observed between household wealth and child marriage, which is more frequent among households in the lowest wealth quintile (79 per cent), falling to 50 per cent in the wealthiest quintiles. Child marriage is relatively higher in Muslim and Hindu families, at 68 per cent and 56 per cent respectively. It is lowest in Buddhist households, at 28 per cent. The prevalence of child marriage is notably higher (at more than 65 per cent) in households where there are children with disabilities and orphaned children and where there are people aged over 70 (54 per cent). The detailed data on child marriage can be seen in Annex I: Table 3.3.4.

Building blocks and strategy partners

The *National Strategy for Accelerated Poverty Reduction* (the PRSP) has enlisted a number of key role players to deal with the cross-cutting issue of child protection, an issue that has been gaining momentum in recent years. The top government agencies with the power to make a difference are working together as partners on child protections issues. These are the Ministries of: Women and Children Affairs; Law, Justice and Parliamentary Affairs; Home Affairs; Labour and Employment; Social Welfare; Youth and Sports; the Local Government Division; and the Ministry of Information. These government agencies are mandated to adopt necessary measures to protect children from direct and indirect abuse, exploitation and violence of all sorts. They are interconnected for this purpose both morally and legally. These Ministries, alongside NGOs, work on the 'Empowerment of Adolescent' programme and in building 'Shishu Paribar' at the grassroots level. There is a need to expand these two vital programmes to protect children at risk. In addition, the Birth Registration Project should be considered for extension as it is making a clear contribution to child protection and welfare.

The Ministry of Women and Children Affairs is the lead Ministry on child protection, providing technical guidance to other partner ministries and agencies and to NGOs, and coordinates their supportive role in fulfilling the objectives set out in the PRSP. Ministries implement the national child protection programme through their Directorates, field offices and grassroots level workforce. NGOs and UN as well as donor agencies play a collaborative role and actively support the government's child protection activities. The key players interact with each other through national committees, making direct contact for concerted efforts and better coordination.

Child Protection is a social responsibility and any noticeable improvement in this area is largely dependent upon changes in the mindsets and attitudes of individual family members, especially parents and guardians. As such, the greater involvement of community, civil society and NGOs is needed to build up the social movement for the effective protection of children. If this is done, it will make a real difference to prevailing child protection in Bangladesh.

Education

National laws, policies and key programmes

The **Constitution of Bangladesh** envisages effective measures to establish a uniform, mass-oriented and universal system of education and to extend free and compulsory education to all children.[93]

Primary Education (Compulsory) Act 1990: To fulfil the constitutional obligation of Universal Primary Education, the Government promulgated the Primary Education (Compulsory) Act 1990.[94] The Act is a landmark piece of legislation that provides legal guarantees to the child's right to education. While making primary education free and compulsory for all children up to Grade 5, the Act also determines the age of formal primary education as between 6-10 years. To implement this Act and to coordinate, monitor and observe the progress of its implementation at field level, a Compulsory Primary Education Implementation Cell/Unit was created under the Ministry of Education in 1990.[95] The government created the Primary and Mass Education Division in 1992 to address management issues and prioritise primary education. The division has the status of an independent ministry and is responsible for the Compulsory Primary Education Implementation Monitoring Unit. This Unit was engaged in the overall supervision of implementation of the Compulsory Primary Education programme that began nationwide on 1 January, 1993.

National Education Policy 2000: The Education Policy of 2000 adopted the following key objectives on child education:

- *Suggests a one-year course of pre-primary education to stimulate the child's interest in education and school*
- *Primary education should be universal, compulsory, free and of the same standard for everybody*
- *The duration of primary education will be extended gradually to six years by 2003, seven years by 2006, and eight years by 2010*
- *The Rule of Admission into Class I at the age of 6+ will be made compulsory*
- *The ratio of teachers to learners will be 1:40 in primary and secondary levels*
- *Aiming at providing education to dropouts, children aged 8 to14 should be enrolled in non-formal education to ensure that they receive schooling*
- *Secondary level education will consist of classes 9 to 12, instead of 6 to 10*
- *There will be provision for technical and vocational education in the madrasahs (religious education institutes)*

Education for All: National Plan of Action (NPA I): Following the World Conference on Education For All (EFA), meeting in Jomtien, Thailand in March 1990, Bangladesh prepared its first EFA National Plan of Action (NPA I)[96] covering the period 1991-2000. Using 1991 as the base-year, the NPA sets the following targets:

- *To raise the gross enrolment rate at the primary level from 76 per cent to 95 per cent*
- *To raise girls' gross enrolment rate at the primary level to 94 per cent*
- *To raise the completion rate at the primary level from 40 per cent to 70 per cent*
- *To raise the adult literacy rate from 35 per cent to 62 per cent; and*
- *To increase the female literacy rate from 24 per cent to 50 per cent by 2000*

In line with the EFA goals, NPA I covered five major basic education programme areas: Early Childhood Education and Development; Universalization of (Formal) Primary Education; Non-formal Basic Education; Adult Education and Continuing Education. Female Education and Gender Equity cut across all five programmes and are described in a separate chapter. NPA I ended in June 2000.

Education for All: National Plan of Action (NPA II): The Government of Bangladesh made commitments at the World Education Forum (Dakar, April 2000) towards the achievement of EFA goals and targets for every citizen by the year 2015. In line with the

93 The Constitution of Bangladesh, Part II, Fundamental Principles Of State Policy: Article-17- Free and compulsory education (a, b, c).

94 The Primary Education (Compulsory) Act-1990 (Act No. 27 of the Parliament, 1990), Government of the People's Republic of Bangladesh, February 13, 1990

95 Ministry of Primary and Mass Education, Government of the People's Republic of Bangladesh. Online. http://www.mopme.gov.bd/CPEIMU_background.htm

96 The National Plan of Action on Education (1991-2000) - Bangladesh, MOPME, Government of Bangladesh.

objectives of the Dakar Framework for Action and achievements of NPA I, and basic education needs of the country in 2001, Bangladesh prepared another National Plan of Action for EFA (draft)[97] with a specific set of goals to be achieved by 2015. The Ministry of Primary and Mass Education started work on the development of NPA II early in 2001 in the context of the aforesaid framework by using UNESCO guidelines for preparation of national plans. The Plan was drafted in May 2003. NPA II had four major objectives, as follows:

- *Institute a well organized and coordinated programme of early childhood care and education for the most vulnerable and disadvantaged children, using both formal and non-formal approaches, with an emphasis on family and community-based programmes*
- *Bring all primary school-age children into school, particularly girls, those with disabilities, those in difficult circumstances and those from ethnic minorities, and enable them to complete a free, compulsory primary education of good quality*
- *Establish programmes of appropriate learning and life-skills to meet the learning needs of all young people and adults, and ensure access, participation and successful completion of relevant courses*
- *Sustain and enhance the near gender-parity found at present in primary education and above parity for girls in secondary education, to achieve gender equity in education by 2005 and gender equality in 2015, by ensuring full and equal access of boys and girls to and the achievement of a basic education of good quality*

The country has already undertaken the major Primary Education Development Programme-II (PEDP-II) programme on the basis of the Dakar Framework and the proposed National Plan of Action (NAP-II).

Bangladesh: Poverty Reduction Strategy Paper (PRSP-I): The first PRSP[98] sets different goals, objectives and targets to be achieved during its implementation period at different levels of education such as primary, secondary, madrasah, technical and non-formal education. The key objectives and targets are as follows:

- *To ensure that all children of age five – irrespective of geographical, socio-economic, ethnic-linguistic, gender, physical and mental capabilities and other characteristics – as well as poor achievers are brought to school and complete the primary education cycle.*
- *School attendance and the completion rate have to be improved substantially.*
- *Primary education has to be made available to all dropouts and left-out boys and girls.*
- *The quality of primary education, including madrasah education, has to be improved so that the competency rate doubles by 2007.*
- *Finally, attention must be paid to maintain gender equality*

Further actions to be taken are:

1. ensure one primary school for every 1,500 people;
2. develop and fund programmes to extend educational coverage, in cooperation with NGOs;
3. support modernization and quality improvement of ibtidayee (primary level) madrasahs;
4. apply quality standards such as physical facilities, learning aids, formation of the managing committee, student-teacher ratio, and involvement of the community in all primary institutions;
5. review the teaching-learning model, recognizing that a large proportion of the pupils – especially the poor – will not go beyond primary education, and that the foundation of literacy and numeracy skills and basic knowledge must be built in the meantime;
6. introduce English language teaching from class one;
7. harmonise regular and madrasah education curriculum; and effectively implement PEDP II to ensure, in particular, quality improvement in primary education.

Secondary Education: For secondary education, the targets to be achieved during the PRSP period in terms of both access and quality are to:

- *Increase access to secondary education by increasing gross enrolment rates by 50 per cent for all levels of secondary education and reduce dropouts by half*
- *Improve the quality of education at the secondary level by enhancing the SSC and HSC pass rate to*

97 Education for All: National Plan of Action II (2003 – 2015) (Draft), MOPME, Govt. of Bangladesh.

98 Unlocking the Potential: National Strategy for Accelerated Poverty Reduction (PRSP-I), General Economic Division, Planning Commission, Government of the People's Republic of Bangladesh, October 16, 2005. The PRSP was adopted in October 2005 to cover the period 2004-2007. The NEC meeting of 30 April 2007 agreed to extend the PRSP to June 2008. The PRSP II "Moving Ahead" has been developed for the period 2009-2011.

at least 65 per cent for both male and female students by the year 2008

- *Ensure a gender balanced approach in the formulation of the curriculum by removing negative images, if any, from the existing curriculum and project a positive image of women and household activities in the curriculum*
- *Improve enrolment, attendance and completion rates among students from poor families by reducing their dropout rate by 50 per cent*
- *Ensure sustainable gender parity in secondary and post-secondary education by making male-female student enrolment ratios equal, ensuring gender equality in completion rates, and making schools girl-friendly*

The PRSP also suggests actions to be taken in the secondary sub-sector of education, such as:

1. make secondary education up to Class X into one unified stream with an adequate focus on communication skills, science and mathematics for all students;
2. undertake a sub-sector development programme for the under-served groups;
3. build new schools based on school mapping and build a model high school in each upazila within 10 years;
4. ensure that NCTB is concerned only with curriculum development and that it has permanent professional staff;
5. apply common minimum standards of inputs and performance in all types of schools;
6. ensure that the teacher-student ratio does not exceed 1 to 40, that competent teachers are appointed, that new schools have libraries, laboratories, toilets, drinking water and other facilities, that all teachers have periodic in-service professional upgrading; and that there is common core content in the curriculum of all secondary level institutions;
7. restrict or, if possible, eliminate private tutoring by teachers and at the same time enhance their salaries;
8. make public examinations and internal assessment mutually complementary and more oriented towards the diagnosis of weaknesses of individual learners, institutions and the system, taking remedial measures rather than branding a large number of students as failures. School-based assessment, currently under implementation, is a move in the right direction and finally;
9. attention must be given to curriculum development in terms of making it gender sensitive. It also needs to pay attention to environmental and reproductive health issues. The curriculum at the intermediate level is in the process of being revised.

The goals and objectives in the PRSP to achieve Technical and Vocational Education include: increasing the proportion of post-primary students who enrol in technical and vocational education; a special stipend programme for women's education in science and technical and vocational education; and increasing enrolment in technical and vocational education by 50 per cent, and female enrolment by 60 per cent by 2007.

Key programmes in the education sector

The emphasis of education interventions is, for the most part, on maintaining the current enrolment rate in primary education and increasing enrolment at secondary levels; reducing dropouts and increasing completion rates to substantial levels in both primary and secondary education; improving the quality of education at all levels and streams; and reducing gender gaps at all levels. There is also an emphasis on including children with disabilities, as far as possible, in mainstream educational institutions. The following programmes are some of the key government initiatives to address these issues.

Primary Education Development Programme II (PEDP-II): The Government has launched the largest multi-year, multi-component education programme for the period 2004-2009, to improve the quality of students' learning achievements while ensuring the Primary School Quality Level standard. Following the completion of all the PEDP I projects, including IDEAL, the Primary Education Development Programme II (PEDP-II) was launched in September 2004 with a focus on four key areas: increasing the number of classrooms and improving the related infrastructure and classroom environment; enhancing training and other incentives for teachers to enable them to teach effectively; systematizing teacher recruitment procedures so that qualified teachers are recruited; and finally, strengthening management practices in schools, devolving education planning and administration to district levels and linking education financing to school performance. The PEDP II represents a major operationalization of a key part of

the Government's Education for All and poverty reduction agenda, which are both linked to the MDGs. The total cost of the Programme is Tk. 74,929.70 million, with the Government of Bangladesh contributing Tk. 24,973.30 million and the ADB-led 11-member Donor Consortium (including the World Bank, NORAD, SIDA, CIDA, EC, DFID, The Netherlands, UNICEF, Aus-AID, and JICA) contributing the remaining Tk. 49,956.40 million.[99] The Directorate of Primary Education of the Ministry of Primary and Mass Education is implementing the Programme with support from the Local Government Engineering Department (LGED). PEDP-II is being implemented in all 64 districts covering approximately 17.7 million children and 280,000 teachers in 61,000 schools.

Primary Education Stipend Project (PESP): This is the single largest project in the education sector in Bangladesh and is being implemented from July 2002 to June 2008 with the following key objectives:

- *to increase the enrolment rate of all primary level school age children from poor families*
- *to increase the attendance rate of enrolled primary school students*
- *to reduce the dropout rate of enrolled primary school students*
- *to establish equity in the financial assistance provided to all primary school age children*
- *to enhance the quality of primary education*

Every year, around 5.5 million students receive stipends from this project. The Government of Bangladesh is covering all the project costs: Tk. 33,123.12 million for the current phase. The Directorate of Primary Education of the Ministry of Primary and Mass Education implements the project nationwide. A selected 40 per cent of pupils enrolled in Grades 1-5 from the poorest households receive cash assistance through a stipend throughout rural Bangladesh. The households of these pupils receive Tk. 100 for one pupil and Tk. 125 per month for more than one pupil (not to exceed Tk. 1,500 annually). To continue to participate in the project, a school must demonstrate at least 60 per cent pupil attendance, and 10 per cent of its Grade 5 pupils must sit for the Primary School Scholarship Examination. At present, the project is being implemented in 469 upazilas across the country.

Reaching Out of School Children (ROSC): In line with the National Plan of Action for Education for All (2001-2015), which embraces all of the goals of Education for All, the Reaching Out of School Children (ROSC) project was launched to cover a six year period from July 2004 to June 2010. Although the PEDP was launched in 2003 to reach commitments made in relation to EFA and the MDGs, it does not incorporate the non-formal education system, which caters for the education of about 10 per cent of those children who do not have access to formal education, often as a result of poverty. The ROSC project aims to address this gap. Children who never enrolled in formal schools or dropped out of school have been targeted to enrol in ROSC learning centres. The main objective is to reduce the number of out of school children through improved access to quality education in support of the government's national EFA goals. In line with PEDP II, the project would use demand-side mechanisms to support the government in achieving these goals. In particular, the project aims to: (i) provide access to primary education and ensure retention of disadvantaged children who are currently out of school; (ii) improve the quality and efficiency of primary education, particularly for out of school children; and (iii) build and strengthen the capacity of learning centres and related infrastructure.

The project provides education allowances for these children to support the continuation and completion of their schooling. The project also provides grants to the school/learning centres to improve the overall quality of education and services provided. The project strives to establish a sound structure for the management and implementation of the project, strengthening the capacity of service providers to deliver quality services and of the community and other relevant stakeholders to monitor and manage the project. The total cost of the programme for the current duration is Tk. 3,830.19 million, with the Government of Bangladesh providing Tk. 236.84 million and the donors (the World Bank and SDC) providing the remaining Tk. 3,593.35 million. Half a million out of school children aged 7 to 14 years of age are now benefiting from the programme, across 60 upazillas in 34 districts of six divisions that are relatively disadvantaged in terms of net enrolment rate, primary cycle completion rate, level of poverty, and gender inequity. Since the inception of the programme, 10,938 learning centres have been established, creating access to primary education for 352,274 children of whom 174,488 are female.[100]

99 Annual Development Programme 2008-2009, Planning Commission, Government of the People's Republic of Bangladesh.

100 Bangladesh Economic Review 2007, Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-157.

Female Secondary School Assistance Project, Phase-II (FSSAP-II): In line with MDG3, this programme aimed to increase the enrolment of girls in secondary education at a cost of Tk. 5029.90 million[101] from July 2005 to December 2008. Under the programme, cash grants, book allowances and examination fees (for secondary school certification) and tuition fees for all girls in secondary schools (5.171 million girls) were given to provide special facilities for girls' education in inaccessible and disadvantaged areas and for the poorest of poor girls. At present, the programme has brought 119 selected upazilas of 61 districts of Bangladesh under its coverage, and 6,666 schools – many more than originally targeted – are participating in the programme through a cooperation agreement with the Ministry of Education. To empower women and to enhance their socio-economic status through expansion of female education, the Government has waived tuition fees for female stipend-holders up to the twelfth grade.[102] As a result of the programme, female enrolment as a share of total enrolment increased from 33 per cent in 1991 to 48 per cent in 1997 and to 56 per cent in 2005. Secondary School Certificate pass rates for girls in the project areas increased from 39 per cent in 2001 to 58 per cent in 2006. The ratio of male to female students at secondary level is now 47:53.[103]

School Feeding Programme: To create an enabling environment for education, School Feeding Programmes are being implemented with the support of the World Food Programme in highly food-deficit districts. Under this Programme, 75 grams of fortified biscuits are being supplied to 600,000 primary school students once each day.

The budgetary allocation for the education sector has been increasing over time and the total budgetary allocation for the education sector was Tk. 93,622 million and Tk. 109,646 million in 2005-2006 and 2006-2007 respectively. The total revenue expenditure and development expenditure in education sector were Tk.79,947 million and Tk. 29,699 million in 2006-2007 respectively. This financial allocation was spent on a number of interventions such as pre-primary schooling, primary education, secondary and higher secondary, and tertiary education, as well as on other types of education such as medical, nursing, and cadet college education (for details see Policy Templates 2 and 7).

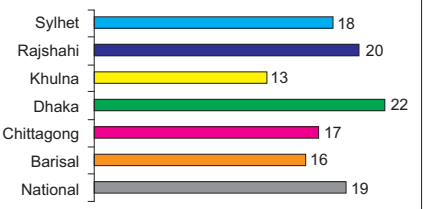
101 Annual Development Programme 2008-2009, Planning Commission, Government of the People's Republic of Bangladesh.

102 Bangladesh Economic Review 2007, Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-157.

103 Bangladesh Economic Review 2007, Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-157.

Child outcomes, disparities and gender Inequality: causality and correlation

Figure 3.23: Education deprivation in primary school by division (in per cent)



Source: MICS 2006 [Reference: Annex I: Table 3.4.1]

Education is a crucial element in economic and social development, and its importance for poverty reduction is well documented. Without education, development can be neither broad based nor sustained. It is one of the basic primary rights but is being denied to millions of children. MDG2 for the achievement of universal primary education and MDG3 for the promotion of gender equality and empowerment of women by 2015 are closely linked. Universal primary education cannot be achieved without gender parity, while gender parity in primary education makes little sense if there is a low level of participation of both boys and girls. The Government of Bangladesh made primary education compulsory in 1990, and, to encourage education for all and for girls in particular, schooling up to higher secondary level is free for girls, and primary level is free for both boys and girls. Though considerable progress has been made in expanding primary education, a major concern is the high dropout rates in the first few years of schooling.

The infrastructure for primary education in Bangladesh is in a better situation for the achievement of universal primary education. In 2005, there were 80,401 primary schools where 16.23 million students were enrolled and 344,789 teachers were employed. Analysis of MICS 2006 data shows that 19 per cent of children of primary school age (6-10 years) are deprived of enrolment in school (Figure 3.23). Such deprivation is almost identical for children living in rural and urban areas. Geographically, deprivation is relatively higher in

Facts: Proportion of children who are out of school

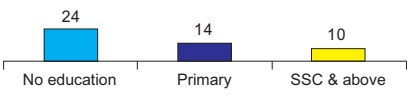
Currently, almost one-fifth of primary education age (6-10 years) children are deprived of school enrolment. This deprivation is highest in Dhaka (22 per cent) followed by Rajshahi (20 per cent) and Khulna (13 per cent)

Dhaka (22 per cent) followed by Rajshahi (20 per cent) with the lowest in Khulna (13 per cent). (Figure 3.23)

The correlation between household size and education deprivation of children is disproportionate. The highest incidence of education deprivation has been found among households with less than three members and the lowest among households with 3-4 members. Children living in male-headed households are more likely to be deprived of education than those in female-headed households (21 per cent vs. 16 per cent).

There is a direct correlation between education deprivation and children living in households where the mother is not educated. In households, where the mother has no education or receives education through non-standard curriculum education, the percentage of children deprived of education ranges between 23 per cent and 24 per cent, compared to 14 per cent in households where the mother has primary education. The figure is even lower (10 per cent) in households where the mother has secondary or post-secondary education (Figure 3.24). Poverty is a key determinant

Figure 3.24: Education deprived child by mothers' education (in per cent)



Source: MICS 2006
[Reference: Annex I: Table 3.4.1]

Facts: A mother's education reduces the educational deprivation of children

Like most outcomes, child education has a direct positive correlation with the education of mothers. About one-quarter of children with illiterate mothers are education-deprived. This falls to 14 per cent for children whose mothers have at least the primary level of education. Education deprivation declines still futher, to 10 per cent when mothers have secondary or post-secondary education

in whether children have access to school or not. Children from the poorest households are twice as likely to suffer education deprivation (27 per cent) than those from the wealthiest households (13 per cent).

There are variations in education deprivation by religion and ethnicity. Deprivation is lower among Hindu children (15 per cent) than it is among Christian children (24 per cent). However, one-fifth of the children from Muslim and Buddhist households are also deprived of education. Massive disparities can be seen among ethnic groups. Nearly half of all the Saontal children are out of school followed by the Tripura community (41 per cent). The percentages are lower again among children of Bangalee and Chakma communities. More than one in four children from households with disabilities or illness, and one in five from households with a single parent or orphaned child, are deprived of education. For detailed data on child education see Annex I: Table 3.4.1.

Building blocks and strategy partners

The education sector – the foundation of human resource development – is a high priority, and has, traditionally, accounted for a large share of the Government's national budget, never falling below 15 per cent.[104]

Education, one of the most important fundamental rights of every citizen, is deemed to be a public-private sector initiative – a responsibility that is shared by the Government, non-government organizations/agencies and private entrepreneurs. To promote the cause of education nationwide, primary and mass education, female education, vocational and technical education have been spread through an implementation network led by the Ministry of Education, and with agencies such as the Ministries of Primary and Mass education; Women and Children Affairs; Youth and Sports; Labour and Employment; Expatriate Welfare and Overseas Employment; Science and Information and Communication Technology; and the Directorate of Technical Education as supporting partners. UN agencies and donors have extended massive support to the Government and NGOs and this has resulted in great success in the education sector.

With a multi-dimensional approach and as a multi-sectoral programme, education stands as a central pillar for reducing both social and economic disparity, as well as alleviating poverty and ensuring overall national welfare and well-being. The Ministries noted above, along with NGOs and UN agencies, and in particular UNESCO, constitute strategic partners in reaching the MDGs. In their coordinating role, UNESCO and the World Bank establish connectivity with donor agencies eager to support the education sector in Bangladesh.

With the massive support of donors and UN agencies, and the active participation of NGOs, three big projects:

104 Bangladesh Economic Review 2008 (Bangalee Version), Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-146.

Female Secondary School Assistance Projects-Phase II; Primary Education Stipend Project (PESP); and Reaching Out of School Children (ROSC) deserve extension and expansion to sustain achievements in girls' education as well as universal primary education.

Again, the strategy of placing due emphasis on the mother's education is making a real difference in the education of children in both urban and rural areas, and this strategy should be pursued tenaciously.

Social Protection

National laws, policies and key programmes

Social protection consists of policies and programmes designed to reduce poverty and vulnerability by promoting efficient labour markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards, and interruption/loss of income.[105] For the UN Economic and Social Council, social protection is broadly understood as *"a set of public and private policies and programmes undertaken by societies in response to various contingencies to offset the absence or substantial reduction of income from work, to provide assistance for families with children as well as provide people with health care and housing".*[106]

The five main areas in social protection are:

1. Labour market policies and programmes to promote employment, the efficient operation of labour markets and the protection of workers;
2. Social insurance programmes to cushion the risks associated with unemployment, ill health, disability, work-related injury and old age;
3. Social assistance and welfare service programmes for the most vulnerable groups with no other means of adequate support, including single mothers, the homeless, or those with physical or mental disabilities;
4. Micro-and area-based schemes to address vulnerability at the community level including micro-insurance, agricultural insurance, social funds, and programmes to manage natural disasters;
5. Child protection to ensure the healthy and productive development of children[107].

105 Asian Development Bank. Online. Topics>>Social Protection>> http://www.adb.org/SocialProtection/default.asp

106 Economic and Social Council, the United Nations. Online. Enhancing Social Protection and Reducing Vulnerability in a Globalizing World: Report of the Secretary-General>> http://www.icsw.org/un-news/pdfs/csdsocprotect.PDF

107 Asian Development Bank. Online. Topics>>Social Protection>> http://www.adb.org/SocialProtection/default.asp

To provide such protection alongside the provision of basic necessities to the people, the Constitution of Bangladesh states, *"It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens:*

1. *The provision of the basic necessities of life, including food, clothing, shelter, education and medical care, and*
2. *The right to work, that is the right to guaranteed employment at a reasonable wage having regard to the quantity and quality of work".*[108]

The same section of the Constitution recognizes work as a right, a duty, and a matter of honour for every citizen who is capable of working. It also calls for the State to create such opportunities for the citizens of the country.[109]

Poverty Reduction Strategy Paper (PRSP-I): The objective of Bangladesh's Poverty Reduction Strategy (PRSP-I) is to reduce poverty substantially within the shortest possible time. The PRSP, taking into consideration Bangladesh's previous official commitment to achieve the MDGs, seeks to promote household income, well-being and social protection by the year 2015 by:

1. Removing the 'ugly faces' of poverty by eradicating hunger, chronic food-insecurity, and extreme destitution; and
2. Reducing the proportion of people living below the poverty line by 50 per cent.

The project of employment in PRSP-I assumes that the recent employment and growth relationship (4.3 per cent between 1999-2000 and 2002-2003) will be sustained through the 2007-2008 financial year.[110] The number of people in employment is projected to increase from 44.30 million in the 2003 financial year (FY) to 58.08 million in FY 2008, adding 13.78 million people to the employed pool. Of these, 9.03 million are expected to find employment in rural areas, while 4.75 million are likely to be absorbed into urban areas. These figures may have been affected by the global financial and economic crisis. During the PRSP period

108 The Constitution of Bangladesh, Part II, Fundamental Principles of State Policy, Article 15 (a, b): Provision of basic necessities. Government of the People's Republic of Bangladesh

109 The Constitution of Bangladesh, Part II, Fundamental Principles of State POLICY, Article 20 (1, 2): Work as a right and duty. Government of the People's Republic of Bangladesh

110 Unlocking the Potential: National Strategy for Accelerated Poverty Reduction (PRSP-I), General Economic Division, Planning Commission, Government of the People's Republic of Bangladesh, October 16, 2005. Page-80

(2005 to 2007), 8.02 million new jobs were estimated to be created, with 5.39 million in rural and 2.63 million in urban areas. The PRSP targets in this sector are summarized in the following table:

Table 3.2: Employment Projections (million persons), FY 2003-2008

	FY03	FY04	FY05	FY06	FY07	FY08
Total employment	44.30	46.73	48.92	51.69	54.75	58.08
Rural	33.60	34.96	36.64	38.30	40.35	42.57
Urban	10.70	11.77	12.28	13.39	14.40	15.51
New employment	-	2.43	2.19	2.77	3.06	3.33
Rural	-	1.36	1.68	1.66	2.05	2.22
Urban	-	1.07	0.51	1.11	1.01	1.11

Source: PRSP-I, page-80

Implementation Policy of the 100-Day Employment Generation Programme: This Policy Document sets out specific targets and strategic methods to implement the 100-Day Employment Generation Programme launched in 2009 by the Government under its social protection strategy for poor and vulnerable people.[111]

In Bangladesh, different kinds of safety net programmes have been implemented for years. The latest and the biggest – the 100-Day Employment Generation Programme – aims to provide employment opportunities to unemployed people in poverty prone areas, and/or unemployment allowances during the lean months of the year. Some of the key programmes in this sector are discussed below:

100-Day Employment Generation Programme: In the FY 2008-2009, the Government launched this Programme to include ultra poor people and marginal farmers in the Social Safety Net Programme during the lean months. The major objectives are: i) to create employment opportunities for the ultra poor unemployed population; and ii) to increase the purchasing power of those who are victims of global food shortages, the price hike in essentials, etc. The Programme will ensure employment for the rural unemployed poor across the country for 100 days each year and, in particular, from mid-September to November (2.5 months) and in March and April (2 months). Approximately two million people will get employment opportunities under this programme, receving Tk. 100 per day in wages and, if no work is available, Tk. 40-50 as an unemployment allowance. In FY 2008-2009, Tk. 20,000 million was allocated for the programme in the budget, the largest allocation under the entire safety net programme.

111 Implementation Policy of the 100-Day Employment Generation Programme, Ministry of Food and Disaster Management, Government of the People's Republic of Bangladesh, August 2008

Other Social Safety Net Programmes (SSNPs) in Bangladesh: Bangladesh has a robust portfolio of social safety net programmes that address various forms of risk and vulnerability and attempt to reduce poverty through direct transfer of resources to the poor. During the last two decades, the Government of Bangladesh has been pursuing a number of such safety net programmes under the following classifications.[112]

Cash transfer programmes include: the Old-Age Allowance Programme; the Allowances Programme for Widowed, Deserted and Destitute Women; the Honorarium Programme for Insolvent Freedom Fighters; the Training and Self-Employment Programme for Insolvent Freedom Fighters and their dependants; the Fund for Rehabilitation of the Acid-Burnt and the Physically Handicapped; the Allowance for the Fully Retarded; Cash transfer programmes for education; the Rural Maintenance Programme (RMP); and the Food for Works Programme (Cash).

Food transfer programmes include: the Food for Work Programme; the Vulnerable Group Development (VGD) Programme; the Vulnerable Group Feeding (VGF) Programme; and the Test Relief (TR) Programme.

Special poverty alleviation programmes include: Programmes under the Poultry and Livestock Sector to alleviate poverty; Poverty Alleviation and Micro-Credit Programmes Undertaken by the Department of Fisheries; the Fund for Housing the Homeless; the Programme for Generating Employment for the Unemployed Youth by the Karmasangsthan Bank, Abashan (Poverty Reduction and Rehabilitation) Project; the Fund for Mitigating Risks due to Natural Disasters; the Programme for Mitigating Economic Shocks; Programmes for Reducing Poverty and Generating Employment under the Ministry of Women and Children Affairs; and the Fund to meet Temporary Unemployment.

112 Bangladesh Economic Review 2007, Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, pp-181-195.

Micro-credit programmes for self-employment:[113] The Government has taken up a few special credit programmes under both revenue and development budgets to create employment for the poor. Up to December 2006, micro-credit amounting to Tk. 160,724.5 million was distributed through different Ministries, Divisions and Departments. To expand the micro credit programme, the government allocated Tk. 1,480 million to the Rural Development and Cooperative Division, the Ministry of Agriculture, the Ministry of Fisheries and Livestock, Ministry of Youth and Sports, Ministry of Liberation War Affairs and the Ministry of Women and Children Affairs in FY 2006-2007. In addition, Tk. 2,170 million was allocated to the Palli Karma Shahayak Foundation (PKSF) to implement micro-credit programmes through NGOs in FY 2006-2007. To accelerate the pace of development of the rural social sector, Tk. 250 million was allocated in FY 2006-2007 to the Bangladesh NGO Foundation. A further, Tk. 1,000 million was allocated in FY 2006-2007 to the Special Fund for Employment Generation of the Hardcore Poor implemented by the PKSF, and Tk. 1,000 million was allocated for the development of rural micro-enterprises.

The budgetary allocation for social safety net programmes in FY 2007-2008 was Tk. 1,146,700 million, which is 13.32 per cent of the total budget and 2.14 per cent of GDP. There are 66 different types of programme/projects in the form of cash transfers, food aid, and micro-credit implemented under the social safety net initiatives.

Social protection in Bangladesh

According to the head count ratio using the DCI method, in 2005, the incidence of absolute poverty in Bangladesh was 40.4 per cent (39.5 per cent in rural areas, and 43.2 per cent in urban areas). Although this method recorded a reduction of absolute poverty at a rate of 4.1 per cent from 2000 to 2005, the absolute number of people living below the poverty line – 55.8 million in 2000 – increased to 56 millon in 2005. The same method was also used to measure the incidence of hardcore poverty, finding that this stood at 19.5 per cent nationally – 17.9 per cent rural, and 24.4 per cent urban in 2005. It may be noted that the number of people living under the hardcore poverty line increased from 24.9 millon in 2000 to 27 million in 2005.

The provisional estimation of the latest Labour Force Survey (2005-2006) by the Bangladesh Bureau of Statistics (BBS) shows that there are 49.5 million economically active people (above the age of 15) in Bangladesh. The estimation also says that a labour force of 47.4 million (36.1 million males and 11.3 million females) is engaged in a variety of professions, with the highest proportion (48.1 per cent) still working in agriculture.[114] The estimations show clearly the scale of disparities on dependency rates and gender disparities in the employment market. It has been found that the 91.1 million people (64.8 per cent of the total population) who are not economically active, are mainly children, the elderly and those with disabilities. A total of 2.1 million economically active people are totally out of the employment market. Economically active females account for only 23.8 per cent of the employment market, even though they constitute almost half of the total population. About 22 per cent of the labour force is engaged in unpaid family labour and this rate has increased at an average rate of 4.73 per cent for the last few years.

The current rise in inflation is the result of the high price of rice, wheat, edible oil, and pulses that have also affected the local market. At the same time, two repeated floods, and cyclone 'Sidr' have destroyed crops and assets in recent times, increasing inflation. This upward trend of inflation has pulled more people into poverty.

Against this backdrop of high poverty rates, the growing number of people in absolute poverty, and the problems of unemployment, economic crisis and natural disasters, the Government has long recognized the importance of reducing both the number and rates of poor people through different social protection programmes. The previous Five Year Plans also undertook different programmes to reduce poverty.

Bangladesh requires an annual rate of poverty reduction at an average of 1.23 per cent to achieve the MDGs[115]. In line with the PRSP targets and objectives and the MDGs, the government has been implementing a number of programmes for employment and income generation and to lift the poor out of poverty. About 56.3 per cent of development and non-development budgets was allocated for direct and indirect poverty reduction activities in FY 2006-2007,[116] which increased to 57 per

113 Bangladesh Economic Review 2007, Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, pp-186.

* It should be noted that the given statistical templates for this particular section were not possible to complete as data and information in the required form are not available.

114 Bangladesh Economic Review 2008 (Bangalee Version), Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-29

115 Bangladesh Economic Review 2008 (Bangalee Version), Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-163

116 Bangladesh Economic Review 2007, Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, March 2008, page-181

cent in the revised budget for FY 2007-2008.[117] These programmes are eventually expected to enhance the entitlement of the poor and at the same time increase their empowerment and raise their awareness. In addition, the Food for Work and the Vulnerable Gtroup Development programmes, the construction and maintenance of rural infrastructure, and a range of other programmes are also generating employment for the poor. Education extension programmes, such as food for education, special stipends and financial assistance, and free primary education are reducing the burden of educational expenses directly, as well as playing an important role in human resources development.

A wide variety of social safety net programmes have been launched in Bangladesh with a distinguished vision: to include the destitute, poor and vulnerable populations in the development process, not only to ensure their survival, but also to help them participate in mainstream socio-economic activities. There are 17 types of programme that can be categorized as cash transfer or food transfer programmes under social safety net programmes in Bangladesh.

Cash Transfer Programme: Among the social safety net programmes, the **Old Age Allowance Programme for the poor** is the biggest in terms of budgetary allocation, beneficiary coverage and the amount of benefit received by the target group. In FY 2007-2008, the total financial allocation was Tk. 3,840 million to be disbursed among a total of 1.7 million beneficiaries (whose numbers are increasing rapidly). Along with the increase in the number of beneficiaries, the amount of

Table 3.3: Major social safety net programmes in Bangladesh

Programme type	Name of programme	Budgetary Allocation (million Tk.)			Beneficiaries (in million)			Amount of benefit (Tk./month)		
		2005-2006	2006-2007	2007-2008	2005-2006	2006-2007	2007-2008	2005-2006	2006-2007	2007-2008
Cash transfer programmes	Old Age Allowance Programme for the Poor	3,240	3,840	3,840	1.5	1.6	1.7	180	200	220
	Allowance Programme for Widowed, Deserted and Destitute Women	1,365	1,560	1,980	0.625	0.65	0.75	180	200	220
	Honorarium Programmes for Insolvent Freedom Fighters	420	600	600	0.07	0.	10		416	600
	Fund for Rehabilitation for the Acid-burnt and the Physically Handicapped	200	100	100	0.02			10,000 (once only)	10,000 (once only)	10,000 (once only)
	Allowance for Fully Retarded	250		314	0.104	0.167	0.200	200	200	220
	Maternity Allowance for the Poor Mothers			170			0.045			
	Food for Works Programme (Cash)	3,000								
Programme type	Name of programme	Budgetary allocation (million Metric Tons)			Beneficiaries (in millions)			Allocation per beneficiary		
Food transfer programmes	Food for Work Programme		0.10	0.10						
	VGD Programme	1.032	0.20	0.126		0.75	0.636			
	VGF Programme		0.25	0.229		7.68	7.68			
	Test Relief (TR)		0.15	0.075						
	Gratiutous Relief			0.025						
Seasonal Unemployment Reduction Fund		500	500							
100 Days Employment Generation Programme (2008-2009)		20,000			2			Tk. 100 per beneficiary per day for a total of 100 days per year		

Source: Compiled by the authors based on Bangladesh Economic Review 2006, 2007, 2008 and Ministry of Food and Disaster Management.

117 Bangladesh Economic Review 2008 (Bangalee Version), Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh, June 2008, page-170

allowance per person per month has also increased. At present, each beneficiary receives Tk. 220 per month, up from Tk. 180 in FY 2005-2006.

The Government has launched the **Allowance Programme for Widowed, Deserted and Destitute Women**, covering a total of 0.65 million vulnerable women with a total budget of Tk. 1,980 million for FY 2007-2008. Under this programme, each beneficiary woman is supposed to get Tk. 220 per month. A more recent programme, **Maternity Allowances for the Poor Mothers** aims to reach 45,000 poor mothers with an allocation of Tk. 170 million to be distributed as maternity allowances.

There are two programmes with relatively low budgetary allocation for physically disabled people. The programme **For Acid Burnt and Physically Handicapped People** was allocated Tk. 100 million in FY 2007-2008 to give targeted beneficiaries one lump sum of Tk. 10,000. The **Allowance for Fully Retarded People** programme has a total budget of Tk. 314 million and a target population of 200,000. The **Food for Work Programme (cash)** is one of the largest safety net programmes in terms of budgetary allocation, with a disbursement of Tk. 3,000 million in FY 2005-2006.

Food Transfer Programme: Existing social safety net programmes also include food transfer programmes to fulfil nutritional requirements and food security. In FY 2007-2008, 100,000 metric tons of food grains were allocated under the Food for Work programme.

The **Vulnerable group development (VGD)** programme is one of the most crucial social safety nets and its activities focus predominantly on the nutritional status of malnourished women and children. The VGD programme has two components: (i) Income Generating VGD (IGVGD) and (ii) Food Security VGD (FSVGD). In the IGVGD component, beneficiaries receive a monthly ration of 30 kilograms of wheat or 25 kilograms of fortified flour (atta). In the FSVGD programme, they receive 15 kilograms of atta and Tk. 150 per month. The components are similar in their beneficiary targeting approach and their development package service delivery. The VGD aims to enhance the income-earning capacity and self-reliance of ultra poor and food-insecure women to ensure their graduation into mainstream development programmes. It covered about 636,000 ultra poor rural women (female-headed households) that are vulnerable to chronic crisis in 480 upazilas (sub-districts) in all 64 districts of Bangladesh in FY 2007-2008. The programme takes an holistic approach, combining food aid with a development package. During this period, 126,000 metric ton food grain was distributed among the beneficiaries.

Vulnerable group feeding (VGF) is another food transfer programme that has been implemented as a post-disaster intervention. In FY 2007-2008, 7.68 million people benefited from this programme, receiving a total allocation of 229,000 metric tons of food grain. Test relief and gratuitous relief are also being implemented in Bangladesh.

In addition to cash transfer and food transfer programmes, **employment generation** is an important and promising initiative undertaken by the Government. In the PRSP, employment generation is seen as a crucial social safety net programme that helps to reduce poverty.

Building blocks and strategy partners

The entire government and civil society machinery needs to be continuously active and vigilant if Social Protection is to be a sustainable pro-poor national programme. To this end, the Ministry of Social welfare is the lead government agency, working in collaboration to achieve the goals of the Social Protection Programme with the Ministries of Women and Children Affairs; Industries; Food and Disaster Management; Local Government Engineering Department (LGED) of the Ministry of Local Government, Rural Development & Cooperatives; Finance Division; Youth and Sports; NGOs (the NGO Affairs Bureau), and the Palli Karma Shahayak Foundation (PKSF). The Directorate of Relief and Rehabilitation, the Department of Social Services and NGOs, with the support of donors are at the vanguard for the provision of social protections during normal times, as well as crisis periods.

As a cross-cutting issue, social protection has been brought into the mainstream of national development planning process as a priority. Social protection, as a multi-sectoral programme with implementation responsibility shared by all, can be achieved if multi-dimensional employment opportunities and income generation activities are created with minimal system loss, management inefficiency and corruption. Various strategies including cash transfer, food transfer, VGF, employment generation, and micro-credit programmes are useful, but have only a temporary impact on improving the conditions of the poor, ultra poor and the destitute who are unable to escape the ugly clutches of poverty and social insecurity. As social protection has strong linkages with the economy and economic security, the Ministry of Planning/Planning Commission, the architect of national development planning, should take more responsibility in designing short and long-term interventions that could have a greater impact on living standards.

CHAPTER FOUR

ADDRESSING CHILD POVERTY AND DISPARITIES – A STRATEGY FOR RESULTS

Introduction

Children are at risk of poverty, vulnerability and disparities at a disproportionately higher rate than adult household members. All development activities must consider children's deprivation as a priority issue for one simple reason: the exclusion of children makes it impossible to achieve real development by any definition.

The reduction of child poverty, vulnerabilities and disparities requires informed policies to address the various dimensions of child poverty and disparities, and the implementation of these policies with full commitment. This chapter attempts to identify the gaps between policy and reality on child poverty and disparities in Bangladesh, and the opportunities available to reduce child poverty. Possible strategies to implement the suggested policy options are also identified, alongside the building blocks and partnerships that will be needed. The recommendations in this chapter are the capstone of this analysis and provide the framework for an evidence-based plan that would formalise effective options and strategies, and a renewed commitment to the fight against child poverty and for the universal realization of child rights.

Recommendations for children and development

The aspirations of Bangladesh on health, education, nutrition, and protection have been documented in its Constitution, the highest legal framework of the State.[118] However, the reality on the ground does not match the aspirations of the nation, as is evident from the child poverty and deprivation scenario prevailing in Bangladesh, and outlined in previous chapters.

*The **improvement of the nutritional status of children*** is seen as a priority issue in policy documents like the PRSP, the National Plan of Action for Nutrition (2005-2010) and the National Health Policy (2000). Specific goals, objectives and targets to improve child nutrition were set out in these policy documents, which are backed by nine major programmes including VAS, the control of Iodine Deficiency Disorder, and the NNP. In terms of budgetary allocation, NNP (2004-2010) is the largest programme to improve nutritional status, with a total budget of Tk. 13,472 million.

Despite all of these policies and programmes, more than half of all children in Bangladesh - 57 per cent - are still undernourished. It is imperative for the government, policy makers and other stakeholders to expand the coverage of nutrition related programmes. For example, the NNP – the largest and comprehensive programme in this area – covers 34 of the country's 64 districts, which means that almost half of all districts are beyond its coverage. As a huge number of children are nutrition deprived, the NNP could expand its coverage, giving priority to those who are the most deprived. Access to adequate nutrition for the particular age group, as a matter of right, needs to be considered seriously at the implementation level of all national and regional programmes.

The allocation for the nutrition sector has been fluctuating in recent years. Total public expenditure on nutrition intervention was Tk. 1,670 million in 2005-2006, but fell to Tk. 1,200 million in the following year. In 2005-2006, the lion's share of total nutrition expenditure of Tk. 1,536 million went to child nutrition interventions, channelled for the most part through three projects and institutions, namely IPHN, NNP, and BNCC. Of total public expenditure, nutrition expenditure stood at 0.19 per cent and 0.11 per cent in the years 2005-2006 and 2006-2007 respectively (for details see, Annex II: Table 2). *In this context, budgetary allocation should be increased substantially to materialize the commitment shown in the policy documents.*

118 The Constitution of Bangladesh, FUNDEMENTAL PRINCIPLES OF STATE POLICY., Articles 15 (A, B), 17, 18(1), 20 (1, 2), 27, 28.

All the key parameters for malnutrition (stunting, wasting and underweight) rise abruptly at the age of 12 months, and then decrease gradually up to the fifth year of life, regardless of sex. Special attention should be given, therefore, to improving the nutritional status of under-two children in terms of appropriate feeding, micronutrient supplementation and management of severe malnutrition.

Among children under the age of five, 46 per cent are stunted, followed by another 40 per cent who are underweight. Stunting is a primary manifestation of malnutrition in early childhood, including malnutrition during foetal development as a result of the malnutrition of mothers. Underweight occurs later, as a result of inadequate intake of calories and vital nutrients, such as vitamins and minerals. *Programmes to provide nutritional supplements to pregnant and lactating mothers need to be implemented with vigour.*

Although household level national poverty estimates are higher (in terms of calorie intake) in urban areas than in rural Bangladesh, child poverty provides an opposite scenario, with stunting and underweight higher among children in rural areas than among those in urban areas by 13 and 12 percentage points respectively. This indicates that *awareness among rural households about the nutritional intake of foodstuff should be raised through BCC efforts to ensure that the nutritional requirements of children are met.*

More than 80 per cent of children are breastfed within one day of birth, which is a satisfactory scenario. However, there is no room for complacency as only one-third of newborns are breastfed within one hour of birth. *To achieve the target of initial breastfeeding within one hour of birth, vigorous efforts should be undertaken in association with NGOs, civil society members, local community leaders and relevant stakeholders.*

The prevalence of stunting, wasting and underweight among children from households where the mother has no education are 53 per cent, 17 per cent and 47 per cent respectively. They are lower (45 per cent, 14 per cent and 39 per cent) among children from households where mothers have at least primary level education. And they are even lower (36 per cent, 10 per cent and 29 per cent) among children from households where mothers have at least secondary education. *Nutrition education has to be promoted to reach illiterate and less literate mothers, and female education has to be promoted.*

The ***health outcomes scenario*** depicts a situation where infant and child mortality have decreased remarkably (but still remain at alarming levels), the incidence of diarrhoea and pneumonia and treatment for these diseases have reached a good level, and coverage and implementation of the immunization programme is a success. A set of objectives and targets on child health outcomes have been incorporated in policy documents such as the PRSP, the National Health Policy, and the National Plan of Action for Children (2005-2010). There are eight major programmes in the area of health and, at the programme level, the HNPSP is the largest umbrella programme in the health sector, with a budget of Tk. 324,503 million for the period 2003-2010.

Health outcomes, however, reveal a worse scenario in rural areas than in urban areas. Spatial analysis also reveals that health performance in some regions is worse, relatively, than in others.

As diarrhoea is the result of contaminated water, it may peak during particular situations such as a floods or natural disasters. In some regions of Bangladesh, such as those that are flood affected or low lying areas, people's access to safe drinking water is often interrupted, which could cause diarrhoea. *In such situations special measures should be taken to ensure a clean, safe water supply.*

Age-specific analysis indicates that the highest incidence (11 per cent) of diarrhoea is found among children aged 6-11 months. *Serious efforts need to be made to reduce the morbidity and mortality of children under-five.*

The prevalence of diarrhoeal disease has been found to be two percentage points higher among households where the mother has no education compared to households where mothers have secondary or post secondary education. Findings show that almost half of the affected under-five children (49 per cent) receive Oral Rehydration Therapy (ORT) (MICS 2006) in cases of diarrhoea. Children in urban areas receive 4 per cent more ORT than their rural counterparts. A wide spatial variation has been found in terms of receiving ORT across administrative divisions, with 58 per cent of children affected by diarrhoea receiving ORT in Barisal, compared to only 43 per cent in Rajshahi. Against this backdrop, *the rate of ORT use should be increased through strong BCC campaigns, as ORT can be easily prepared within the household.*

An estimated 12 per cent of children under five continue to suffer from pneumonia, which is solely responsible for 18 per cent of under-five deaths in

Bangladesh. Almost 78 per cent of those who suffer from pneumonia do not receive antibiotic treatment. *Prevention of pneumonia should be a top priority at policy and programme levels, and matched by appropriate budgetary provisions.*

The child immunization programme has been recognized as the most successful health intervention in Bangladesh. Regional disparities. however, show areas where immunization for children under 24 months is relatively low, such as 78 per cent in Sylhet, compared to the national figure of 84 per cent. The coverage is three per cent higher in urban areas than in rural. Coverage for immunization against measles (87 per cent) is relatively lower than for other antigens/vaccines. *Therefore, special programmatic intervention is needed to address immunization disparities.*

Though the prevalence of HIV/AIDS is low, knowledge about HIV/AIDS prevention is considered to be a crucial factor that can prevent or restrain its spread in Bangladesh. It may be noted that Bangladesh is vulnerable to HIV/AIDS through cross-border movement of people and goods and services to and from neighbouring India, which has a higher prevalence rate. It has been observed that an insignificant proportion – only 16 per cent of young women aged 15-24 – has comprehensive knowledge about HIV/AIDS prevention. While 24 per cent of women in urban areas know about the preventive measures of HIV/AIDS, this falls to 12 per cent in rural areas, and is particularly low in Sylhet, at just 8 per cent. *The existing policies and programmes on HIV/AIDS should be implemented, with the highest importance given to prevention to reduce the risk of infection.*

The emergence of Avian Influenza has had a devastating impact, not only on the health of the people but also on the economy of the country. The first confirmed case of the virus responsible for avian influenza (H5N1) was identified in Bangladesh in February 2007. Bangladesh has taken the issue seriously and, to halt the outbreak and potential loss, the Government, with assistance from the UN Food and Agriculture Organization (FAO) and other organizations has taken effective measures. These have included the burning or burying of eggs and chickens, the establishment of laboratory facilities and the installation of modern equipment. The Government has also employed field volunteers to strengthen avian influenza surveillance in rural areas.

Key recommendations for policies and programmes

Nutrition

- *Expand nationwide evidence-based and proven nutrition interventions and improve coordination of nutrition programmes, including: use of multiple micronutrients for control and prevention of anaemia; exclusive breastfeeding and timely introduction of appropriate complementary feeding; and iron and folic acid supplementation for pregnant women.*
- *Implement interventions at both facility and community levels to manage severe acute malnutrition.*

Health

- *Ensure universal access to Zinc and oral rehydration therapy (ORT) to tackle acute childhood diarrhoea.*
- *Sustain and further increase immunization coverage in every district.*
- *Strengthen programmes to prevent and manage pneumonia through: improving family and community knowledge and care seeking practices; and increasing access to quality of care through strengthening community-based management of pneumonia.*
- *Adopt the strategy recommended by WHO and UNICEF (2009) of providing home visits for newborn care in the first week of life by a skilled attendant.*
- *Accelerate implementation of existing policies and strategies that are most likely to reduce risks to child well-being, and increase gender and age-sensitive care and support services for Most at Risk Adolescents (MARA) and Especially Vulnerable Adolescents (EVA).*

Water and sanitation

- *Access to safe drinking water and sanitation needs to be consolidated, expanded and sustained. Special emphasis should be given to arsenic affected, flood and disaster prone areas.*
- *Arsenic contaminated drinking water is one of the greatest challenges in providing safe water in Bangladesh. Therefore, a new category – "children drink arsenic contaminated tube-well water" – should be added to the list of deprivation indicators under "Safe Drinking Water."*

- *Because children are most vulnerable to diseases related to the lack of clean water and proper sanitation, their needs should be prioritized.*

Social protection and child protection

- *The Government of Bangladesh should strengthen existing social protection programmes to reduce the vulnerabilities of hard-core poor families and ensure better inter-ministerial coordination in the area. In parallel, the international community should provide harmonized and coordinated support to the Government of Bangladesh in stimulating further development of an effective and efficient safety net in the country. Special attention should be paid to support for families' coping mechanisms to keep their children within a family environment and prevent the separation of children from their families and their institutionalization. Additionally, the expansion of NGO-provided non-formal basic as well as vocational education to street and working children should be incorporated in the social protection system.*
- *Alternative care facilities for children deprived of parental care and children in contact with the law should be increased and developed. The existing network of institutional care should be transformed into a family-type environment and monitoring and supervision mechanisms should be strengthened in order to ensure the quality of care.*
- *Appropriate and adequate programmatic interventions should be developed and implemented in phases to support the social reintegration of children who are homeless and living or working on the street.*
- *Birth registration interventions should be further strengthened, with a special focus on disadvantaged and vulnerable children.*

Education

- *The inclusion of children who are out of school, including those from ethnic minorities, needs the highest level priority.*
- *The education of mothers appears to be a crucial contributing factor in improving all the indicators related to child well-being. Therefore, interventions to enhance female education, as well as the adult literacy programme for women, should be given a high priority. The female stipend programme should be continued and made more effective in keeping girls from the hard-core poor families in schools.*
- *High quality non-formal education opportunities should be provided as alternative modes of learning for the poorest children until the formal system becomes attractive and affordable for such children.*
- *Schools need to be made friendly and inclusive for children from the poorest families and education needs to be made relevant to their lives.*
- *Financial benefits for teachers in primary schools need to be increased.*

Laws and policy

- *Child related national legislation should be harmonized with the United Nations Committee on the Rights of the Child Concluding Observations and Recommendations for the Government of Bangladesh 2009. A comprehensive child protection policy, addressing early marriage, child labour and street children issues, should be developed that articulates a clear and structured action plan to ensure preventive and protective measures for children.*
- *There should be greater promotion of the implementation of policies that support: improving family and community knowledge and practice related to prevention and care seeking; and increasing access to quality of care through strengthening community-based management of diarrhoea and pneumonia.*
- *Social transfers could be linked to education. As more than 80 per cent of children aged 6 to 10 are enrolled in schools, primary schools should be used as a medium to reach the poorest children and their families. Providing social transfers to the poorest families through schools can motivate their parents to enrol, and keep, their children in schools. However, the level of incentives provided should be commensurate to the opportunity cost of sending the child to school.*
- *To ensure sustainable human development, child well-being must be considered as the highest priority and recognized in all national policy and planning documents.*
- *To address child poverty and deprivation at national policy and programme level, it is necessary to strengthen the capacity of key relevant government officials, and private and public sector research institutions.*
- *Increased budgetary allocation and better targeting of the most deprived unions, upazilas and districts*

is necessary to materialize the relevant policy commitments.

Research and advocacy

- *In-depth and rigorous studies should be encouraged on multidimensional issues on child well-being, child poverty and disparities, and an NGO Child Rights Network should be activated and promoted.*
- *In all relevant national surveys, data on children should be disaggregated by gender.*
- *Workshops should be organised for policy makers and civil society leaders – both at national and regional levels – to obtain their expert opinions and involve them in the process to address child poverty and deprivation and put children at the centre of the development agenda.*
- *The key findings of this study should be widely disseminated across all 64 districts to ensure the proactive participation of both people at large and local government bodies in the child poverty and deprivation reduction process.*
- *Knowledge and awareness on child well-being and the means to draw children out of poverty and deprivation are crucial. Relevant behaviour change communication (BCC) should, therefore, be a high priority.*

Child rights are protected in a number of policy and legal documents. Important legal documents for child protection such as the Children Act 1974 and the Children Rules 1976 need to be reviewed and reformulated, keeping in mind the contemporary situation in Bangladesh as well as legal developments that have taken place nationally and internationally.

Birth registration for children has been introduced to prevent child marriage, ensure children's enrolment in school at the right age, protect underage children from working, and to ensure special treatment for children in the juvenile justice system. This project is focused on children under the age of 18. Adults and elderly people of all ages would also be covered under the project with a total allocation of Tk. 4,460.05 million. As of 2006, more than 60 per cent of all children were not covered by the birth registration project. Birth registration of under-five children is comparatively higher (49 per cent) in Rajshahi division and lower (28 per cent) in Chittagong division. *Quality implementation and timely completion of birth registration, with the help of civil society members and local elites, should be given special attention, considering the high practical utility of birth registration.*

Protection of Children at Risk is a project for street children and children without parental care (orphans and vulnerable children) which costs Tk. 194.18 million and covers a small portion of street, orphan and vulnerable children. *Because of the high practical utility of this project, its coverage in terms of number of right-holders and financial allocation should be significantly increased, and alternative care facilities for children deprived of parental care should be developed.* There are a number of state orphanages, safe baby homes and juvenile correction centres, but their capacity to provide shelter, education, skill training and other facilities is limited, as shown by the total number of beneficiaries. *There is a need to develop and expand alternative care activities for deprived children and allocate more financial resources to them.*

Among all children aged 0-17, there are a large number of adolescent boys and girls for whom no adequate development initiatives could be traced. There are few programmes on reproductive health, and programmes to expand knowledge on HIV/AIDS have lower coverage and budgetary allocations than many other programme. Existing policies and strategies with the highest importance to reduce the risk, increase gender and age sensitive care, and support services for most at risk adolescents, especially vulnerable adolescents, should be implemented.

Education deprivation among children has been reduced as a result of various national policies and programmes implemented in the education sector since 1990. The Primary Education (compulsory) Act of 1990 is a landmark piece of legislation that provides legal guarantees to a child's right to education and is a major milestone in achieving universal primary education. The EFA National Plan of Action (NPA II) for Education for All has addressed the issue of the excluded and hard-to-reach children in primary education. The PRSP addresses issues such as reducing school dropout, sustaining gender parity in primary education, ensuring quality education for children, enlarging coverage of primary schooling, and improving physical facilities in primary schools.

Although policies and programmes are in place, almost one-fifth of all children of primary education age (6-10 years) are deprived of school enrolment. Such deprivation is relatively high in Dhaka (22 per cent) followed by Rajshahi (20 per cent) and Khulna (13 per cent). About three million children are involved in child labour and a large number of children are living and working on the streets. It has been found that education deprivation of children is higher among poor

and illiterate parents. *The inclusion of children who are currently excluded from education, and getting them into school, should be given high priority.*

The quality of education for children should be improved in mainstream educational institutions, which, in turn, will improve the development of human capital in Bangladesh. *Incentives for teachers in terms of financial benefits should be raised and the curriculum and methods of teaching should be improved through training.*

Mothers' education appears as a crucial contributing factor in improving all the indicators pertaining to child well-being. Therefore, interventions to support female education and the adult literacy programme for women should be given a high priority. The female stipend programme should be continued.

High quality non-formal education opportunities should be provided as a alternative mode of learning for the poorest children.

Cash and food transfer programmes for the vulnerable and social insurance for ill health, disability, the elderly destitute women, and promotion of employment are some of the major ***social protection programmes in Bangladesh.***

The coverage of the existing cash transfer programme is inadequate in terms of number of beneficiaries and the amount of money disbursed per beneficiary. To get the highest benefit, *such programmes should be implemented on a long-term basis rather than on an adhoc basis.*

Food transfer programmes have been implemented to improve food security status directly and to meet nutritional requirements. These programmes are also small in coverage compared to their target population.

The PRSP sees the creation of employment as a priority to provide social protection for the Bangladeshi population and accordingly, in FY-2008-2009, the 100 day employment generation programme for the extreme poor was launched by the Government. *The successful and high quality implementation of such programmes is crucial to achieve the objective of providing social protection.*

Access to the micro-credit programme for the extreme poor remains insignificant in terms of its coverage. *The micro-credit programme should be designed in such a way that it can include the poorest of the poor.*

Even though ***ensuring shelter*** for all citizens is recognized in the Constitution of Bangladesh, over 40 per cent of children are shelter deprived. At the policy and programme levels, there is little provision to provide shelter to the poor, homeless households or to children who are living on the street or homeless. *Appropriate and adequate programmatic interventions to provide of shelter to those in need should be undertaken and implemented intensively.*

About 64 per cent of children are deprived of sanitation: Statistics on the percentage of children deprived of water would also be alarming, if arsenic contamination were taken into consideration. *Strong programmatic interventions on water and sanitation should be launched, expanded and sustained with special emphasis on arsenic affected, flood, and disaster prone areas.*

A high percentage of children – 59 per cent – lack ***access to information.*** *Adequate and intensive programme initiatives should be taken to ensure that children have the information they need on issues that concern them.*

Household poverty status is strongly associated with child poverty and disparities, which have both been found to be worst in the poorest households. The promotion of household income has been given importance in policy documents, but programmatic intervention is neither adequate nor implemented with vigour. Unless land, agrarian and aquarian reforms are implemented and rapid industrialization is promoted, a few income promotion and safety net programmes cannot contribute significantly towards promoting household income and reducing vulnerability.

Building blocks and partnerships for a Strategy on Children and Development

The formulation of polices, strategies, programme planning and implementation on children's issues warrants high level coordination and effective support to meet national aspirations, goals and objectives. The task involves Government agencies (including the Planning Commission), civil society, NGOs, community leaders, development partners, UN agencies and experts in this field. This is a participatory process and all are of equal importance in this process – all work together, hand in hand. Processes that are not participatory jeopardize the spirit of collaboration and mutual support that is crucial to child well-being. While a favourable situation prevails, in general, in Bangladesh, returns on outputs in terms of outcomes

can diminish because of bureaucratic bottlenecks and a lack of strong political will.

An extensive review of all relevant policies and programmes in Bangladesh provides a scenario of current skills in planning and implementation. While planning skills at the national level are advancing, implementation skills lag behind at all levels. For this reason, the outcomes of policies and strategies do not reflect 'hoped-for results' in Bangladesh.

Appropriate policy and programme formulation and smooth and vigorous implementation of the objectives and/or targets set out in policy or programme documents require the highest level of coordination among relevant government and civil society, including non-governmental agencies involved in the planning and implementation process.

Nutrition: The Government's policy, strategies and programmes on nutrition to improve child well-being, though gradually evolved, could be considered robust. Budgetary allocations to improve child nutrition should be increased and the private sector could participate intensively in nutrition improvement initiatives to help turn policy options into material progress. Human development and poverty alleviation is a shared responsibility and there is ample scope in this field for real work in a spirit of collaboration and partnership.

As the lead agency and chief coordinator of the National Nutrition Programme, the MOHFW is in the driving seat and guides the onward movement of the Programme. Other Ministries participating actively on national nutrition programmes are: the Ministry of Agriculture; the Ministry of Food and Disaster Management; the Ministry of Fisheries and Livestock; and the Ministry of Women and Children Affairs. DGHS, DGFP, IPHN, and NNP are the four cornerstones of the programme. However, they cannot undertake this task by themselves: NGOs, development partners, and UN agencies (particularly UNICEF and the World Bank) play a vital role and support the government agencies not only technically, but also through substantial financial allocation. The strategy should prioritize the needs of the children and rationalize the distribution system for their access to the necessities of life (basic needs).

For functional convenience, the Ministries mentioned above act as independent bodies to ensure the smooth implementation of nutrition programmes, but in matters of policy and strategy formulation they stand together to provide momentum for child well-being by raising the nutritional status of children and reducing poverty and disparities.

Health: Access to medical services and the availability of quality health services in institutions that provide health care for all, and especially the poor, are the responsibility of the Government and are essential to reduce child health deprivation. The MOHFW and the MOWCA work hand-in-hand, especially on child health and well-being. Although these two ministries have different mandates and distinct functions and responsibilities, they share a common goal under the MDGs: to reduce infant and child mortality and morbidity and achieve infant and child health and well-being.

With the Ministry of Health and Family Welfare as the lead agency, major partners and role-players include: the Ministries of Women and Children Affairs; Social Welfare, Food and Disaster Management; Industry and Labour; Education; and Primary and Mass Education. UN agencies, development partners and NGOs also provide policy, programme and resource mobilization support and guidance. The responsibilities for the National Health Programme and child well-being are carried out by major implementing agencies consisting of the DGHS, DGFP and NNP, along with their field offices, grassroots workers, and a large number of NGOs. As partners, they work in a collaborative spirit to implement health objectives.

While the Ministries noted above provide the overall umbrella, the implementing agencies (DGHS, DGFP, NNP and NGOs) are the cornerstones of the national health programme. Coordination with development partners is led by the World Bank as well as the Asian Development Bank, who contribute soft loans and mobilize grant money for national health and primary health care and reproductive health/family planning programmes.

NGOs, the Government and community workers have to address re-emerging health-hazards such as Avian Influenza (Bird Flu) jointly. Partnership with NGOs who have a good track record will ensure positive results in this endeavour.

Child Protection: In Bangladesh, child protection is, indeed, a cross-cutting issue. A multi-sectoral approach with robust multi-dimensional programmes can move the mountains of misfortune that result from child disparities and deprivations within the foreseeable future. Government agencies are working together with UNICEF and other development partners for the

protection, and improvement, of child well-being as a whole.

The top Government agencies with the power to make a difference on child protection issues are working together as partners, and include the Ministries of Women and Children Affairs; Law; Justice and Parliamentary Affairs; Home Affairs; Labour and Employment; Social Welfare; Youth and Sports; Local Government Division; and Information. These Government agencies are mandated to adopt necessary measures to protect children from direct and indirect abuse, exploitation and violence.
The MOWCA, as a lead Ministry, provides technical guidance to other partner Ministries and agencies and also to NGOs, and coordinates their supportive role in fulfilling the objectives set out in the PRSP. These Ministries implement the national child protection programme through their Directorates, field offices and grassroots work-force. NGOs have been playing a collaborative role and provide active support to the Government's child protection activities. The areas where NGOs with Government support can work better and faster are: breastfeeding; diarrhoea control; baby homes/shelters; sanitation; potable water supply; mothers' education; mobilizing community support; and in hard-to reach locations. The strategy should include building confidence and partnership with NGOs at local as well as national levels.

Education: Education – viewed as a fundamental right to every citizen, is deemed to be a public/private sector initiative – a responsibility that is shared by the Government, non-government organizations and agencies, and private entrepreneurs. To ensure sustainable primary school enrolment, reduce the dropout rate, and ensure quality education, the Ministry of Education (the lead agency) works with the support of partner agencies such as: the Ministry of Primary and Mass education; the Ministry of Women and Children Affairs; the Ministry of Finance; the Ministry of Youth and Sports; the Ministry of Science and Information and Communication Technology; and the Directorate of Technical Education and provides support for NGOs working in the education sector. The Ministries noted above, alongside NGOs and UN agencies, notably UNICEF, constitute strategic partners in reaching the education MDG targets.

A partnership consisting of the Government of Bangladesh, civil society members, NGOs, as well as donors and UN agencies, working hand in hand, can give more thrust to the current slow moving effort to improve the education of mothers and out of school children. These collaborative efforts deserve a higher priority to protect children from abuse and violence of various types and dimension.

Social Protection*:* Coverage of the safety net programmes should be increased by a great extent in terms of the number of beneficiaries and financial allocation, and micro-credit programmes should be designed to include the poorest of the poor. For Social Protection as a sustainable national programme, the entire Government machinery should be more pro-active. To this end, the Ministry of Social Welfare as the lead agency, works in collaboration with the Ministries of Women and Children Affairs; Food and Disaster Management; Local Government Engineering Division; Finance Division; Youth and Sports; Home Affairs; Law and Parliamentary Affairs; NGOs (NGO Affairs Bureau); and PKSF to achieve the goals of Social Protection Programme. The Directorate of Relief and Rehabilitation, the Department of Social Services and NGOs are at the vanguard of the provision of social protection in normal times and during periods of crisis. As a cross-cutting issue, social protection has been brought into the mainstream of the national development planning process and is being dealt with as a multi-sectoral programme with implementation responsibility shared by all partners. The UN agencies – especially FAO, UNDP, WFP – provide significant contribution in terms of technical and financial assistance. *All partners share the same goals – the alleviation of poverty, the removal of disparities and the protection of underprivileged and disadvantaged people, especially children – and follow consultative and participatory processes for action.*

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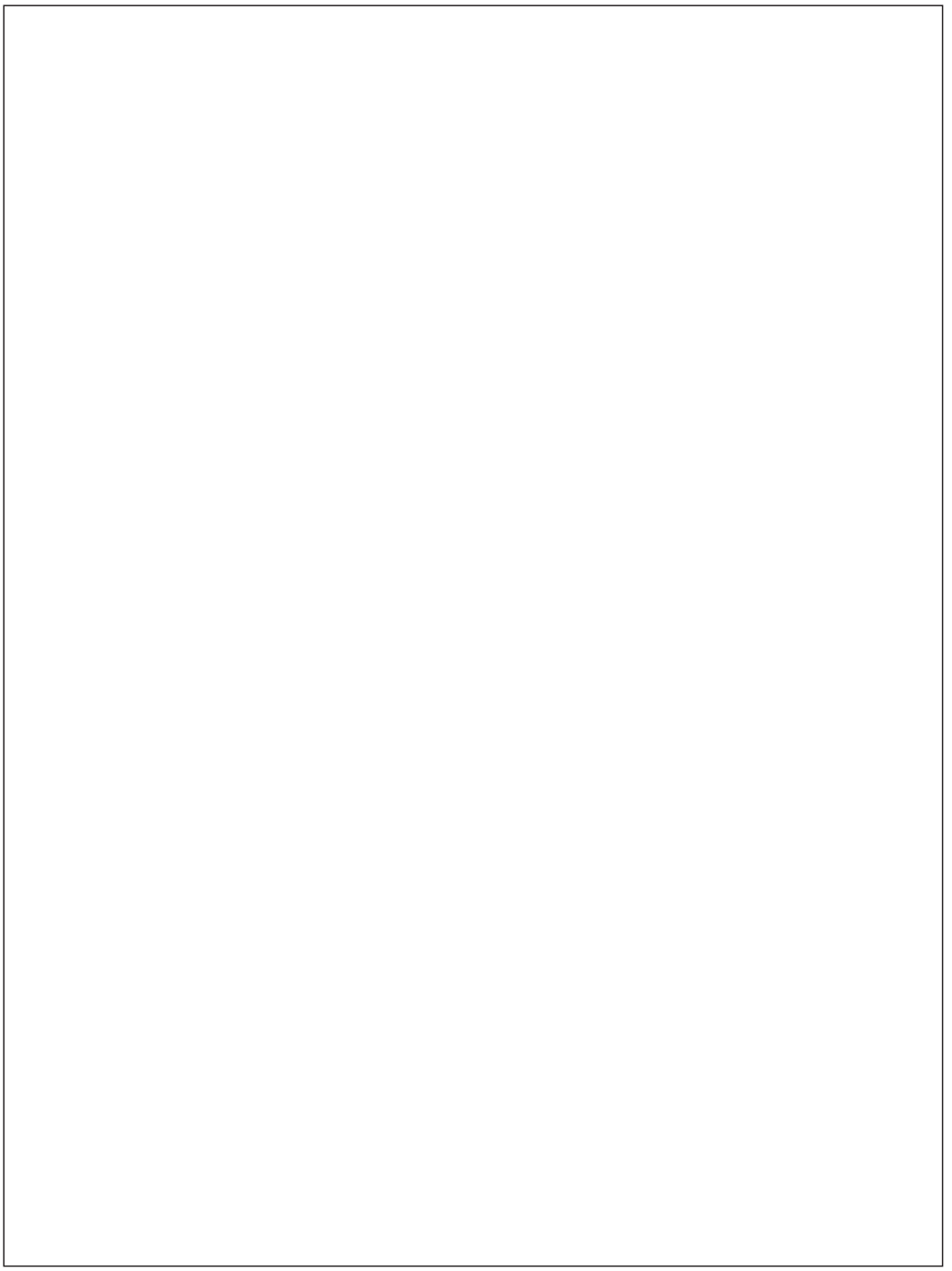

ANNEX I

STATISTICAL TEMPLATE

STATISTICAL TEMPLATE
PART ONE: CHILDREN AND DEVELOPMENT

Table 1.1.1: The population pyramid in 2006 and changes between 1996 and 2016

(in millions)

Bangladesh	Female					Males				
	1996 Pop^n	2006 Pop^n	Projected 2016 Pop^n	Change between 1996 and 2006	Projected change between 2006 and 2016	1996 Pop^n	2006 Pop^n	Projected 2016 Pop^n	Change between 1996 and 2006	Projected change between 2006 and 2016
Total	62.35	68.77	78.31	6.42	9.54	59.52	73.03	82.65	13.51	9.62
By age group										
0-4	7.51	7.53	6.70	0.02	-0.83	7.89	8.02	7.15	0.13	-0.87
5-9	8.89	7.91	6.55	-0.98	-1.36	9.16	8.60	7.01	-0.56	-1.59
10-14	8.81	8.30	7.35	-0.51	-0.95	9.42	9.21	7.87	-0.21	-1.34
15-19	6.17	7.76	7.85	1.59	0.09	6.97	8.80	8.54	1.83	-0.26
20-24	4.56	5.91	8.24	1.35	2.33	4.56	6.57	9.15	2.01	2.58
25-29	4.89	6.31	7.69	1.42	1.38	4.21	5.07	8.72	0.86	3.65
30-34	4.82	6.10	5.84	1.28	-0.26	4.41	5.09	6.50	0.68	1.41
35-39	3.21	4.60	6.21	1.39	1.61	3.40	4.47	4.99	1.07	0.52
40-44	2.70	3.92	5.97	1.22	2.05	3.26	4.33	4.98	1.07	0.65
45-49	2.14	2.84	4.46	0.7	1.62	2.42	3.49	4.31	1.07	0.82
50-54	1.58	2.01	3.73	0.43	1.72	1.85	2.62	4.08	0.77	1.46
55-59	1.43	1.80	2.62	0.37	0.82	1.55	2.12	3.16	0.57	1.04
60-64	0.81	1.00	1.76	0.19	0.76	0.99	1.23	2.23	0.24	1
65-69	0.96	1.17	1.45	0.21	0.28	1.04	1.35	1.65	0.31	0.3
70-74	0.40	0.52	0.71	0.12	0.19	0.49	0.66	0.84	0.17	0.18
75-79	0.37	1.07	0.68	0.7	-0.39	0.45	1.37	0.78	0.92	-0.59
80+	0.22	0.01	0.53	-0.21	0.52	0.27	0.02	0.70	-0.25	0.68

Sources: 1. Bangladesh Population Census 1991 Vol.1 Analytical report, Sep-1994 (p. 221).
2. Sectoral Need Based Projection, BBS, May-2006 p. 27, 28.

Note: 1. Projected population change to 2016 is calculated by the difference in population between the years 2006 and 2016.
2. Population change tor 1996 is calculated by the difference in population between the years 1996 and 2006.
3. According to the Guide Book, data are required for the year 1995, 2005 and 2015. Data shown here are for the years 1996, 2006 and 2016 as these are the years covered by the above mentioned sources.

Table 1.1.2: Mapping poverty determinants and child outcomes in survey data

Child population by			Total number of children (0-17) in year 2006	Percentage over total children	Sources
A. Geographic dimension	Region	Barisal	8290 (4118286)	6.5	Multiple Indicator Cluster Survey (MICS) 2006
		Chittagong	27267 (13558666)	21.4	
		Dhaka	39654 (19704416)	31.1	
		Khulna	13056 (6462542)	10.2	
		Rajshahi	29667 (14762473)	23.3	
		Sylhet	9575 (4751869)	7.5	
	Residence	Rural	91877 (45681300)	72.1	MICS 2006
		Urban	34538 (17676952)	27.1	
B. Household dimension (not all mutually exclusive categories)	Household income poverty	Under the national poverty line[1]	27402257	45.80	Household Income Expenditure Survey (HIES) 2005
		Under 1.08 dollar (ppp) a day	35536563	59.4	
		Under 50% of the median income[2]	53012574	88.6	
		In persistent poverty[3]	13514283	22.6	
	Deprivation of materials, goods and services(household/ community indicators)	Shelter deprived[4]	52840 (26230316)	41.4	MICS 2006
		Sanitation deprived[5]	81346 (40422565)	63.8	
		Water deprived[6]	4010 (1964106)	3.1	
		Information deprived[7]	90372 (45082888)	59.4	
	Deprivation of materials goods and services (individual child indicators)	Nutrition deprived[8]	2153 (10320220)	56.7	CMNS 2005
		Education deprived[9]	6015 (2887345)	7.7	MICS 2006
		Health deprived[10]	965 (1580663)	16	
	Household size	< 3 HH members	941 (443508)	0.7	MICS 2006
		3-4 members	33768 (16789937)	26.5	
		5-6 members	53717 (26673824)	42.1	
		7+	39083 (19450983)	30.7	
	Education of the HH Head	None	57162 (28384497)	44.8	MICS 2006
		Primary	33661 (16726579)	26.4	
		Secondary+	31353 (15586130)	24.6	
	Gender of the HH head	Male	118763 (2661047)	93.1	MICS 2006
		Female	8745 (58986533)	6.9	
	Wealth index quintiles[11]	Q1 (poorest)	28986 (4371719)	22.7	MICS 2006
		Q2	27079 (14382323)	21.2	
		Q3	25595 (13431949)	20.1	
		Q4	23921 (12735009)	18.8	
		Q5 (Richest)	21927 (11911351)	17.2	
	Religion	Islam	115464 (10897619)	90.6	MICS 2006
		Hindu	10568	8.3	

Child population by			Total number of children (0-17) in year 2006	Percentage over total children	Sources
			(57402576)		
		Christian	390 (5258735)	0.3	
		Buddhist	1079 (190075)	0.8	
	Illness and disability in the household	Child with disability (in MICS children aged 2-9)[12]	10254 (5481838)	17.5	
	Family vulnerability	Single parent[13]	1385 (3421346)	5.4	
		Orphan child in household[14]	1726 (3674779)	5.8	
		Elder (70+) person in household	16702 (8299931)	13.1	MICS 2006
	Access to social security and security of tenure	Young children (36-59 months) attending pre-school (MICS indicator no. 52)	1977 (1272474)	14.6	
		Children 0-5 whose birth is not registered	20135 (11612523)	63.8	
		No security of tenure in urban areas (MICS indicator 93)	13228 (23062404)	38.3	
	Demographic, nutrition, health and protection indicators among boys	Boys aged 0-4 total, of which			
		Under nourished children (stunting, wasting, or underweight (MICS indic. 6,7,8)	1117 (5385035)	56.9	CMNS 2005
		Had diarrhoea in survey period[15]	1200 (700338)	7.4	
		Had fever in survey period[16]	1978 (1154612)	12.2	MICS 2006
		Children whose birth is not registered	10282 (6000197)	63.4	
		Boys aged 5-14 total, of which			
		Attends school (MICS Indicator 55)	25071 (13324291)	68.4	
		Orphaned children (MICS indicator 75 and 76)	2075 (1110358)	5.7	
		Child labourer (MICS indicator 71)	6415 (3408992)	17.5	
		Boys aged 15-17 total, of which			
		Attends secondary school (MICS Indicator 56)	345 (1447155)	32.0	MICS 2006
		Does not attend secondary school but completed primary education (MICS Indicator 59)	151 (560773)	12.4	
		Comprehensive knowledge about HIV prevention (MICS Indicator 82)	Comprehensive knowledge about HIV is available for adolescent women in MICS		
	Demographic, nutrition, health and protection indicators among girls	Girls aged 0-4 total, of whom			
		Undernourished (stunting, wasting or underweight)	1036 (4936639)	56.5	CMNS 2005
		Had diarrhoea in survey period	1054 (585407)	6.7	
		Had fever in survey period	1756 (996065)	11.4	MICS 2006
		Children whose birth is not registered	9852 (5609420)	64.2	
		Girls aged 5-14 total, of whom			
		Attends school (MICS Indicator 55)	265110 (13121833)	74.7	
		Orphaned children (MICS indicator 75 and 76)	2110 (1036396)	5.9	MICS 2006
		Child labourer (MICS indicator 71)	2875 (1405283)	8.0	
		Girls aged 15-17 total, of whom			

Child population by			Total number of children (0-17) in year 2006	Percentage over total children	Sources
		Attends secondary school (MICS Indicator 56)	3330 (1051415)	29.3	MICS 2006
		Does not attend secondary school but completed primary education (MICS Indicator 59)	136 (340903)	9.5	
		Comprehensive knowledge about HIV prevention (MICS Indicator 82)	1453 (566975)	15.8	

Source: Generated data from MICS 2006, CMNS 2005 and HIES 2005.

Methodological Note: Numbers in parenthesis indicates national figures.

1 Upper poverty line of CBN method is considered as national poverty line and national poverty line is about Tk. 843.
2 50 per cent of the median income is about Tk. 2,237.
3 Lower poverty line of CBN method is considered as persistent poverty line.

4 **Shelter deprived**: Children living in dwellings with 4 or more people per room.
5 **Sanitation deprived**: Children using unimproved sanitation facilities.
Unimproved sanitation facilities include pit latrine without slab/open pit, bucket, hanging toilet/hanging latrine, flush to somewhere else, flush to unknown place/not sure/ DK.
6 **Water deprived**: Children using water from an unimproved source.(i.e. unprotected well, unprotected spring, surface water etc.
7 **Information deprived**: Children (aged 3-17 years) with no access to a radio or television (i.e. broadcast media) are defined as information deprived.
8 **Nutrition deprived**: Children who are stunting or wasting or underweight are defined as nutrition deprived.
9 **Education deprived**: Children of schooling age (aged 7-17) not currently attending school but attended and did not complete their primary education.
10 **Health deprived**: Children (aged12-23 months) who have not been immunized against all vaccinations include BCG, DPT1, DPT2, DPT3, polio0, polio1, polio2, polio3 and measles by age 12 months.
11 **Wealth index**: In MICS 2006 report, an index of household economic status was created and used as a background characteristic with information on household ownership of assets and use of selected services. # it is an indicator of the level of wealth that is consistent with expenditure and income measures (Rutstein, 1999).
The wealth index was constructed using principal components analysis (Rutstein and Johnson, 2004).

For wealth index variables include ownership of items listed in Table below.

Items		
1. Main material of the dwelling floor	11. Sofa	22. Bicycle
2. No. of sleeping rooms	12. Mobile phone	23. Rickshaw van
3. Main material of the roof	13. Non-Mobile Telephone	24. Main source of drinking water for the members of household
4. Main material of the walls	14. Refrigerator	
5. Type of fuel household mainly used for cooking	15. Electric Fan	25. Main source of water used by household for cooking and hand washing
6. Electricity	16. Computer	
7. Radio	17. Washing machine	26. Kind of toilet facility usually used by the members of household.
8. Television	18. Motorcycle or scooter	
9. Watch	19. Animal-drawn cart	
10. Air conditioner/cooler	20. Car/truck/bus/micro-bus	
	21. Boat with a motor/trawler	

12 **Child disability**: Children 2-9 years of age with at least one reported disability. Reported disabilities are: delay in sitting standing or walking; difficulty seeing either in the daytime or night; appears to have difficulty hearing; no understanding of instructions; difficulty in walking or moving, arms; weakness or stiffness; has fits; becomes rigid; loses consciousness; not learning to do things like other children of his/her age; not speaking/cannot be understood in words; appears mentally backward, dull or slow.
13 **Single parents**: Single parents means: child living with either mother or father who are separated/divorced/deserted, and/or temporarily separated (one of the spouses is not residing with the child temporarily).
14 **Orphaned child**: death of one or both parents.
15 **Child diarrhoea**: Information on child diarrhoea for children under five who have had diarrhoea in the two weeks prior to the survey.
16 **Child fever**: Children under five years of age who have had fever at any time during the two weeks preceding the interview.

Note:
Information/data for working status, access to land in rural areas, adult with chronic illness and high dependency ratio (4+children per adult) are not available in MICS 2006.
Women covered by health insurance are not present in any survey in Bangladesh.
Comprehensive knowledge about HIV is available only for adolescent girls in MICS 2006.
In place of orphaned and vulnerable children, information was used only on orphaned children, as information on vulnerable children is not present in MICS 2006.

Table 1.1.3: Number of households (HHs) and children affected by deprivations targeted by the MDGs

Country, survey, year, unit	Number of					Total number					sources
	HHs with such children or youth	Girls or women of this age	Boys or men of this age	Girls or women of this age	Boys or men of this age	Girls aged 0-5	Boys aged 0-5	HHs	Girls aged 0-5	Boys aged 0-5	
	i.	ii.	iii.	iv.	v.	vi.	vii.	viii.	ix.	x.	
	in this category			not in this category		in these households		in the sample estimate			
A. Nutrition poor											
1. Underweight children under five years of age (MDG 1 Indicator 4)	1157 (4163500)	692 (3298576)	775 (3734534)	1141 (5438838)	1189 (5729499)	692 (3298376)	775 (3734534)	8060 (28640000)	1833 (29004519)	1964 (9464033)	CMNS 2005
Country, survey, year, unit	Number of					Total number of					Multiple indicator cluster survey (MICS) 2006
	HHs with such children or youth	girls or women of this age	boys or men of this age	girls or women of this age	boys or men of this age	girls aged 0-17	boys aged 0-17	HHs	girls aged 0-17	Boys aged 0-17	
	i.	ii.	iii.	iv.	v.	vi.	vii.	viii.	ix.	x.	
	in this category			not in this category		in these households		in the sample estimate			
B. Education poor											
2. Enrolled in primary education[1] (MDG 2 and 3 Indicator 6 & 9)	22979 (10670234)	15023 (7116398)	15203 (7899713)	2958 (1401205)	4014 (2085736)	35791 (16954203)	36361 (18893735)	62463 (29004519)	63103 (8737414)	64406 (9464033)	
3. Completing the final year of primary education in proper age (MDG 2, Indicator 7 proxy)	2629 (1220769)	1436 (680233)	1216 (631852)	1320 (625284)	1714 (890620)	4235 (2006120)	4062 (2110678)	62463 (29004519)	63103 (8737414)	64406 (9464033)	
4. Attending primary and secondary school in proper age (MDG 3, Indicator 9)	45046 (20916983)	25684 (12166516)	23918 (12428161)	17952 (8503866)	19954 (10368406)	55657 (26364731)	56747 (29486015)	62463 (29004519)	63103 (8737414)	64406 (9464033)	
C. Health poor											
5. Children died under age one (MDG 4, Indicator 12)											
6. Children died between ages one and five (MDG 4, Indicator 13 proxy)											

7. Number of 1 year-olds immunized against measles[2]	5172 9 (24020216)	2518 (1192777)	2740 (1423746)	392 (185690)	358 (186022)	7244 (3431484)	7075 (3676279)	62463 (29004519)	63102 (8737414)	64406 (9464033)
8. 15-24 years with comprehensive correct knowledge of HIV/AIDS[3] (MDG 7 Indicator 30)	4022 (1867604)	4410 (2151674)		23504 (11466518)		4520 (625861)	3313 (486823)	62463 (29004519)	63102 (8737414)	64406 (9464033)
9. Households and/or children with sustainable access to an improved water source[4] (MDG 7 Indicator 30)	60117 (27915160)	145766 (69049382)	148586 (77207573)	3644 (1726163)	3736 (1941283)	61537 (29150089)	62801 (32632366)	62463 (29004519)	63102 (8737414)	64406 (9464033)
10. Households and/or children with access to improved sanitation[5] (MDG 7 Indicator 31)	23402 (10866653)	58788 (27847887)	59491 (30912439)	90622 (42927658)	92831 (48236417)	23053 (10920210)	23109 (12007792)	62463 (29004519)	63102 (8737414)	64406 (9464033)

Sources: MICS 2006 and CMNS 2005.

Notes: Numbers in parenthesis indicates national figures
In Child and Mother Nutrition Survey (CMNS) 2005, information is only available on children under five.
[1] Enrolled in primary education is replaced by attendance in primary education at primary schooling age (6-11).
[2] Number of 1 year-olds immunized against measles is considered as children aged 12-23 months immunized against measles before their first birthday.
[3] Information on those aged 15-24 years with comprehensive correct knowledge of HIV/AIDS is available only for females.
[4] Number of household members living with households using improved source of drinking water.
[5] Number of household members living with households using improved sanitation facilities.

Table 1.1.4: Number of females in multiple indicator cluster survey (MICS) in 2006 in Bangladesh

Bangladesh	Survey name: MICS 2006							
	Number of females in MICS 2006 (by age group in years)							
	0-2	3-4	5-9	10-14	15-17	18-24	25-49	50-
Total	9825 (4514356)	7159 (3286287)	18228 (8370083)	17261 (7924136)	10629 (4877975)	22026 (10112707)	45954 (21103587)	18328 (8418108)
Household dimension								
Household size								
Less than 3	17 (7899)	17 (7899)	57 (26149)	132 (60743)	382 (175419)	817 (375081)	1901 (873011)	2609 (1197972)
3-4 members	3091 (1419215)	2298 (1054739)	4670 (2144094)	3444 (1582109)	2547 (1168765)	8309 (3815794)	15552 (7140870)	4432 (2034140)
5-6 members	3611 (1659242)	2773 (1272085)	8170 (3750413)	8000 (3674035)	4136 (1898910)	6378 (2928694)	18176 (8346250)	6112 (2807543)
7+	3107 (1427354)	2072 (951569)	5331 (2447989)	5684 (2609142)	3564 (1636469)	6522 (2994757)	10325 (4740580)	5175 (2377005)
Mother's education								
None	9825 (4516270)	7159 (3275886)	10457 (4802513)	1363 (636094)	943 (445266)	3693 (1685650)	21776 (9986682)	14047 (6456358)
Primary			6847 (3144643)	10862 (4987482)	2626 (1205785)	5515 (2531595)	11486 (5273695)	2877 (1320270)
Secondary+				4510 (2070707)	7007 (3217991)	12715 (5837856)	12506 (5743415)	1349 (619114)
Non standard curriculum			923 (423812)	519 (238318)	50 (22942)	93 (42700)	163 (74867)	30 (13798)
Gender of the head of the HH								
Male	9344 (4289467)	6762 (3107033)	17019 (7817899)	15810 (7258130)	9760 (4484442)	20654 (9484627)	41849 19214546)	15773 7245551)
Female	482 (221084)	397 (182237)	1210 (555851)	1451 (666107)	869 (398750)	1372 (630117)	4105 (1885209)	2555 (1173400)
Wealth index quintiles								
Q1 (Poorest)	2351 (1079282)	1769 (812929)	4807 (2207118)	3596 (1650830)	1582 (726920)	3589 (1648055)	9038 (4150658)	3479 (1598114)
Q2	2063 (946851)	1488 (683761)	3904 (1792303)	3712 (1704606)	2164 (993440)	4038 (1853965)	8743 (4014868)	3729 (1712828)
Q3	1900 (872765)	1400 (642301)	3552 (1630980)	3519 (1615979)	2387 (1096411)	4465 (2049635)	8747 (4016084)	3728 (1711438)
Q4	1874 (860550)	1338 (614095)	3079 (1413371)	3242 (1488261)	2299 (1055263)	4850 (2227626)	9090 (4173394)	3881 (1782373)
Q5 (Richest)	1637 (752300)	1164 (534601)	2887 (1325481)	3192 (1466020)	2196 (1008578)	5084 (2334059)	10336 (4746654)	3510 (1612071)
Religion								
Islam	8952 (4108189)	6517 (2993897)	16560 (7604130)	15545 (7138821)	9509 (4365334)	19746 (9067405)	40611 (18649098)	15893 (7298006)
Hindu	756 (346831)	567 (260286)	1457 (668935)	1490 (683901)	1006 (462008)	2030 (932474)	4724 (2169483)	2141 (983230)
Christian	37 (16985)	24 (11013)	51 (23421)	59 (27092)	30 (13778)	54 (24792)	168 (77140)	83 (38105)

Bangladesh	Survey name: MICS 2006							
	Number of females in MICS 2006 (by age group in years)							
	0-2	3-4	5-9	10-14	15-17	18-24	25-49	50-
Buddhist	80 (36764)	51 (23425)	161 (73912)	164 (75316)	84 (38552)	195 (89549)	446 (204821)	209 (95996)
Ethnicity								
Bangalee	9663 (4439786)	7049 (3233835)	17912 (8226068)	16942 (7781416)	10451 (4796855)	21665 (9950780)	45098 (20710019)	17939 (8239543)
Chakma	34 (15596)	30 (13781)	85 (39024)	89 (40873)	46 (21109)	105 (48200)	239 (109745)	104 (47763)
Saontal	19 (8728)	11 (5048)	22 (10107)	24 (11019)	14 (6427)	32 (14689)	69 (31679)	25 (11476)
Marma	32 (14701)	13 (5972)	54 (24788)	54 (24788)	24 (11026)	54 (24788)	136 (62441)	68 (31220)
Tripura	15 (6886)	8 (3670)	30 (13772)	28 (12855)	10 (4588)	26 (11937)	60 (27553)	17 (7804)
Garo	11 (5054)	10 (4596)	23 (10559)	18 (8266)	12 (5513)	16 (7348)	62 (28466)	33 (15155)
Others	50 (22973)	37 (16973)	99 (45454)	99 (45454)	69 (31686)	122 (56016)	282 (129498)	137 (62920)
Illness and disability in the HH								
Child/children with disability	1797 (824702)	1736 (797387)	4332 (1988740)	2456 (1127268)	1007 (462253)	3105 (1425631)	6593 (3027759)	1853 (850966)
Family vulnerability (not mutually exclusive categories)								
Single parent	123 (56488)	149 (68435)	173 (79408)	149 (68435)	92 (42269)	218 (100121)	370 (169919)	140 (64280)
Orphaned child in household	182 (83538)	163 (74884)	202 (92773)	190 (87282)	125 (57411)	301 (138203)	464 (213087)	185 (84952)
Elder (70+) person in HH	1403 (644226)	947 (435352)	2283 (1047895)	2199 (1009171)	1487 (682950)	3463 (1590031)	5869 (2695425)	7904 (3629494)
Geographic dimension								
Barisal	595 (273400)	433 (198836)	1224 (562061)	1256 (576887)	658 (302179)	1261 (579067)	2775 (1274123)	1294 (594329)
Chittagong	2086 (957737)	1495 (686834)	3785 (1737609)	3795 (1743081)	2274 (1043933)	4303 (1975675)	8470 (3889781)	3588 (1647308)
Dhaka	3153 (1447254)	2302 (1056517)	5774 (2652207)	5382 (2471028)	3182 (1460351)	7106 (3263416)	14922 (6852081)	5717 (2626013)
Khulna	1003 (460602)	775 (356199)	1838 (843669)	1759 (807589)	1146 (525854)	2474 (1136152)	5522 (2535614)	2201 (1011022)
Rajshahi	2206 (1012525)	1605 (736829)	4220 (1938074)	3852 (1769047)	2605 (1196322)	5474 (2514081)	11494 (5277601)	4282 (1965972)
Sylhet	783 (359389)	549 (251991)	1387 (636951)	1217 (558843)	764 (351020)	1408 (646714)	2771 (1272507)	1246 (572326)
Residence								
Rural	7236 (3323322)	5214 (2392406)	13339 (6125718)	12215 (5609614)	7300 (3352263)	15073 (6921579)	31168 (14311027)	13497 (6198069)
Urban	2507 (1151914)	1895 (869369)	4724 (2169471)	4886 (2244553)	3245 (1489783)	6776 (3111946)	14366 (6597326)	4630 (2126003)

Sources: Data generated from MICS 2006.
Notes: Numbers in parenthesis indicates national figures.

Table 1.1.4a: Percentage of females in multiple indicator cluster survey (MICS) in 2006 in Bangladesh

Bangladesh	Survey name: MICS 2006							
	Percentage of females in MICS 2006 (by age Group in years)							
	0-2	3-4	5-9	10-14	15-17	18-24	25-49	50-
Total	6.58	4.79	12.20	11.55	7.11	14.74	30.76	12.27
Household dimension								
Household size								
Less than 3	0.29	0.29	0.96	2.23	6.44	13.77	32.05	43.98
3-4 members	6.97	5.18	10.53	7.77	5.74	18.74	35.07	9.99
5-6 members	6.30	4.83	14.24	13.95	7.21	11.12	31.69	10.66
7+	7.44	4.96	12.76	13.60	8.53	15.61	24.71	12.39
Mother's education								
None	14.2	10.3	15.1	2.0	1.4	5.3	31.4	20.3
Primary			17.03	27.01	6.53	13.71	28.56	7.15
Secondary+				11.84	18.40	33.38	32.84	3.54
Non standard curriculum			51.91	29.19	2.81	5.23	9.17	1.69
Gender of the head of the HH								
Male	6.82	4.94	12.43	11.54	7.13	15.08	30.55	11.52
Female	3.87	3.19	9.73	11.66	6.98	11.03	33.00	20.54
Wealth index quintiles								
Q1 (poorest)	7.78	5.86	15.91	11.90	5.24	11.88	29.92	11.52
Q2	6.91	4.99	13.08	12.44	7.25	13.53	29.30	12.50
Q3	6.40	4.71	11.96	11.85	8.04	15.03	29.45	12.55
Q4	6.32	4.51	10.38	10.93	7.75	16.36	30.65	13.09
Q5 (Richest)	5.46	3.88	9.62	10.64	7.32	16.94	34.45	11.70
Religion								
Islam	6.71	4.89	12.42	11.66	7.13	14.81	30.46	11.92
Hindu	5.33	4.00	10.28	10.51	7.10	14.33	33.34	15.11
Christian	7.31	4.74	10.08	11.66	5.93	10.67	33.20	16.40
Buddhist	5.76	3.67	11.58	11.80	6.04	14.03	32.09	15.04
Ethnicity								
Bangalee	6.59	4.80	12.21	11.55	7.12	14.77	30.74	12.23
Chakma	4.64	4.10	11.61	12.16	6.28	14.34	32.65	14.21
Saontal	8.80	5.09	10.19	11.11	6.48	14.81	31.94	11.57
Marma	7.36	2.99	12.41	12.41	5.52	12.41	31.26	15.63
Tripura	7.73	4.12	15.46	14.43	5.15	13.40	30.93	8.76
Garo	5.95	5.41	12.43	9.73	6.49	8.65	33.51	17.84
Others	5.59	4.13	11.06	11.06	7.71	13.63	31.51	15.31
Illness and disability in the HH								
Child/children with disability	7.85	7.59	18.93	10.73	4.40	13.57	28.82	8.10
Family vulnerability (not mutually exclusive categories)								
Single parent	8.70	10.54	12.23	10.54	6.51	15.42	26.17	9.90
Orphaned child in household	10.04	9.00	11.15	10.49	6.90	16.61	25.61	10.21
Elder (70+) person in HH	5.49	3.71	8.93	8.60	5.82	13.55	22.97	30.93
Geographic dimension								
Barisal	6.27	4.56	12.89	13.23	6.93	13.28	29.22	13.63
Chittagong	7.00	5.02	12.70	12.74	7.63	14.44	28.43	12.04
Dhaka	6.63	4.84	12.15	11.32	6.69	14.95	31.39	12.03
Khulna	6.00	4.64	10.99	10.52	6.85	14.80	33.03	13.17
Rajshahi	6.17	4.49	11.81	10.78	7.29	15.32	32.16	11.98
Sylhet	7.73	5.42	13.70	12.02	7.55	13.91	27.37	12.31
Residence								
Rural	6.89	4.96	12.70	11.63	6.95	14.35	29.67	12.85
Urban	5.83	4.40	10.98	11.36	7.54	15.75	33.39	10.76

Source: Data generated from MICS 2006.

Table 1.1.5: Number of males in multiple indicator cluster survey (MICS) 2006 in Bangladesh

Bangladesh	Survey name: MICS 2006							
	Number of males in MICS 2006 (by age Group in years)							
	0-2	3-4	5-9	10-14	15-17	18-24	25-49	50-
Total	9825 (5011788)	7159 (3562158)	18228 (8938175)	17261 (8588515)	10629 (4698552)	22026 (8916321)	45954 (22472917)	18328 (10657335)
Household dimension								
Household size								
Less than 3	17 (5817)	17 (7687)	57 (26384)	132 (61285)	382 (60662)	817 (286896)	1901 (705296)	2609 (923428)
3-4 members	3091 (1566550)	2298 (1151875)	4670 (2474886)	3444 (2053629)	2547 (1228667)	8309 (2273033)	15552 (8254008)	4432 (2937830)
5-6 members	3611 (1834900)	2773 (1396423)	8170 (3890435)	8000 (3893228)	4136 (1910307)	6378 (3178259)	18176 (8082497)	6112 (3742414)
7+	3107 (1603054)	2072 (1007395)	5331 (2549839)	5684 (2579099)	3564 (1502733)	6522 (3174758)	10325 (5434082)	5175 (3049356)
Mother's education								
None	9825 (5008410)	7159 (3563448)	10457 (5506877)	1363 (999902)	943 (554842)	3693 (1255069)	21776 (7744046)	14047 (50380800)
Primary			6847 (3007665)	10862 (5698201)	2626 (1621998)	5515 (2480464)	11486 (5134643)	2877 (2256253)
Secondary+				4510 (1560506)	7007 (2434740)	12715 (5105522)	12506 (9452647)	1349 (3304601)
Non standard curriculum			923 (420390)	519 (324275)	50 (88030)	93 (65973)	163 (86533)	30 (12875)
Gender of the head of the HH								
Male	9344 (4773206)	6762 (3369731)	17019 (8351374)	15810 (7920604)	9760 (4314645)	20654 (8295790)	41849 (21927567)	15773 (10526066)
Female	482 (237661)	397 (190196)	1210 (591122)	1451 (668883)	869 (385778)	1372 (617716)	4105 (547697)	2555 (126573)
Wealth index quintiles								
Q1 (poorest)	2502 (1196696)	1977 (944760)	4796 (2293189)	3986 (1906697)	1620 (774417)	2208 (1056413)	8994 (4301519)	3849 (1840849)
Q2	2207 (1055836)	1506 (720487)	4056 (1940336)	3885 (1858329)	2095 (1001653)	3519 (1682600)	8861 (4237986)	4492 (2148281)
Q3	1934 (924570)	1379 (659987)	3665 (1752126)	3674 (1756535)	2184 (1045102)	4152 (1985840)	9125 (4364145)	4623 (2210735)

Bangladesh	Survey name: MICS 2006							
	Number of males in MICS 2006 (by age Group in years)							
	0-2	3-4	5-9	10-14	15-17	18-24	25-49	50-
Q4	2014 (962783)	1398 (669251)	3263 (1560119)	3346 (1599745)	2068 (989200)	4438 (2122231)	9418 (4504237.5)	4744 (2268996)
Q5 (Richest)	1816 (869186)	1191 (570267)	2916 (1394470)	3065 (1465572)	1863 (890952)	4321 (2066312)	10600 (507000)	4570 (2185298)
Religion								
Islam	9493 (4537939)	6770 (3239530)	17036 (8147516)	16249 (7770977)	8834 (4226321)	16584 (7933278)	41293 (19748799)	19491 (9322575)
Hindu	858 (410643)	600 (287099)	1430 (683703)	1517 (725820)	885 (423278)	1845 (882356)	5085 (2431568)	2458 (1175772)
Christian	34 (16249)	20 (9557)	61 (29164)	46 (22002)	28 (13384)	49 (23434)	154 (73637)	99 (47338)
Buddhist	87 (41577)	59 (28206)	169 (80825)	142 (67919)	82 (39248)	157 (75104)	464 (221919)	231 (110494)
Ethnicity								
Bangalee	10286 (4921701)	7339 (3512435)	18373 (8784664)	17665 (8448443)	9661 (4621248)	18336 (8770356)	46125 (22061811)	21799 (10422846)
Chakma	45 (21523)	31 (14838)	97 (46388)	79 (37794)	49 (23433)	87 (41613)	253 (120983)	127 (60749)
Saontal	18 (8603)	10 (4777)	25 (11954)	18 (8603)	15 (7177)	27 (12916)	78 (37299)	35 (16742)
Marma	33 (15782)	20 (9556)	50 (23920)	44 (21043)	21 (10049)	42 (20078)	133 (63602)	69 (33003)
Tripura	15 (7171)	10 (4787)	35 (16735)	23 (10997)	12 (5739)	19 (9084)	60 (28693)	27 (12910)
Garo	10 (4786)	10 (4786)	27 (12908)	18 (8608)	10 (4786)	14 (6697)	54 (25825)	42 (20083)
Others	66 (31584)	29 (13887)	86 (41134)	106 (50684)	60 (28693)	109 (52129)	289 (138209)	171 (81786)
Illness and disability in the HH								
Child/children with disability	2116 (1012308)	2001 (956502)	4568 (2184219)	2436 (1165214)	1024 (489970)	1517 (725468)	7566 (3618414)	2110 (1008959)
Family vulnerability (not mutually exclusive categories)								
Single parent	144 (68866)	154 (73637)	198 (94676)	128 (61220)	75 (35870)	133 (63577)	243 (116232)	127 (60760)
Orphaned child in household	185 (88459)	190 (90885)	232 (110972)	163 (77923)	94 (44950)	191 (91339)	348 (166457)	182 (87019)
Elder (70+) person in household	1495 (714998)	999 (477453)	2322 (1110906)	2213 (1058906)	1355 (647635)	2835 (1355542)	6690 (3199173)	6803 (3253537)

Bangladesh	Survey name: MICS 2006							
	Number of males in MICS 2006 (by age Group in years)							
	0-2	3-4	5-9	10-14	15-17	18-24	25-49	50-
Geographic dimension								
Barisal	600 (287031)	443 (211714)	1208 (577736)	1258 (601617)	615 (293920)	1008 (482212)	2843 (1359837)	1628 (778428)
Chittagong	2260 (1081070)	1676 (801947)	3988 (1907104)	3790 (1812174)	2117 (1013060)	3727 (1782420)	8095 (3870883)	3974 (1900020)
Dhaka	3226 (1543239)	2315 (1106906)	5848 (2797120)	5490 (2624883)	2982 (1426118)	5947 (2843050)	15006 (7176519)	7206 (3447025)
Khulna	999 (477771)	705 (336816)	1925 (920303)	1843 (881786)	1063 (508092)	2006 (959639)	15006 (2786314)	7206 (1323499)
Rajshahi	2517 (1203123)	1727 (826697)	4297 (2055035)	4256 (2035223)	2382 (1138284)	4679 (2236944)	12459 (5957979)	5344 (2555735)
Sylhet	871 (416574)	585 (280009)	1432 (684793)	1318 (630265)	670 (320291)	1271 (607668)	2768 (1323901)	1357 (648932)
Residence								
Rural	7618 (3641405)	5458 (2610528)	13545 (6477597)	12911 (6175002)	7041 (3369582)	12676 (6062169)	31903 (15257999)	16091 (7693109)
Urban	2769 (1323868)	1932 (924407)	4972 (2377943)	4897 (2342389)	2710 (1296680)	5825 (2785770)	14673 (7016710)	5954 (2846421)

Sources: Data generated from MICS 2006.

Notes: Numbers in parenthesis indicates national figures.

Table 1.1.5a: Percentage of males in multiple indicator cluster survey (MICS) 2006 in Bangladesh

	Survey name: MICS 2006							
	Percentage of males in MICS 2006 (by age Group in years)							
	0-2	3-4	5-9	10-14	15-17	18-24	25-49	50-
Total	6.88	4.89	12.27	11.79	6.45	12.24	30.85	14.63
Household dimension								
Household size								
Less than 3	0.28	0.37	1.27	2.95	2.92	13.81	33.95	44.45
3-4 members	7.14	5.25	11.28	9.36	5.60	10.36	37.62	13.39
5-6 members	6.57	5.00	13.93	13.94	6.84	11.38	28.94	13.40
7+	7.67	4.82	12.20	12.34	7.19	15.19	26.00	14.59
Mother's education								
None	16.88	12.01	18.56	3.37	1.87	4.23	26.10	16.98
Primary			14.89	28.21	8.03	12.28	25.42	11.17
Secondary+				7.14	11.14	23.36	43.25	15.12
Non standard curriculum			42.12	32.49	8.82	6.61	8.67	1.29
Gender of the head of the HH								
Male	6.87	4.85	12.02	11.40	6.21	11.94	31.56	15.15
Female	7.06	5.65	17.56	19.87	11.46	18.35	16.27	3.76
Wealth index quintiles								
Q1 (poorest)	8.36	6.60	16.02	13.32	5.41	7.38	30.05	12.86
Q2	7.21	4.92	13.25	12.69	6.84	11.49	28.94	14.67
Q3	6.29	4.49	11.92	11.95	7.11	13.51	29.69	15.04
Q4	6.56	4.56	10.63	10.90	6.74	14.46	30.69	15.46
Q5	5.99	3.93	9.61	10.10	6.14	14.24	34.94	15.06
Religion								
Islam	6.99	4.99	12.55	11.97	6.51	12.22	30.42	14.36
Hindu	5.85	4.09	9.74	10.34	6.03	12.57	34.64	16.75
Christian	6.92	4.07	12.42	9.37	5.70	9.98	31.36	20.16
Buddhist	6.25	4.24	12.15	10.21	5.90	11.29	33.36	16.61
Ethnicity								
Bangalee	6.88	4.91	12.28	11.81	6.46	12.26	30.84	14.57
Chakma	5.86	4.04	12.63	10.29	6.38	11.33	32.94	16.54
Saontal	7.96	4.42	11.06	7.96	6.64	11.95	34.51	15.49
Marma	8.01	4.85	12.14	10.68	5.10	10.19	32.28	16.75
Tripura	7.46	4.98	17.41	11.44	5.97	9.45	29.85	13.43
Garo	5.41	5.41	14.59	9.73	5.41	7.57	29.19	22.70
Others	7.21	3.17	9.39	11.57	6.55	11.90	31.55	18.67
Illness and disability in the HH								
Child/children with disability	9.07	8.57	19.57	10.44	4.39	6.50	32.42	9.04
Family vulnerability (not mutually exclusive categories)								
Single parent	11.98	12.81	16.47	10.65	6.24	11.06	20.22	10.57
Orphaned child in household	11.67	11.99	14.64	10.28	5.93	12.05	21.96	11.48
Elder (70+) person in household	6.05	4.04	9.40	8.96	5.48	11.47	27.07	27.53
Geographic dimension								
Barisal	6.25	4.61	12.58	13.10	6.40	10.50	29.61	16.95
Chittagong	7.63	5.66	13.46	12.79	7.15	12.58	27.32	13.41
Dhaka	6.72	4.82	12.18	11.43	6.21	12.38	31.25	15.01
Khulna	5.83	4.11	11.23	10.76	6.20	11.71	34.00	16.15
Rajshahi	6.68	4.59	11.41	11.30	6.32	12.42	33.08	14.19
Sylhet	8.48	5.70	13.94	12.83	6.52	12.37	26.95	13.21
Residence								
Rural	7.10	5.09	12.63	12.04	6.57	11.82	29.75	15.00
Urban	6.33	4.42	11.37	11.20	6.20	13.32	33.55	13.61

Source: Data generated from MICS 2006.

Table 1.2.1: Population and economic growth since 1990

Bangladesh Year	Population in millions	GDP (at constant price) 1995-96 = 100 (in million Tk.)	GDP ppp
1990-1991	109.6[1]	514442	
1991-1992	111.4[1]	536189	
1992-1993	113.2[2]	1455680[1]	118348
1993-1994	117.7[2]	1515139[1]	119302
1994-1995	119.9[2]	1589762[1]	115200
1995-1996	122.1[2]	1663240[1]	113146
1996-1997	124.3[2]	1752847[1]	116083
1997-1998	126.5[2]	1844478[1]	114564
1998-1999	128.2[2]	1934291[1]	110531
1999-2000	129.8[2]	2049276[1]	111982
2000-2001	129.9[2]	2157353[2]	117463
2001-2002	131.6[2]	2252609[2]	119186
2002-2003	135.2[2]	2371006[2]	116798
2003-2004	137.0[2]	2669740[2]	116652
2004-2005	137.1[2]	2669740[2]	116583
2005-2006	138.6*	2846726[2]	118121
2006-2007	140.6*	3032068* provisional	116618

Sources: [1] Statistical Yearbook 2000, p-581, 451.
[2] Statistical Yearbook 2006, p–563, 468.
*http://www.bbs.gov.bd/na_wing/key_bulletin.pdf, page-3.

Notes:
- The conversion rate of PPP dollar was $1 = Tk. 12.7 in 1993. (Source: http://www.povertytools.org/other_documents/Calculating_PPP_Conversion.pdf
- The conversion rates of various years have been estimated by adjusting the inflation rates of respective years.

Table 1.2.2: Total fertility rate (TFR) by year (children per women), 1990-2005

1990	1995	2000	2005
4.33*	3.45*	2.59*	2.48*
4.6**	4.1**	3.5**	3.2**
4.3 (1991)***	3.4 (1993-94)**	3.3 (1999-2000)***	3 (2004)***

Sources: * Statistical Yearbook 2006, p. 47; Based on Sample Vital Registration System
** http://unstats.un.org/unsd/cdb/cdb_series_xrxx.asp? series_code=13700 provided in guide.
*** Bangladesh Demographic and Health Survey 2004, p.53.

Table 1.2.3: The structure of the economy

Sectors	Share (per cent) in total GDP at constant price 2005-2006[1] (base 1995-96 = 100)	Share (per cebt) in total employment 2005-2006[2]
Agriculture forestry and fishery	21.77	48.1
Mining and quarrying	1.16	0.1
Industry	17.05	11.0
Services	60.02	40.8

Sources: [1] Bangladesh Economic Review 2006, p.27, 34.
[2] Bangladesh Labor Force Surveys 2005-06 (Provisional).

Notes: Services = Electricity, Gas & Water + Construction + Wholesale & Retail Trade + Hotel & Restaurant + Transport, Storage & Communication + Financial & Intermediations + Real State, Renting & other Business Activities + Public Administration & Defense + Education + Health & Social Work + Community, Social and Personal Services.

Table 1.2.4: Income inequality in 2005 and 1991-1992

Gini index of HH income*		P_{10}/P_{90} (decile ratios)*	
2005	1991-92	2005	1991-1992
0.467	0.388	0.133	0.165

Sources: *Statistical Yearbook of Bangladesh 2006, p. 586, 588.

Table 1.2.5: Sub-national dimensions of development in Bangladesh

Sub-national region	Population (in thousands)			HDI scores (or similar socioeconomic indicator)		
	2001*	Percentage of change over 1991	1991*	2005**	Change over 1990	1990
Barisal	8153.960	691.317 (9.26 per cent)	7462.643	National 0.547	0.125 (29.6 per cent)	National 0.422**
Chittagong	24119.660	3596.752 (17.53 per cent)	20522.908			
Dhaka	38987.140	6321.165 (19.35 per cent)	32665.975			
Khulna	14604.900	1916.517 (15.10 per cent)	12688.383			
Rajshahi	30088.740	3878.696 (14.80 per cent)	26210.044			
Sylhet	7896.720	1131.681 (16.73 per cent)	6765.039			
Residence						
Urban	28605.200	7732.996 (37.05 per cent)	20872.204			
Rural	95245.920	9803.132 (11.47 per cent)	85442.788			

Sources: * Population census 2001, p.124-133.
** http://hdrstats.undp.org/indicators/10.html

Notes:
- At present only national values for HDI are available.
- According to the Guide Book, data are required for the year 1995 and 1990 but here data are presented for the years 1991 and 2001 as no Population Census was conducted in 1991 and 2001.

1.3 MACRO ECONOMIC STRATEGIES AND RESOURCES ALLOCATION

Table 1.3.1: Public revenues and expenditures as per cent of GDP* 1995-1996 to 2005-2006

Bangladesh	1995-1996	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006
Total public revenues								
Taxes on commodities and transactions	5.7	5.4	5.8	6.1	6.2	6.8	6.9	6.8
Grants from foreign governments and international organizations	1.7	1.5	1.1	1.0	0.8	0.8	0.7	0.6
Royalties, rents								
Total public expenditures								
Health sector (Total govt. expenditure on health including family planning)[1]	1.0	0.8	0.8	0.8	0.8	0.8	0.8	0.8
Current expenditures								
Hospital services								
Education (Total govt. expenditure on education) (Rev+ Dev)[2, 3]	1.5	1.9	1.6	2.1	1.9	1.9	1.8	1.7
Current expenditures								
Pre-Primary								
Primary								20714.2
Lower secondary								11970.5
Upper secondary								7259.5
Social protection								
Old age pensions								
Labour market policies								
Family and children								
Social work (welfare) services								
Consumer price subsidies								
Water and sanitation								
Memorandum items:								
Bangladesh	1995-96	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06
GDP at constant price	1663200	2049300	2157400	2252600	2371000	2519700	2669700	2849000
GDP at current price	1663200	2370900	2535500	2732000	3005800	3329700	3707100	4161600
Total public revenues	9.2	8.5	9.6	10.2	10.4	10.6	10.6	10.8

Sources: *Statistical Year Book 2006, p. 376, 1996, p. 378.
1. Statistical Pocket Book -1997, 2003, 2006.
2. Statistical Pocket Book -1997, 2003.
3. Bangladesh Economic Review-2006, p. 225, 226.

Notes: Taxes on international trade and transactions are replaced by taxes on commodities and transactions.
Taxes on commodities and transactions includes custom, excise and sales tax/VAT.

Table 1.3.2: Selected social expenditures at the sub-national level 2005

Bangladesh	Public expenditures	Child population (0-17 in millions)
	2005-06	
Current health expenditures		
Barisal	1307.929	
Chittagong	3156.347	
Dhaka	4419.134	
Khulna	1899.450	
Rajshahi	4400.870	
Sylhet	1086.439	
Current education expenditures		
Barisal		
Chittagong		
Dhaka		
Khulna		
Rajshahi		
Sylhet		
Current water and sanitation expenditure		
Barisal		
Chittagong		
Dhaka		
Khulna		
Rajshahi		
Sylhet		
Memorandum items:		
Total public expenditures		
Current health expenditures	1627.0169	
Current education expenditures		
Current water and sanitation expenditures		

Sources: Public Expenditure Review of the Health Sector 2003-2004 to 2005-2006.
Health Economic Unit (HEU) Research Paper 34 October, 2007 p.24.

Table 1.3.3: Total and private social expenditures in 2005

Bangladesh	Social Expenditures (in million Tk.)
Total health expenditures	32010
Private health expenditures	
Total education expenditures	71300
Private education expenditures	
Total primary and lower secondary education expenditures	
Private expenditures on primary and lower secondary education	
Total water and sanitation expenditures	
Private expenditures on water and sanitation	

Sources: Statistical Pocket Book-2006, p.357, 375.

Table 1.3.4: Financing from abroad by year (in million Tk.)

Bangladesh	1995-1996	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007
Balance of payments								
Trade balance (in million Tk.)	-122200	-155100	-146800	-127800	-136700	-276600	-193100	-229800
Debt service/repayment	-12900	-22400	-24700	-28900	30900	27100	33800	-38700
Remittances***	49704.00	101700.100	143770.30	177288.20	198698.00	236469.70	322756.80	412985.29
Foreign Direct Investment (FDI)	3769.53	31221.26	20358.90	19008.57	20448.18	28263.96	51892.97	54706.27
Aid disbursed (ODA/OA) of which								
for general budget support								
for health (less HIV/AIDS)								
for HIV/AIDS								
for education								
for water and sanitation								
Aid allocated but not disbursed/used (ODA/OA) of which								
for general budget support								
for health (less HIV/AIDS)								
for HIV/AIDS								
for education								
for water and sanitation								
Memorandum items:								
Bangladesh	1995-1996	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007
GNI (at constant market price) Base 1995-96 = 100	67207[1]	2232581*	2356025*	2501815*	2652506*	2806055*	3033031*	3273784[2]
Total government revenue (in million Tk.)	154495[1]	241726*	276700*	311200*	354000*	392000*	448680*	494720[2]
Net aid allocated (ODA/OA) in US$								

Sources: * Statistical Yearbook 2006, p. 297, 375, 468.
** Statistics dept. Bangladesh Bank, R = Revised, P = Provisional.
*** http://www.bangladesh-bank.org/
1 Statistical Yearbook 1996, p. 377, 478.
2 Statistical Pocketbook 2007, p.289, 309.
http://www.banglaembassy.com.bh/FDI% 20in%20Bangladesh.htm

PART TWO: POVERTY AND CHILDREN
POVERTY AND DEPRIVATIONS AFFECTING CHILDREN

Table 2.1.1: Trends in income/consumption poverty since 1990

Indicator	1991-1992	1995-1996	2000	2005
Poverty headcount among households with children (0-17)				
- by CBN method				
Upper poverty line				42.0
Lower poverty line				26.6
- by DCI method				
Poverty line 1: Absolute poverty (2122 K.Cal/person/day)				42.4
Poverty line 2: Hardcore poverty (1805 K.Cal/person/day)				20.6
- by international poverty line (below $1 ppp threshold)				51.1
Poverty headcount among all households				
- by CBN method*				
Upper poverty line	56.6	50.1	48.9	40.0
Lower poverty line	41.0	35.1	34.3	25.1
- by DCI method*				
Poverty line 1: Absolute poverty (2122 K.Cal/person/day)	47.5	47.5	44.3	40.4
Poverty line 2: Hardcore poverty (1805 K.Cal/person/day)	28.0	25.1	20.0	19.5
- by international poverty line (below $1 ppp threshold)		49.8[1]		49.6
Number of children in poverty				
- by CBN method				
Upper poverty line				45.8
Lower poverty line				29.9
- by DCI method				
Poverty line 1: Absolute poverty (2122 K.Cal/person/day)				45.3
Poverty line 2: Hardcore poverty (1805 K.Cal/person/day)				22.6
- by international poverty line (below $1 ppp threshold)				55.7
National poverty line (per capita income of the poor) Tk.				731.73
Number of households with children (in millions)				24.69
Total number of households (in millions)			24.35	28.64
Total number of children				59.83
Average household size			5.18	4.85
Average household size among families with children				5.21

*Sources: Data generated from HIES-2005. p.57, 162, and vii.

[1] http://hdrstats.undp.org/countries/data_sheets/cty_ds_BGD.ht

Table 2.1.2: Correlation of income/consumption poverty among households with children: 2005

Indicator	CBN method				DCI method			
	Upper poverty line		Lower poverty line		Poverty line 1: 2122 K.Cal/person/day		Poverty line 2: 1805 K.Cal/person/day	
	Head count (per cent)	Poverty gap	Head count (per cent)	Poverty gap	Head count (per cent)	Poverty gap	Head count (per cent)	Poverty gap
All households (0-17) with children	42.0	9.5	26.6	5.0	42.4	6.9	20.6	2.3
Individual dimension								
Sex and age								
Male								
Age (0-14) year	47.7	11.2	31.2	6.0	46.1	7.6	22.8	2.6
Age (15-24) year	33.2	6.6	18.7	3.1	29.8	4.2	11.8	1.1
Age (25-44) year	42.3	9.4	26.6	4.8	44.9	7.4	22.6	2.5
Age (45-64) year	34.2	7.2	20.2	3.6	34.7	5.2	14.9	1.5
Age (65-) year	36.3	7.7	21.2	3.8	37.9	5.5	14.8	1.5
Female								
Age (0-14) year	48.5	11.6	32.2	6.2	49.4	8.4	25.7	3.0
Age (15-24) year	36.6	7.8	21.8	3.8	39.1	6.2	18.6	2.0
Age (25-44) year	40.7	9.3	25.9	4.9	42.6	7.0	21.2	2.4
Age (45-64) year	36.9	8.0	22.5	4.1	36.3	5.4	15.3	1.6
Age (65-) year	37.2	8.9	24.5	4.9	41.9	6.3	18.6	1.8
Household dimension								
Household size								
Less than 3	29.6	7.5	19.5	4.4	25.3	4.7	13.6	2.4
3-4 members	35.9	7.6	21.7	3.8	38.6	6.4	19.7	2.2
5-6 members	44.3	10.3	28.9	5.5	43.8	7.0	20.7	2.3
7+	44.6	10.2	28.0	5.4	44.4	7.2	21.4	2.2
Education of the head of the household								
None	53.3	12.6	35.4	6.8	48.0	7.9	23.9	2.8
Primary	39.6	8.5	23.2	4.1	39.4	6.1	18.2	1.8
Secondary+	19.0	3.5	9.8	1.5	32.4	5.2	15.0	1.6
Gender of the head of the household								
Male	42.7	9.6	26.7	4.9	42.5	6.8	20.3	2.2
Female	31.4	8.7	24.2	5.2	41.9	8.0	24.1	3.3
Wealth (consumption) index quintiles[1]								
Q1 (poorest)	100.0	33.6	100.0	22.0	75.6	13.6	42.8	5.5
Q2	85.0	10.8	26.4	1.5	53.0	7.9	24.2	2.4
Q3	15.8	1.0	0.0	0.0	38.1	5.6	15.9	1.6
Q4	0.8	0.0	0.0	0.0	23.8	3.6	9.2	0.9
Q5 (Richest)	0.0	0.0	0.0	0.0	17.6	2.9	8.4	0.8
Religion								
Muslim	41.1	9.4	26.3	4.9	43.0	7.0	21.1	2.3
Hindu	46.4	10.3	28.8	5.5	38.9	6.0	16.6	2.1
Buddhist	62.8	8.6	23.7	2.3	29.5	4.5	15.5	1.1
Christian	49.1	7.3	34.6	1.7	47.5	1.4	0.0	0.0
Work (not mutually exclusive categories)								
Both parents working	47.9	11.7	29.9	6.4	47.8	8.1	24.7	3.1
None of the parents are working	30.7	5.9	15.1	2.6	37.1	5.8	16.2	1.6
No adult in primary working age (18-54)	28.7	6.6	17.9	3.3	36.7	5.8	17.3	1.8
At least one child under15 working	56.1	15.3	38.7	8.7	43.1	7.0	21.7	2.3
Access to land in rural areas[2]								
Have not own land	68.8	17.1	50.7	10.3	69.9	11.6	36.7	4.0
Have own land	45.5	10.3	29.9	5.6	41.1	6.3	18.6	2.0
Have not own operational land	65.9	17.4	47.4	10.5	64.8	12.1	43.3	4.9
Have own operational land	45.6	10.3	30.0	5.6	41.3	6.3	18.6	2.0
Illness and disability in the household								

Indicator	CBN method				DCI method			
	Upper poverty line		Lower poverty line		Poverty line 1: 2122 K.Cal/person/day		Poverty line 2: 1805 K.Cal/person/day	
	Head count (per cent)	Poverty gap	Head count (per cent)	Poverty gap	Head count (per cent)	Poverty gap	Head count (per cent)	Poverty gap
Adult(s) with chronic illness	48.6	11.3	32.8	5.8	44.2	6.7	21.5	2.1
Child/children with chronic illness[3]	37.2	8.3	23.9	4.4	39.5	5.9	16.7	1.8
Family vulnerability (not mutually exclusive categories)								
Orphaned child in household[4]	32.8	9.0	25.7	5.3	42.2	7.9	22.7	3.1
High dependency ratio (4+children per adult)	35.7	11.4	26.9	7.1	52.0	7.8	20.7	2.5
Elder (70+) person in household	35.5	8.0	22.3	4.2	41.6	6.2	17.1	1.7
Geographic dimension								
Region								
Barisal	54.0	16.2	37.2	9.6	55.4	9.9	31.1	3.4
Chittagong	35.7	6.6	17.0	2.4	44.1	7.8	23.9	2.7
Dhaka	33.8	7.3	21.2	3.9	39.8	6.3	18.2	1.9
Khulna	47.9	11.4	33.6	6.6	43.2	7.3	23.0	2.6
Rajshahi	53.7	12.6	36.5	6.8	40.8	5.8	16.6	1.9
Sylhet	35.4	7.6	22.1	3.7	42.2	7.3	22.0	2.6
Residence								
Rural	45.8	10.3	30.1	5.7	41.4	6.4	18.8	2.0
Urban	30.2	7.0	15.6	2.8	45.6	8.4	26.1	3.1

Sources: Data are generated from HIES 2005

Notes: [1] Wealth index quintiles are determined by considering consumption.
[2] *Access to land in rural areas is classified into four classes such as* have not own land, have own land, have not own operational land and have own operational land.
[3] Child/children with disability are replaced by Child/children with chronic illness.
[4] *Orphaned children are considered those for whom one or both biological parents are dead.*

Table 2.1.3: Odds for the probability of income and consumption poverty: 2005

Indicator	CBN method				DCI method			
	Upper poverty line		Lower poverty line		Poverty line 1: 2122 K.Cal/person/day		Poverty line 2: 1805 K.Cal/person/day	
	HH with children	All HHs	HH with children	All HHs	HH with children	All HHs	HH with children	All HHs
Individual Dimension								
Sex and age								
Male								
Age (0-14) year	0.91	0.91	0.45	0.45	0.86	0.86	0.30	0.30
Age (15-24) year	0.50	0.45	0.23	0.21	0.42	0.39	0.13	0.12
Age (25-44) year	0.73	0.66	0.36	0.33	0.81	0.73	0.29	0.27
Age (45-64) year	0.52	0.46	0.25	0.22	0.53	0.46	0.18	0.16
Age (65-) year	0.57	0.48	0.27	0.23	0.61	0.49	0.17	0.15
Female								
Age (0-14) year	0.94	0.94	0.47	0.47	0.98	0.98	0.35	0.35
Age (15-24) year	0.58	0.52	0.28	0.25	0.64	0.58	0.23	0.21
Age (25-44) year	0.69	0.64	0.35	0.33	0.74	0.69	0.27	0.25
Age (45-64) year	0.58	0.47	0.29	0.23	0.57	0.45	0.18	0.15
Age (65-) year	0.59	0.54	0.32	0.29	0.72	0.61	0.23	0.21
Household dimension								
Household size								
Less than 3	0.42	0.24	0.24	0.10	0.34	0.22	0.16	0.09
3-4 members	0.56	0.50	0.28	0.25	0.63	0.55	0.25	0.22
5-6 members	0.80	0.77	0.41	0.39	0.78	0.75	0.26	0.25
7+	0.81	0.80	0.39	0.39	0.80	0.80	0.27	0.27
Education of the head of the household								
None	1.14	1.05	0.55	0.51	0.92	0.85	0.31	0.30
Primary	0.66	0.62	0.30	0.29	0.65	0.61	0.22	0.21
Secondary+	0.23	0.22	0.11	0.10	0.48	0.43	0.18	0.16
Gender of the head of the household								
Male	0.75	0.69	0.36	0.34	0.74	0.68	0.25	0.24
Female	0.46	0.42	0.32	0.28	0.72	0.63	0.32	0.29
Wealth index quintiles								
Q1 (poorest)				999	3.10	3.02	0.75	0.74
Q2	5.67	5.45	0.36	0.35	1.13	1.08	0.32	0.31
Q3	0.19	0.18	0.00	0.00	0.62	0.57	0.19	0.18
Q4	0.01	0.01	0.00	0.00	0.31	0.30	0.10	0.10
Q5 (Richest)	0.00	0.00	0.00	0.00	0.21	0.19	0.09	0.08
Religion								
Muslim	0.41	0.39	0.26	0.25	0.43	0.41	0.21	0.20
Hindu	0.79	0.72	0.39	0.36	0.68	0.62	0.21	0.20
Buddhist	1.17	1.02	0.33	0.28	0.48	0.42	0.19	0.17
Christian	1.32	1.08	0.45	0.44	0.67	0.63	0.00	0.25
Work (not mutually exclusive categories)								
Both parents working	0.92	0.79	0.43	0.37	0.92	0.78	0.33	0.29
None of the parents are working	0.44	0.38	0.18	0.16	0.59	0.51	0.19	0.18
No adult in primary working age (18-54)	0.40	0.37	0.22	0.20	0.58	0.51	0.21	0.19
At least one child under 15 working	1.28	1.23	0.63	0.61	0.76	0.79	0.28	0.30
Access to land in rural areas								
Have not own land	2.21	1.99	1.03	0.97	2.32	2.07	0.58	0.56
Have own land	0.83	0.77	0.43	0.39	0.70	0.64	0.23	0.22
Have not own operational land	1.93	1.75	0.90	0.86	1.84	1.67	0.76	0.74
Have own operational land	0.84	0.78	0.43	0.40	0.70	0.65	0.23	0.22
Illness and disability in the household								
Adult(s) with chronic illness	0.95	0.72	0.49	0.59	0.79	0.56	0.27	0.22
Child/children with disability	0.58	0.47	0.31	0.37	0.63	0.45	0.20	0.16
Family vulnerability (not mutually exclusive categories)								
Orphaned child in household	0.49	0.46	0.35	0.30	0.73	0.61	0.29	0.25
High dependency ratio (4+children per adult)	0.56	0.56	0.37	0.37	1.08	1.08	0.26	0.26

Elder (70+) person in household	0.55	0.52	0.29	0.27	0.71	0.66	0.21	0.19
Geographic dimension								
Region								
Barisal	1.17	1.08	0.59	0.55	1.24	1.11	0.45	0.41
Chittagong	0.56	0.52	0.20	0.19	0.79	0.73	0.31	0.29
Dhaka	0.51	0.47	0.27	0.25	0.66	0.61	0.22	0.21
Khulna	0.92	0.85	0.51	0.46	0.76	0.70	0.30	0.28
Rajshahi	1.16	1.05	0.57	0.53	0.69	0.63	0.20	0.19
Sylhet	0.55	0.51	0.28	0.26	0.73	0.67	0.28	0.26
Residence								
Urban	0.85	0.78	0.43	0.40	0.71	0.65	0.23	0.22
Rural	0.43	0.40	0.18	0.17	0.84	0.76	0.35	0.32

Sources: Data generated from HIES 2005.

Table 2.1.4: Child poverty as multiple deprivations: 2006

Indicators	Number of children in relevant age cohort	Percentage experiencing 'severe' deprivation	Percentage experiencing 'less severe' deprivation
a) Incidence (prevalence) of deprivation			
1. Shelter (0-17 age group)	127509 (63358252)	21.1	41.4
2. Sanitation (0-17 age group)	127509 (63358252)	8.0	63.8
3. Water (0-17 age group)	127509 (63358252)	1.7	3.1
4. Information (3-17 age group)	107209 (53479108)	51.7	59.4
5. Food (< 5 age group)	3797 (18201447)	6.2	35.4
6. Education (7-17 age group)	78503 (37497989)	8.4	7.7
7. Health (0-2 age group)	6032 (9879144)	0.8	16
b) The incidence of the most frequent combinations of deprivations			
The most frequent case of any deprivation	107209 (53479108)	51.7 (Information)	84.3 (Information)
Two most frequent combinations	127509 (63358252)	12.3 (Shelter +Information)	48.4 (Sanitation+Information)
Two second most frequent combinations	127509 (63358252)	1.7 (Shelter+Education	16.3 Shelter+Sanitation
Three most frequent combinations	127509 (63358252)	1.3 (Shelter+Information+ Education)	23.9 Shelter+Sanitation+ Infomation
Three second most frequent combinations	127509 (63358252)	0.2 (Shelter+Sanitation+ Education)	0.3 (Shelter+Sanitation+ Health)
The most frequent associate of food	3797 (18201447)	6.2	35.4
The most frequent associate of education	78503 (37497989)	8.4	7.7
The most frequent associate of health	6032 (9879144)	0.8	16
c) The incidence of multiple deprivations			
One deprivation (shelter)	127509 (63358252)	21.1	41.4
Two of deprivations	127509 (63358252)	2.49	30.77
Three of deprivations	127509 (63358252)	.05	29.71
Four of deprivations	127509 (63358252)	.04	23.08
Five of deprivations	127509 (63358252)	.01	1.53
Six of deprivations	127509 (63358252)		

Sources: • Data generated from MICS 2006.
• Data for food are generated from CMNS 2005 for under five children, as this is the only age group for which information is available

Notes: Numbers in parenthesis indicates national figures.

	METHODOLOGY FOR DEFINING DEPRIVATION
1. Shelter	
Severe	Children living in a dwelling with 5 or more people per room.
Less severe	Children living in dwellings with 4 or more people per room.
2. Sanitation facilities	
Severe	Children with no access to a toilet facility of any kind.
Less severe	Children using unimproved sanitation facilities. Unimproved sanitation facilities are: Pit latrine without slab/open pit; Bucket; Hanging toilet/ hanging latrine; Flush to somewhere else; Flush to unknown place/not sure/ don't know.
3. Safe drinking water	
Severe	Children using surface water such as rivers, ponds, streams and dams,
Less severe	Children using water from an unimproved source such as unprotected well, unprotected spring, surface water.
4. Information	
Severe	Children (aged 3-17 years) with no access to a radio or television or telephone (mobile and non mobile) or computer (i.e. all forms of media).
Less severe	Children (aged 3-17 years) and adults with no access to a radio or television (i.e. broadcast media).
5. Food	
Severe	Children who are more than three standard deviations below the international reference population for stunting (height for age) or wasting (height for weight) or underweight (weight for age). This is also known as severe anthropometric failure.
Less severe	Children who are more than two standard deviations below the international reference population for stunting (height for age) or wasting (height for weight) or underweight (weight for age).
6. Education	
Severe	Children (aged 7-17) of schooling age who have never been to school i.e., who are not currently attending school.
Less severe	Children (aged 7-17) of schooling age not currently attending school but attended and did not complete their primary education.
7. Health	
Severe	Children who did not receive immunization against any diseases.
Less severe	Children who have not received all immunizations by two years of age.

If the child has not received all nine of the following vaccinations they are defined as deprived:
BCG, DPT1, DPT2, DPT3, polio 0, polio1, polio2, polio3 and measles.

Table 2.1.5: Change in the incidence/prevalence of severe deprivations over the last decade among children

Indicator	2006		Last available between 1990 and 1995[2]	
	Number of children in relevant age cohort	Of which experiencing 'severe' deprivation, per cent	Number of children in relevant age cohort	Of which experiencing 'severe' deprivation, per cent
1. Shelter	127509 (63358252)	21.1		
2. Sanitation	127509 (63358252)	8.0		
3. Water	127509 (63358252)	1.7		
4. Information	107209 (53479108)	51.7		
5. Food[1]	3797 (18201447)	6.2		
6. Education	78503 (37497989)	8.4		
7. Health	6032 (9879144)	0.8		
Two severe deprivations (Shelter + information)	127509 (63358252)	12.3		

Sources: Data generated from MICS 2006.
1. Data for food indicator are generated from CMNS 2005.
2. Data are not available between 1990 and 1995.

Notes: Numbers in parenthesis indicates national figures.

Table 2.1.6: Correlation of severe child deprivations (by individual, households and geographic dimensions): 2006

Indicator	At least one severe deprivation (per cent)	At least two severe deprivations (per cent)
Total	57.85	20.27
Individual dimension		
Sex and age (year)		
Male		
Age (0-4) year	48.87	13.75
Age (5-9) year	65.15	26.14
Age (10-14) year	61.53	23.02
Age (15-17) year	56.20	19.24
Female		
Age (0-4) year	48.51	14.00
Age (5-9) year	65.07	26.49
Age (10-14) year	60.65	21.06
Age (15-17) year	53.47	15.33
Household dimension		
Household size		
Less than 3	72.54	21.61
3-4 members	51.77	10.00
5-6 members	65.07	28.54
7+	52.84	17.75
Education of household head		
None	74.12	31.22
Primary	56.51	16.35
Secondary+	29.32	5.04
Non-standard curriculum	69.77	22.67
Gender of the head of the household		
Male	58.31	20.54
Female	51.68	16.61
Wealth index quintiles		
Q1 (poorest)	93.17	51.49
Q2	82.64	24.20
Q3	54.51	11.00
Q4	27.67	4.65
Q5 (Richest)	17.39	2.02
Religion		
Islam	57.83	20.15
Hindu	57.25	21.27
Christian	67.31	30.67
Buddhist	62.58	20.09
Ethnicity		
Bangalee	57.65	20.06
Chakma	63.48	15.50

Indicator	At least one severe deprivation (per cent)	At least two severe deprivations (per cent)
Saontal	92.71	62.40
Marma	68.49	32.68
Tripura	81.34	38.84
Garo	65.47	18.07
Others	67.97	41.17
Illness and disability in the household		
Child/children with disability	64.58	25.92
Family vulnerability (not mutually exclusive categories)		
Single parent	62.31	26.97
Orphaned child in household	56.98	23.53
Elder (70+) person in household	48.71	14.15
Geographic dimension		
Region		
Barisal	61.06	13.01
Chittagong	51.64	14.84
Dhaka	56.86	21.20
Khulna	57.02	17.48
Rajshahi	63.42	25.85
Sylhet	60.75	24.70
Residence		
Rural	63.27	22.74
Urban	42.91	13.18

Sources: Data generated from MICS. Here we consider six deprivation indicators Shelter, Sanitation, Water, Information, Education and Health as MICS 2006 did not collect data on food.

Table 2.1.7: Odds for the probability that children will or will not experience deprivations

Indicator	Odds of children having			
	'At least one less severe' deprivations*		at least two 'severe' deprivations	
Total (average)	127248/12765	9.97	25846/101662	0.25
Individual dimension				
Sex and age				
Male				
Age (0-4) years	17844/2888	6.18	2464/15460	0.16
Age (5-9) years	18687/1255	14.89	4886/13811	0.35
Age (10-14) years	17967/1339	13.42	4133/13822	0.30
Age(15-17) years	9814/859	11.42	1891/7939	0.24
Female				
Age (0-4) years	16866/2725	6.19	2379/14606	0.16
Age (5-9) years	18266/1240	14.73	4829/13400	0.36
Age (10-14) years	17366/1396	12.44	3635/13626	0.27
Age (15-17) years	10438/1063	9.82	1629/8999	0.18
Household dimension				
Household size				
Less than 3	905/51	17.75	203/737	0.28
3-4 members	33607/3320	10.12	3346/30392	0.11
5-6 members	54016/5002	10.80	15329/38388	0.40
7+	38720/4392	8.82	6938/32144	0.22
Education of household head				
None	57472/1616	35.56	17847/39315	0.45
Primary	34112/2667	12.79	3643/15117	0.20
Secondary+	30572/8078	3.78	1861/13041	0.05
Non-standard curriculum	379/22	17.23	102/347	0.29
Gender of the head of the household				
Male	118802/11668	10.18	24394/94370	0.26
Female	8446/1097	7.70	1452/7292	0.20
Wealth index quintiles				
Q1 (poorest)	28115/135	208.26	14924/14062	1.06
Q2	27835/496	56.12	6553/20526	0.32

Indicator	Odds of children having			
	'At least one less severe' deprivations*		at least two 'severe' deprivations	
Q3	26336/715	36.83	2815/22780	0.12
Q4	24361/3697	6.59	1111/22810	0.05
Q5 (Richest)	206011/7722	26.68	443/21485	0.02
Religion				
Islam	110100/11051	9.96	23261/92203	0.25
Hindu	12231/1397	8.76	2248/8320	0.27
Christian	1869/120	15.58	119/270	0.44
Buddhist	3030/197	15.38	217/862	0.25
Ethnicity				
Bangalee	120478/12440	9.68	25143/100197	0.25
Chakma	1612/77	20.94	91/496	0.18
Saontal	471/7	67.29	110/66	1.66
Marma	1108/80	13.85	112/232	0.49
Tripura	507/13	62.08	73/114	0.63
Garo	1304/81	16.10	288/412	0.22
Others	1736/66	26.30	27/121	0.70
Illness and disability in the household				
Child/children with disability	23103/1662	13.90	6083/17389	0.35
Family vulnerability (not mutually exclusive categories)				
Single parent	1347/131	10.28	373/1011	0.37
Orphaned child in household	1666/194	8.59	406/1320	0.31
Elder (70+) person in household	16772/2473	6.78	2363/14338	0.16
Geographic dimension				
Region				
Barisal	11809/1335	8.85	1078/7212	0.15
Chittagong	27421/3021	9.08	4046/23221	0.17
Dhaka	32790/22931	1.43	8408/31246	0.27
Khulna	16379/1622	10.10	2282/10774	0.21
Rajshahi	27532/2548	10.81	7668/21999	0.35
Sylhet	11317/1308	8.65	2365/7210	0.33
Residence				
Rural	87060/6362	13.68	20893/70984	0.29
Urban	35730/6284	5.69	4553/29985	0.15

Sources: Data generated from MICS

Notes: • Odds Ratio = At least one 'less severe' deprivations/Not 'less severe' deprivations.
• Odds Ratio = At least two 'severe' deprivations/less than two 'severe' deprivations.

Table 2.1.7a: Odds ratio of at least two 'severe' deprivations between male headed and female headed households

	Odds	Odds ratio
Male	0.26	1.3
Female	0.2	

Table 2.1.7b: Odds ratio of at least two 'severe' deprivations between urban and rural households

	Odds	Odds ratio
Rural	0.29	1.9
Urban	0.15	

Table 2.1.7c: Odds ratio of at least one less 'severe' deprivations between urban and rural households

	Odds	Odds ratio
Rural	13.68	2.40
Urban	5.69	

Table 2.1.7d: Odds ratio of at least one less 'severe' deprivations between male headed and female headed households

	Odds	Odds ratio
Male	10.18	1.32
Female	7.7	

Table 2.1.8: Prevalence of seven severe deprivations by region and residence: 2006 (in percentage)

Region	Shelter	Sanitation	Water	Information	Food	Education	Health
Barisal	12.18	1.13	2.66	60.88	9.3	6.61	31.04
Chittagong	15.01	4.49	0.97	48.38	7.0	7.96	26.23
Dhaka	27.48	6.32	0.09	47.22	5.3	9.83	27.79
Khulna	18.48	3.86	8.25	49.68	3.9	4.80	19.56
Rajshahi	20.25	18.18	0.04	58.58	6.6	8.00	25.31
Sylhet	26.21	4.78	6.34	53.62	6.7	11.68	26.68
Residence							
Rural	21.45	9.61	2.15	59.04	7.1	8.23	27.88
Urban	20.41	2.89	0.59	31.90	4.4	8.68	20.95

Sources: MICS 2006 and CMNS 2005.

Notes: Data for food indicator are generated from CMNS 2005 and data for others are generated from MICS 2006.

Table 2.1.9: Correlation between different indicators for child poverty/disparity

	Bottom asset quintile (Q1)	Two deprivations (H,Sh)	First four deprivations (Sh, S, W, I)	Last three deprivations (F, E, H)	Shelter	Sanitation	Water	Information	Education	Health
Asset Q1.	1.000	.056*	.024*	.010*	.273*	.312*	.050*	.009*	.070*	.018*
Two deprivations.	.056*	1.000	-.002*	-.002	.161*	.017*	-.001	-.187*	-.019*	.487*
First four	.024*	-.002	1.000	.261*	.047*	.079*	.157*	.010*	.021*	-.004
Last three	.010**	-.002	.261**	1.000	.045**	.016**	.150**	.010**	.099**	-.004
Shelter	.273*	.161**	.047**	.045**	1.000	.070**	.010**	.003	.071*	.015**
Sanitation	.312**	.017*	.079*	.016*	.070*	1.000	.004	-.003*	.055*	.011*
Water	-.050*	-.001	.157*	.150*	.010*	.004	1.000	.003	.014*	.004
Information	-.009*	-.187*	.010*	.010*	.003	..003	..003	1.000	.101*	-383*
Education	.070*	.-.019*	.021*	.096*	..071*	.055*	.014*	.101	1.000	-.040
Health	.018*	.487*	-.004	-.004	.015*	.011*	.004	-.383*	-.040	1.000

Sources: MICS 2006.

* Correlation is significant at the 0.01 level (2-tailed).

** Correlation is significant at the 0.05 level (2-tailed).

Information for household income ($1.08 a day per person in ppps and food are not available in MICS 2006.

Table 2.1.10: Combined child poverty incidence

Indicator	Percentage of children in relevant category		
	Who live in households under the $1 day/person ppp-s threshold	Who are experiencing severe deprivation of human need	Who are experiencing less severe deprivation of human need
		While their households live above the $1 day/person PPP threshold	
All children (0-17)	51.14	7.42	12.30
Individual dimension			
Sex and age			
Male			
0-4 years	58.43	5.14	10.99
5-9 years	59.60	7.12	1.81
10-14 years	54.10	9.58	11.79
15-17 years	44.47	11.88	14.46
Female			
0-4 years	58.46	6.33	11.32
5-9 years	60.91	6.86	10.25
10-14 years	53.86	7.36	12.14
15-17 years	45.12	6.54	14.63
Household dimension			
Household size			
Less than 3	1.4	3.5	2.1
3-4 members	36.3	44.8	46.1
5-6 members	42.7	35.4	34.7
7+	19.5	16.3	17.1
Education of household head			
None	69.3	71.3	44.6
Primary	14.7	14.2	19.6
Secondary+	16.0	14.5	35.8
Gender of the head of the household			
Male	92.8	90.1	90.7
Female	7.2	9.9	9.3
Wealth index quintiles			
Q1 (poorest)	36.6	13.4	3.8
Q2	29.2	25.4	13.0
Q3	19.4	32.2	26.4
Q4	11.1	20.2	31.6
Q5 (Richest)	3.6	8.8	25.1
Religion			
Islam	87.5	87.3	91.4
Hindu	10.1	10.5	7.8
Buddhist	2.0	1.3	0.4
Christian	0.4	0.6	0.3
Work (among H. holds with children)			
Both parents working	3.9	6.6	3.7
None of the parents are working	3.3	3.3	5.1
No adult in primary working age (18-54)	22.5	39.0	27.4
At least one child under 15 working	3.8	8.5	4.3
Illness and disability in the household			
Adult (s) with chronic illness	38.4	42.5	42.6
Child/children with chronic illness[1]	7.9	8.3	6.3
Family vulnerability (not mutually exclusive categories)			
Orphaned child in household	38.4	42.5	42.6
High dependency ratio (4+children per adult)	7.9	8.3	6.3
Elder (70+) person in household	38.4	42.5	42.6
Geographic dimension			
Region			
Barisal	6.9	3.1	8.1
Chittagong	16.3	18.0	16.7
Dhaka	28.3	22.6	37.1
Khulna	13.8	10.2	11.0
Rajshahi	29.2	39.0	21.7

Indicator	Percentage of children in relevant category		
	Who live in households under the $1 day/person ppp-s threshold	Who are experiencing severe deprivation of human need	Who are experiencing less severe deprivation of human need
		While their households live above the $1 day/person PPP threshold	
Sylhet	5.6	7.1	5.4
Residence			
Urban	16.1	11.0	26.4
Rural	83.9	89.0	73.6

Sources: Data generated from HIES 2005.

Notes:
- Child/children with disability is replaced by Child/children with chronic illness.
- Data/information on Child are not available in HIES 2005. Information for household with children is available in HIES.
- Here we assume that if households with children live under the $1 day/person PPP threshold then the children of these households live under that threshold. Similarly, if households with children live above the $1 day/person PPP threshold then the children of these households live above that threshold.
- If households with children are experiencing severe deprivation of human need or experiencing less severe deprivation of human need, then the children of these households are experiencing severe deprivation of human need or experiencing less severe deprivation of human need.

2.2 CHILD SURVIVAL AND POVERTY

Table 2.2.1: Change in under five mortality rate (U5MR)* by wealth quintile and gender (in thousands)**

Indicator	BDHS 1993-94			BDHS 1996-97			BDHS 1999-2000			BDHS 2004		
	Q1	Q5	Total	Q1	Q5	Total	Q1	Q5	Total	Q1	Q5	Total
U5MR (of which)			133			116			94	121	72	88
U5MR girls			149.9			127.2			111.7			91
U5MR boys			149.1			128.4			108.3			102

Sources: Bangladesh Demographic and Health Survey (BDHS) Report for the year 1994, 1997, 2000, 2004.

* **U5MR**: Number of deaths in children under five years of age per 1,000 live births.
Numerator: Number of deaths of children under five years in a given year.
Denominator: All children under five years in a given year.

**A quintile is one fifth or 20 per cent of a sorted data set so that each part represents 1/5th of the sampled population. The term is used when describing the statistical distribution of a population.
First quintile (designated Q1) = lower quintile = cuts off lowest 20 per cent of data.
Fifth quintile (designated Q5) = upper quintile = cuts off highest 20 per cent of data, or lowest 80 per cent.

Table 2.2.2: U5MR and infant mortality rate (IMR)* and their correlations: 2004 (in thousands)

Indicator	Infant mortality rate	Under 5 mortality rate
Total	65	88
Individual dimension		
Sex		
Male	80	102
Female	64	91
Mother's education		
None	81	113
primary	82	96
Secondary+	57	70
Wealth index quintiles		
Q1 (Poorest)	90	121
Q2 (Poor)	66	98
Q3 (Middle)	75	97
Q4 (Rich)	59	81
Q5 (Richest)	65	72
Geographic dimension		

Indicator	Infant mortality rate	Under 5 mortality rate
Region		
Barisal	61	92
Chittagong	68	103
Dhaka	75	99
Khulna	66	78
Rajshahi	70	86
Sylhet	100	126
Residence		
Urban	72	92
Rural	72	98

Sources: Bangladesh Demographic and Health Survey (BDHS) Report 2004, p.117, 118,120.

* Infant mortality: Number of deaths in infants under one year of age per 1,000 live births.
Numerator: Number of deaths of infant under one year of age in a given year.
Denominator: All infants under one year of age in a given year, CRC definition 2005.

Table 2.2.3: Relationship between U5MR and income/consumption poverty at sub-national level

Region	U5MR* (2004 BDHS) (per thousands)	CBN method		DCI method	
		Upper poverty line (%)	Lower poverty line (%)	Poverty line 1: 2122 K.Cal/person/day	Poverty line 2: 1805 K.Cal/person/day
Barisal	92	52.0	35.6	52.7	42.1
Chittagong	103	34.0	16.1	37.9	41.3
Dhaka	99	32.0	19.9	38.6	40.2
Khulna	78	45.7	31.6	29.1	22.7
Rajshahi	86	51.2	34.5	17.2	21.9
Sylhet	126	33.8	20.8	15.8	20.8

Sources: Data generated from HIES 2005, *BDHS 2004, p.118.

PART THREE: THE PILLARS OF CHILD WELL-BEING
3.1 NUTRITION

Table 3.1.1: Child nutrition outcome and its correlates (by individual, households and geographic dimensions): 2004

Indicator	Stunting[1] (per cent)	Wasting[2] (per cent)	Underweight[3] (per cent)
Total incidence/prevalence	46.2	14.5	39.7
Individual dimension			
Sex			
Male	47.1	14.5	40.3
Female	45.3	14.5	39.0
Sex and age			
Male			
Age (0-11) months	21.8	19.0	31.1
Age (12-23) months	51.1	21.8	43.7
Age (24-35) months	52.4	13.0	43.2
Age (36-47) months	59.2	10.1	42.6
Age (48-59) months	45.8	9.8	39.5
Female			
Age (0-11) months	14.5	23.6	26.3
Age (12-23) months	46.1	14.8	40.4
Age (24-35) months	54.1	14.6	39.9
Age (36-47) months	55.4	8.6	44.7
Age (48-59) months	52.3	12.2	42.3
Household dimension			
Household size			
Less than 3	42.9	15.1	35.2
3-4 members	44.9	13.0	37.0
5-6 members	47.0	15.7	40.5
7+	46.5	14.3	41.3
Women's education			
None	52.6	17.1	46.5
Primary	45.4	14.1	38.8
Secondary+	36.1	10.4	29.1
Gender of the head of the household			
Male	46.3	14.7	40.1
Female	45.4	10.1	32.6
Wealth index quintiles			
Q1 (poorest)	54.0	19.3	48.7
Q2	50.4	16.5	44.6
Q3	51.7	15.6	43.7
Q4	44.5	11.0	37.3
Q5 (Richest)	29.8	10.4	24.9
Geographic dimension			
Region			
Barisal	52.9	14.7	41.6
Chittagong	51.5	13.4	39.7
Dhaka	42.9	15.3	39.6
Khulna	43.6	8.4	35.1
Rajshahi	45.7	16.6	41.1
Sylhet	47.0	15.4	40.5
Residence			
Rural	48.8	15.1	42.2
Urban	35.9	12.2	29.9

Sources: Data generated from CMNS 2005.

1 Stunting: Percentage of children under five years of age moderately or severely stunted.

2 Wasting: Percentage of children under five years of age moderately or severely wasted.

3 Underweight: Percentage of children under five years of age moderately or severely underweight.

Table 3.1.2: Child nutrition: supply side and uptake variables by region 1990-2006

Indicator	1993**	1996**	2000**	2004**	2006*
Major nutrition supply indicator*					
- supply/delivery indicator* (e.g. unit number/per capita)					
- Coverage rates* (per cent)					
Initial breastfeeding within one hour of birth	8.6	13.2	16.5	23.7	35.6
Iodized salt consumption	NA	NA	NA	69.6	84.3
Vitamin A supplementation	48.8	NA	NA	81.8	89.2
By region					
Barisal					
Initial breastfeeding	8.2	9.7	19.5	19.8	41.9
Iodized salt consumption	NA	NA	NA	70.4	90.3
Vitamin A supplementation	67.2	NA	NA	73.7	88.4
Chittagong					
Initial breastfeeding	8.9	12.0	16.1	20.8	32.4
Iodized salt consumption	NA	NA	NA	69.2	77.7
Vitamin A supplementation	43.0	NA	NA	83.8	90.0
Dhaka					
Initial breastfeeding	8.1	14.1	17.0	20.6	36.5
Iodized salt consumption	NA	NA	NA	69.6	84.0
Vitamin A supplementation	39.2	NA	NA	83.9	88.7
Khulna					
Initial breastfeeding	9.4	10.5	15.7	24.5	32.7
Iodized salt consumption	NA	NA	NA	84.4	93.6
Vitamin A supplementation	61.5	NA	NA	83.5	91.7
Rajshahi					
Initial breastfeeding	8.8	13.9	14.9	28.4	34.3
Iodized salt consumption	NA	NA	NA	61.8	81.7
Vitamin A supplementation	58.2	NA	NA	81.5	88.9
Sylhet					
Initial breastfeeding		19.0	19.2	31.8	42.3
Iodized salt consumption		NA	NA	74.3	92.1
Vitamin A supplementation		NA	NA	72.9	87.3
By residence					
Urban					
Initial breastfeeding	10.5	19.1	22.8	22.2	36.0
Iodized salt consumption	NA	NA	NA	87.6	91.5
Vitamin A supplementation	47.7	NA	NA	85.2	92.0
Rural					
Initial breastfeeding	8.4	12.7	15.3	24.1	35.5
Iodized salt consumption	NA	NA	NA	64.5	90.4
Vitamin A supplementation	48.9	NA	NA	80.9	88.3

Sources: *MICS 2006, p.20. **BDHS 1993, p.115, 116, 1996, p.130, 2000.p.134 and 2004, p.166.

3.2 HEALTH

Table 3.2.1: Young child health outcomes, related care and correlations (by individual, households and geographic dimensions) 2006

Indicator	Child diarrhoea*		Received ORT or increased fluids and continued feeding (per cent)	Child fever**		Antibiotic treatment of suspected pneumonia (per cent)
	Absolute number of cases	Per 1,000 children aged 0-4		Absolute number of cases	Per 1,000 children aged 0-4	
Total incidence	2254 (1292303)	71	49	3734 (2153313)	118	21.50
Individual dimension						
Sex						
Male	1200 (692017)	74	51	1978 (1140501)	122	21.75
Female	1054 (607838)	69	47	1756 (1012812)	114	21.18
Sex and age						
Male						
< 6 months	50 (29000)	42	20	182 (104869)	153	23.78
(6-11) months	192 (110809)	110	45	344 (198305)	197	23.84
(12-23) months	329 (189499)	106	50	454 (261774)	146	22.98
(24-35) months	235 (135288)	72	46	416 (239918)	127	18.19
(36-47)months	208 (119898)	62	54	326 (188253)	97	23.01
(48-59) months	186 (107522)	53	68	256 (147383)	72	18.5
Female						
< 6 months	58 (33307)	52	34	169 (97417)	152	21.23
(6-11) months	183 (105574)	113	44	292 (168274)	180	23.61
(12-23) months	278 (160125)	95	40	400 (230618)	137	22.36
(24-35) months	209 (120484)	69	54	327 (188812)	107	22.90
(36-47) months	180 (104047)	53	53	316 (182089)	92	19.20
(48-59) months	145 (83827)	45	52	252 (145602)	78	16.2
Household dimension						
Household size						
Less than 3	3 (1748)	49	4.5	10 (5490)	155	44.86
3-4 members	715 (412154)	69	45.6	1296 (747445)	125	23.54
5-6 members	908 (523414)	75	51.6	1353 (780360)	112	19.94
7+	629 (362538)	69	49.2	1075 (620017)	119	20.98
Women's education						
None	882 (508568)	79	46.5	1290 (743816)	115	18.84
Primary	691 (398514)	76	49.2	1166 (672190)	128	22.54
Secondary+	667 (384430)	60	52.3	1259 (725899)	113	23.61
Non-standard curriculum	14 (8343)	136	22.7	20 (11407)	186	0.00
Gender of the head of the household						
Male	2155 (1243029)	72	48.4	3545 (2044343)	118	20.81
Female	99 (56826)	63	58.7	189 (108970)	121	34.15
Wealth index quintiles						
Q1 (poorest)	685 (394992)	86	44.5	1011 (583317)	127	17.18
Q2	502 (289747)	76	46.9	863 (497516)	130	22.23
Q3	420 (242306)	71	49.4	746 (429941)	126	22.82
Q4	325 (187711)	56	54.6	631 (364021)	108	21.28
Q5 (Richest)	321 (185098)	62	55.1	483 (278518)	93	28.07
Religion						
Islam	2082 (1200813)	73	48.6	3415 (1969466)	119	21.61
Hindu	149 (85872)	59	51.4	296 (170912)	118	19.02
Christian	9 (5308)	92	63.5	7 (3966)	69	19.06
Buddhist	14 (7862)	56	58.3	16 (8969)	64	43.62
Ethnicity						
Bangalee	2225 (1283267)	72	48.9	3693 (2129602)	119	21.29
Chakma	5 (3122)	45	56.6	7 (4109)	59	0.00
Saontal	6 (3576)	119	44.2	9 (5016)	167	54.46
Marma	5 (2887)	55	43.7	3 (1661)	32	56.02
Tripura	3 (2011)	84	38.4	2 (1313)	55	100.00
Garo	2 (1094)	56	65.2	2 (1426)	73	45.45
Others	7 (3898)	41	64.1	17 (9871)	104	54.36
Illness and disability in the household						

Indicator	Child diarrhoea*		Received ORT or increased fluids and continued feeding (per cent)	Child fever**		Antibiotic treatment of suspected pneumonia (per cent)
	Absolute number of cases	Per 1,000 children aged 0-4		Absolute number of cases	Per 1,000 children aged 0-4	
Child/children with disability	605 (348855)	86	47.0	1026 (591707)	145	16.87
Family vulnerability (not mutually exclusive categories)						
Single parent	27 (15734)	65	75.5	30 (17378)	72	6.59
Orphaned child in household	39 (6549)	74	48.5	41 (5998)	78	13.69
Elder (70+) person in household	299 (172432)	72	50.6	470 (270995)	114	23.64
Geographic dimension						
Region						
Barisal	167 (96448)	89	57.6	250 (144347)	134	13.08
Chittagong	515 (296931)	76	48.1	794 (457993)	117	22.01
Dhaka	704 (405986)	71	52.6	1080 (622717)	109	25.21
Khulna	139 (80366)	44	48.1	295 (170185)	94	24.37
Rajshahi	540 (311452)	74	42.6	1008 (581227)	138	20.04
Sylhet	188 (108671)	75	47.8	307 (176844)	122	18.50
Residence						
Rural	1630 (939885)	71	47.8	2781 (1603922)	121	19.30
Urban	611 (352612)	74	51.6	927 (534837)	112	22.05

Sources: Data generated from MICS 2006.

Notes: • Numbers in parenthesis indicates the National figures.

*__Child Diarrhoea__: Proportion of children under five years of age with diarrhoea at any time during the two weeks preceding the interview.

Numerators: Number of children ill with diarrhoea (as defined by the respondent—child's mother) at any time during the two weeks preceding the interview.

Denominators: Number of children under five years of age.

**__Child fever__: Proportion of children under five years of age with fever at any time during the two weeks preceding the interview.

Numerators: Number of children ill with a fever at any time during the two weeks preceding the interview.

Denominators: Number of children under five years of age.

Received ORT or increased fluids and continued feeding: Proportion of children aged 0-59 months who had diarrhea in the last two weeks and received ORT (oral rehydration salts or an appropriate household solution) or increased fluids, AND continued feeding.

Antibiotic treatment of suspected pneumonia: Proportion of children aged 0-59 months with acute respiratory infections in the last two weeks that are receiving antibiotics.

Numerators: Number of children aged 0-59 months with acute respiratory infections in the last two weeks that are receiving antibiotics.

Denominators: Number of children under five years of age.

Table 3.2.2: Adolescent health outcomes, care and correlates (by individual, households and geographic dimensions): 2006

Indicator	Comprehensive knowledge about HIV prevention among young people		Counseling coverage for the prevention of mother to child transmission of HIV	
	Absolute number of cases in the survey	Per 1,000 person aged 15-24	Absolute number of cases in the survey	Per 1,000 women aged 15-49 who gave birth in the two years preceding the survey
Total incidence	4403 (13618213)	158		
Individual dimension				
Sex and age				
Female				
Age (15-19) years	2471 (7453799)	162		
Age (20-24) years	1932 (6164414)	153		
Age (15-16)years	946 (3104311)	149		
Age (17-18) years	1088 (3102540)	171		
Age (19-20)years	876 (2661808)	160		
Age (21-22) years	759 (2380995)	156		
Age (23-24) years	734 (2368558)	151		
Household dimension				
Household size				
Less than 3	167 (531936)	154		
3-4 members	1440 (4761149)	148		
5-6 members	1540 (4348889)	173		
7+	1255 (3976239)	154		
Women's education				
None	112 (1927552)	28		
Primary	464 (3481494)	65		
Secondary+	3823 (8156795)	229		
Non standard	5 (50981)	43		
Gender of the head of the household				
Male	4068 (12709770)	156		
Female	335 (908443)	180		
Wealth index quintiles				
Q1 (poorest)	201 (2173796)	45		
Q2	374 (2603548)	70		
Q3	770 (2833142)	133		
Q4	1141 (2954470)	188		
Q5 (Richest)	1917 (3053256)	306		
Religion				
Islam	3951 (12179342)	158		
Hindu	402 (1289890)	152		
Christian	16 (33433)	229		
Buddhist	33 (114691)	139		
Others	2 (857)	890		
Ethnicity				
Bangalee	4351 (13394785)	158		
Chakma	17 (60866)	137		
Saontal	1 (17819)	32		
Marma	6 (33331)	89		
Tripura	2 (15552)	77		
Garo	10 (11315)	443		
Others	15 (80952)	89		
Illness and disability in the household				
Child/children with disability	358 (1760274)	99		
Family vulnerability (not mutually exclusive categories)				
Single parent	39 (129304)	148		
Orphaned child in household	55 (173135)	155		
Elder (70+) person in household	630 (2012541)	153		
Geographic dimension				
Region				
Barisal	188 (784158)	117		
Chittagong	813 (2746351)	144		
Dhaka	1769 (4278401)	202		

Indicator	Comprehensive knowledge about HIV prevention among young people		Counseling coverage for the prevention of mother to child transmission of HIV	
	Absolute number of cases in the survey	Per 1,000 person aged 15-24	Absolute number of cases in the survey	Per 1,000 women aged 15-49 who gave birth in the two years preceding the survey
Khulna	632 (1510003)	204		
Rajshahi	842 (3360018)	122		
Sylhet	159 (939281)	82		
Residence				
Rural	2288 (9396552)	120		
Urban	2093 (4221640)	240		

Sources: Data generated from MICS 2006.

Notes: • Numbers in parenthesis indicates the National figures.
• Information on Comprehensive knowledge about HIV prevention among young people is only for young women age (15-24) in MICS.

*** Comprehensive knowledge about HIV prevention among young people (MICS Indicator No 82):** Proportion of young women aged 15-24 years that both correctly identify ways to prevent the sexual transmission of HIV and that reject major misconceptions about HIV transmission.

Table 3.2.3: Child and youth health: supply side and uptake variables by region 1990-2006 (percentage)

Indicator	1993*	1996*	2000*	2004**	2006*
Bangladesh					
Major health supply indicator*					
- supply/delivery indicator* (e.g. unit number/per capita)					
- Coverage rates* (per cent)					
BCG	85.4	86.2	91.0	93.4	97.0
DPT1	83.6	84.9	88.9	93.1	96.6
DPT2	77.4	79.2	81.6	87.2	94.6
DPT3	66.0	69.3	72.1	81.0	90.1
Polio0	NA	NA	NA	1.9	7.2
Polio1	84.2	86.9	89.4	96.4	99.1
Polio2	77.7	80.4	81.6	88.3	98.2
Polio3	66.8	62.3	70.8	82.3	95.6
Measles	68.9	69.9	70.8	75.7	87.5
All	58.9	54.1	60.4	73.1	83.7
By region					
Barisal					
BCG	91.2	91.1	94.8	96.2	98.1
DPT1	88.8	91.1	93.7	95.4	97.6
DPT2	86.3	86.6	88.5	90.0	95.8
Indicator	1993*	1996*	2000*	2004**	2006*
DPT3	80.8	76.4	76.9	81.5	89.6
Polio0	NA	NA	NA	4.0	13.1
Polio1	89.6	93.8	95.3	98.0	98.9
Polio2	85.5	86.6	89.0	91.5	97.6
Polio3	82.0	71.8	78.8	84.6	94.4
Measles	81.2	77.5	70.2	77.3	90.4
All	73.2	62.4	63.0	72.5	83.4
Chittagong					

Indicator	1993*	1996*	2000*	2004**	2006*
BCG	78.7	82.2	94.1	93.1	96.4
DPT1	77.7	81.2	91.1	91.9	95.7
DPT2	71.8	86.6	85.7	88.4	94.3
DPT3	59.5	76.4	78.1	84.3	91.3
Polio0	NA	NA	NA	2.7	6.2
Polio1	77.5	93.8	92.6	94.0	98.9
Polio2	72.3	86.6	87.9	89.2	97.6
Polio3	61.0	71.8	76.5	84.4	94.4
Measles	63.2	77.5	77.2	77.1	90.4
All	53.7	51.0	68.4	75.1	83.4
Dhaka					
BCG	84.6	82.7	86.5	95.5	97.4
DPT1	82.1	81.2	84.8	95.7	96.7
DPT2	73.6	75.0	76.8	85.7	94.8
DPT3	56.8	63.8	68.8	78.1	89.1
Polio0	NA	NA	NA	2.0	6.6
Polio1	83.0	82.8	86.8	98.5	99.4
Polio2	73.9	74.2	79.2	87.2	98.6
Polio3	57.4	58.7	68.2	79.5	96.2
Measles	60.7	65.5	65.9	72.0	85.5
All	49.2	49.3	57.8	68.8	81.8
Khulna					
BCG	91.8	96.9	95.1	96.9	98.9
DPT1	91.0	95.7	93.9	96.9	98.9
DPT2	89.4	92.8	90.3	93.2	97.5
DPT3	87.8	85.5	80.8	87.6	95.9
Polio0	NA	NA	NA	2.8	6.2
Polio1	91.0	96.9	95.6	100	99.8
Polio2	90.2	95.9	91.0	95.1	99.5
Polio3	87.8	74.0	78.5	90.2	98.6
Measles	85.4	87.1	81.0	86.6	92.8
All	80.7	68.3	68.6	82.8	90.6
Rajshahi					
BCG	92.3	91.2	94.3	91.1	97.9
DPT1	90.1	89.3	92.0	90.8	97.6
DPT2	82.9	83.7	81.8	87.2	95.4
DPT3	73.5	74.1	69.5	82.9	90.6
Polio0	NA	NA	NA	0.9	8.0
Polio1	95.2	91.4	88.9	95.0	99.6
Polio2	91.6	84.8	77.0	87.7	98.8
Polio3	83.0	64.9	67.3	84.2	96.4
Measles	87.8	74.9	70.4	77.0	90.8
All	65.0	58.0	56.4	76.4	85.9
Sylhet					
BCG		76.5	80.4	87.1	91.9
DPT1		75.2	78.3	86.8	91.7
DPT2		65.7	69.3	79.6	87.7
DPT3		53.8	58.3	68.3	83.3
Polio0		NA	NA	0.6	6.3
Polio1		76.3	77.7	94.0	96.4
Indicator	1993*	1996*	2000*	2004**	2006*
Polio2		65.2	65.9	81.1	94.7

Indicator	1993*	1996*	2000*	2004**	2006*
Polio3		47.8	56.7	69.5	91.5
Measles		56.0	58.2	66.3	79.9
All		41.5	45.3	61.5	77.5
By residence					
Urban					
BCG	91.3	91.9	95.2	94.2	98.0
DPT1	89.9	91.0	95.0	93.4	97.7
DPT2	88.4	88.1	90.3	90.0	96.1
DPT3	78.5	75.0	82.0	85.7	92.5
Polio0	NA	NA	NA	3.6	10.8
Polio1	90.4	92.8	95.3	96.6	99.4
Polio2	89.3	86.2	90.7	90.8	98.9
Polio3	79.3	65.2	79.6	85.8	96.6
Measles	77.9	79.7	80.7	82.8	88.7
All	70.4	58.2	69.7	80.9	85.7
Rural					
BCG	84.7	85.7	90.2	93.2	96.7
DPT1	82.9	84.4	87.7	93.0	96.2
DPT2	76.1	78.4	79.9	86.5	94.1
DPT3	64.5	68.8	70.0	79.8	89.4
Polio0	NA	NA	NA	1.5	5.9
Polio1	83.5	86.4	88.2	96.4	99.0
Polio2	76.4	79.9	79.7	87.7	98.0
Polio3	65.3	62.1	69.0	81.4	95.3
Measles	67.8	69.1	68.9	73.9	87.2
All	57.5	53.7	58.5	71.1	83.1

Sources: *MICS-2006, p.20

** BDHS-1993, p.108, 1996, p.118, 2000, p.123 and 2004, p.152.

3.3 CHILD PROTECTION

Table 3.3.1: Birth registration and its correlations (individuals, households and geographic dimension): 2006

Bangladesh	Number of children whose birth is not registered	Of whom: due to high cost, travel too far	Number of children aged 0-59 months
Total incidence/prevalence	20135 (11609951)	220 (126950)	31567 (18201447)
Individual dimension			
Sex and Age			
Male (age in months)			
0-11	1839 (1060431)	26 (15085)	2939 (1694368)
12-23	2002 (1154189)	22 (13032)	3108 (1792006)
24-35	2066 (1190969)	23 (13306)	3274 (1887564)
36-47	2120 (1222292)	19 (11005)	3371 (1943623)
48-59	2252 (1298344)	29 (17312)	3526 (2033147)
Female(age in months)			
0-11	1782 (1027361)	21 (12740)	2730 (1574278)
12-23	1918 (1105639)	19 (11062)	2924 (1686055)
24-35	1950 (1124395)	20 (11462)	3046 (1756559)
36-47	2172 (1252375)	22 (12726)	3419 (1971175)
48-59	2032 (1171722)	16 (9221)	3225 (1859766)
Sex			
Male	10282 (5928460)	123 (69740)	16221 (9352944)
Female	9853 (5681491)	99 (57211)	15346 (8848306)
Household dimension			
Less than 3	43 (24911)	0(0)	61 (35333)
3-4 members	6553 (3778624)	59 (35213)	10376 (5982802)
5-6 members	7743 (4464320)	93 (51918)	12070 (6959678)
7+	5796 (3342097)	70 (39819)	9059 (5223437)
Women's education			
None	6996 (4033973)	56 (33576)	11225 (6472024)
Primary	5850 (3373080)	64 (37950)	9082 (5236483)
Secondary	7231 (4169643)	94 (55125)	11153 (6430537)
Non-standard curriculum	57 (32771)	1 (299)	106 (61229)
Gender of the head of the household			
Male	19106 (11016282)	191 (114105)	30011 (17304070)
Female	1030 (593669)	23 (12845)	1556 (897180)
Wealth index quintiles			
Q1 (poorest)	4863 (2803795)	49 (28995)	7987 (4605123)
Q2	4191 (2416326)	46 (25754)	6615 (3814272)
Q3	3835 (2211154)	46 (26009)	5919 (3412640)
Q4	3903 (2250217)	47 (27354)	5854 (3375592)
Q5(Richest)	3345 (1928460)	33 (18839)	5192 (2993622)
Ethnicity			
Bangalee	19862 (11452295)	218 (126395)	31057 (17907297)
Chakma	63 (36201)	0 (176)	122 (70123)
Saontal	31 (17932)	0 (0)	52 (29973)
Marma	46 (26480)	0 (0)	91 (52220)
Tripura	21 (12305)	0 (243)	42 (24045)
Garo	14 (8175)	0 (0)	34 (19439)
Others	95 (54520)	0 (136)	165 (94994)
Religion			
Islam	18293 (10547940)	201 (116421)	28711 (16554663)
Hindu	1665 (959934)	18 (10183)	2512 (1448338)
Christian	49 (28373)	0 (0)	100 (57749)
Buddhist	127 (73460)	1 (346)	241 (139196)
Others	0 (243)	0 (0)	2 (1304)
Illness and disability in the household			
Child/children with disability	4275 (2447286)	38 (22025)	7074 (4078810)
Family vulnerability (not mutually exclusive categories)			
Single parent	260 (149791)	2 (1185)	420 (242320)
Orphaned child in household	328 (189315)	3 (1755)	522 (301064)

Bangladesh	Number of children whose birth is not registered	Of whom: due to high cost, travel too far	Number of children aged 0-59 months
Elder (70+) person in household	2667 (1537553)	33 (19204)	4140 (2387091)
Geographic dimension			
Barisal	1118 (644739)	22 (12582)	1873 (1079845)
Chittagong	4889 (2819060)	59 (32785)	6799 (3920027)
Dhaka	6691 (3857866)	47 (25837)	9942 (5732507)
Khulna	2408 (1388532)	12 (7286)	3148 (1815212)
Rajshahi	3693 (2129235)	63 (35633)	7284 (4199960)
Sylhet	1336 (770519)	23 (12827)	2521 (1453698)
Residence			
Rural	14642 (8442739)	176 (104308)	23035 (13427127)
Urban	5348 (3083474)	37 (22399)	8280 (4774122)

Sources: Data generated from MICS-2006.

Notes: • Numbers in parenthesis indicates the National figures.
• **Birth Registration**: Proportion of children aged 0-4 whose births are reported registered.

Numerator: Number of children aged 0-4 whose births are reported registered.
Denominator: Total number of children aged 0-4 surveyed.

Table 3.3.2: Orphanhood, child vulnerability and their correlations: 2006

Bangladesh	Orphans and vulnerable children	One or both parents dead (orphans)*	Number of children aged 0-17 years
Total incidence/prevalence		7395 (3692418)	127508 (63357802)
Individual dimension			
Sex			
Male		3607 (1777400)	64406 (32002714)
Female		3849 (1915018)	63102 (31355088)
Sex and Age group (in years)			
Male (in years)			
0-4		269 (137893)	17924 (8906287)
5-9		710 (350642)	18697 (9290395)
10-14		1365 (679581)	17955 (8921813)
15-17		1229 (609285)	9830 (4884219)
Female (in years)			
0-4		238 (114703)	16984 (8439441)
5-9		729 (358966)	18228 (9057581)
10-14		1381 (685242)	17261 (8576737)
15-17		1520 (756108)	10629 (5281329)
Household dimension			
Household size			
Less than 3		355 (176354)	941(467438)
3-4 members		2330 (1159370)	33768 (16779015)
5-6 members		2578 (1285741)	53717 (26691551)
7+		2150 (1070953)	39083 (19419798)
Women's education			
None		3830 (1911858)	57162 (28403184)
Primary		1313 (654016)	33661 (16726105)
Secondary+		1003 (499738)	31353 (15579064)
Non-standard curriculum		23 (11434)	449 (223156)
Gender of the head of the household			
Male		4807 (2388366)	118763 (59012670)
Female		2624 (1304052)	8745 (4345132)
Wealth index quintiles			
Q1 (poorest)		1681 (841655)	28986 (14402940)
Q2		1679 (835548)	27079 (13455162)
Q3		1587 (784637)	25595 (12717864)
Q4		1220 (609697)	23921 (11886238)
Q5(Richest)		1250 (620881)	21927 (10895598)
Religion			
Islam		6812 (3364467)	115464 (57373344)
Hindu		581 (289718)	10568 (5250949)
Christian		19 (9377)	390 (193557)
Buddhist		57 (28369)	1079 (536233)
Others		1 (488)	5 (2238)
Ethnicity			
Bangalee		7270 (3634597)	125340 (62280656)
Chakma		30 (14900)	587 (291519)
Saontal		6 (2777)	177 (87745)
Marma		20 (10047)	344 (171050)
Tripura		10 (4867)	187 (92824)
Garo		10 (4901)	148 (73384)
Others		41 (20218)	700 (348003)

Bangladesh	Orphans and vulnerable children	One or both parents dead (orphans)*	Number of children aged 0-17 years
Illness and disability in the household			
Child/children with disability		1033 (518408)	23472 (11663241)
Family vulnerability (not mutually exclusive categories)			
Single parent		983 (488569)	1385 (688092)
Elder (70+) person in household		936 (464962)	16702 (8298934)
Geographic dimension			
Barisal		439 (218632)	8290 (4119469)
Chittagong		1827 (903832)	27267 (13548522)
Dhaka		2181 (1087632)	39654 (19703556)
Khulna		548 (274540)	13056 (6487204)
Rajshahi		1513 (758528)	29667 (14741242)
Sylhet		900 (449258)	9575 (4757809)
Residence			
Rural		5145 (2559325)	91877 (45653106)
Urban		2210 (1103906)	34538 (17161469)

Sources: Data generated from MICS 2006.

Notes:
- Numbers in parenthesis indicates the National figures.
- Information for vulnerable children is not available in MICS

***Orphan**: An **orphan** is a child below the age of 18 who has lost one or both parents.

Percentage of children who are orphans: Percentage of children aged 0-17 whose mother, father or both parents have died

Numerator: Number of children aged 0-17 whose mother, father or both parents have died.

Denominator: All children aged 0-17.

Vulnerable:

1) Either parent has been chronically ill for three of the 12 months preceding the survey (HL10A = 1 or HL12A = 1 for the specific child).

2) Adult death in the household after a chronic illness of three of the 12 months preceding the survey (OV4 = 1).

3) Any adult in the household has been sick for three of the 12 months preceding the survey (HL5 = 15-59 and HL8A = 1 for any household member).

4) A vulnerable child is defined as a child who lives in a household where any of the preceding three conditions is true.

Table 3.3.3: Child labour and its correlations in 2006

Bangladesh	Total child labour (children aged 5-14 years)	Of which: paid work outside the HH	Number of children aged 5-14 years
Total incidence/prevalence	9234 (4753721)	231 (116647)	72141 (37046218)
Individual dimension			
Sex			
Male	6414 (3284842)	237 (120396)	36652 (18821724)
Female	2875 (1468878)	34 (17666)	35489 (18224494)
Male (in years)			
Age 5-11	3809 (1951358)	61 (30496)	26268 (13489044)
Age 12-14	2596 (1333484)	234 (119790)	10385 (5332680)
Female (in years)			
Age 5-11	1502 (772009)	11 (5289)	25027 (12852150)
Age 12-14	1360 (696869)	33 (17009)	10462 (5372344)
Male (in years)			
Age 5-6	260 (133526)	1 (242)	7230 (3712855)
Age 7-8	911 (467981)	5 (2597)	8137 (4178650)
Age 9-10	1801 (926918)	52 (26786)	7970 (4092821)
Age 11-12	1699 (871317)	93 (48135)	7231 (3713428)
Age 13-14	1721 (885101)	186 (95342)	6083 (3123970)
Female (in years)			
Age 5-6	165 (82940)	0 (269)	6867 (3526269)
Age 7-8	424 (216362)	2 (873)	8153 (4186624)
Age 9-10	609 (312037)	5 (2725)	7253 (3724701)
Age 11-12	724 (373182)	14 (7339)	6640 (3409851)
Age 13-14	940 (484358)	25 (13094)	6576 (3377049)
Household dimension			
Household size			
Less than 3	88 (45297)	7 (3540)	371 (190733)
3-4 members	2145 (1104732)	49 (25688)	17581 (9028182)
5-6 members	4348 (2231256)	109 (56676)	32449 (16663298)
7+	2674 (1372435)	62 (32079)	21740 (11164004)
Women's education			
None	5924 (3036261)	225 (116199)	36345 (18664155)
Primary	2139 (1100393)	34 (17114)	19620 (10075456)
Secondary +	1143 (590026)	5 (2484)	15873 (8150995)
Non-standard curriculum	50 (25855)	1(708)	266 (136563)
Gender of the head of the household			
Male	8612 (4422403)	200 (102743)	66846 (34326737)
Female	645 (331317)	26 (13589)	5296 (2719480)
Wealth index quintiles			
Q1 (poorest)	2750 (1408232)	93 (47448)	17185 (8824850)
Q2	2287 (1173557)	64 (33384)	15556 (7988314)
Q3	1873 (965669)	45 (23058)	14410 (7399839)
Q4	1358 (700181)	26 (13332)	12930 (6639853)
Q5 (Richest)	989 (506082)	13 (6646)	12061 (6193361)
Religion			
Islam	8370 (4304820)	209 (107384)	65389 (33578843)
Hindu	772 (396522)	16 (8389)	5895 (3027018)
Christian	41 (21340)	1 (726)	217 (111526)
Buddhist	59 (30216)	1 (265)	636 (326626)
Others	0 (116)	0 (0)	2 (792)
Ethnicity			
Bangalee	9074 (4645378)	218 (113550)	70892 (36404552)
Chakma	34 (17684)	0 (200)	351 (180205)
Saontal	18 (9359)	1 (571)	90 (46394)
Marma	18 (9541)	0 (77)	201 (103215)
Tripura	19 (9809)	1 (262)	116 (59700)
Garo	18 (9127)	1 (317)	85 (43641)
Others	99 (51002)	5 (2338)	390 (200212)

Bangladesh	Total child labour (children aged 5-14 years)	Of which: paid work outside the HH	Number of children aged 5-14 years
Illness and disability in the household			
Child/children with disability	1986 (1022292)	52 (26883)	13792 (7082465)
Family vulnerability (not mutually exclusive categories)			
Single parent	87 (44774)	3 (1591)	648 (332560)
Orphaned child in household	100 (51406)	3 (1517)	787 (404310)
Elder (70+) person in household	1005 (516270)	18 (9390)	9017 (4630339)
Geographic dimension			
Barisal	495 (254606)	8 (4348)	4946 (2539883)
Chittagong	1352 (696052)	20 (10189)	15359 (7887103)
Dhaka	3127 (1609777)	100 (50775)	22494 (11551084)
Khulna	891 (457571)	19 (9752)	7365 (3782065)
Rajshahi	2760 (1417110)	80 (40409)	16625 (8537192)
Sylhet	621 (318606)	14 (7165)	5353 (2748891)
Residence			
Rural	6969 (3570069)	146 (75841)	52010 (26708252)
Urban	2182 (1124618)	72 (37302)	19479 (10003024)

Sources: Data generated from MICS 2006

Notes: • Numbers in parenthesis indicates the National figures.
• **Child labour**: Proportion of children aged 5-14 years involved in child labor activities.

Paid work: a) Children 5-11 years of age who, during the week preceding the survey, did at least one hour of economic activity or least 28 hours of domestic chores and

b) children 12-14 years of age who, during the week preceding the survey did at least 14 hours of economic activity or at least 28 hours of domestic chores outside the home (and were paid for that work).

Table 3.3.4: Child marriage and its correlations (individual, household and geographic dimensions) in 2006

Bangladesh	Number of women aged 15-49 married before age 15	Number of women aged 15-49 married before age 18	Number of women aged 15-49
Total incidence	23111 (11605495)	46415(23307938)	69864 (35083298)
Individual dimension			
Age group (in years)			
Age (15-19) years	2506 (1255880)	6005 (3018874)	15281 (7673733)
Age (20-24) years	3513(1765904)	8139 (4083962)	12638 (6346303)
Age (25-29) years	3678 (1845641)	7824 (3927314)	11146 (5597143)
Age (30-34) years	3499 (1755729)	7130 (3580498)	9381 (4710700)
Age (35-39) years	3558 (1785549)	6894 (3460779)	8850 (4444332)
Age (40-44) years	3009 (1510388)	5342 (2683078)	6628 (3328295)
Age (45-49) years	3356 (1686403)	5085 (2553432)	5940 (2982792)
Household dimension			
Household size			
Less than 3	1243 (624180)	2158 (1083373)	2877 (1444639)
3-4 members	8641 (4338223)	17282 (8682126)	24205 (12154777)
5-6 members	8559 (4297716)	16836 (8458830)	25626 (12868345)
7+	4667 (2345376)	10123 (5083609)	17157 (8615537)
Women's education			
None	11955 (5998112)	20075 (10082500)	23814 (11958637)
Primary	7128 (1473707)	13628 (3026922)	17955 (4160962)
Secondary +	3926 (228325)	12529 (1166999)	27842 (4480890)
Non-standard curriculum	108 (54127)	190 (95313)	247 (123844)
Gender of the head of the household			
Male	21272 (10690632)	42930 (21556055)	64266 (32272422)
Female	1819 (914864)	3487 (1751883)	5597 (2810877)
Wealth index quintiles			

Bangladesh	Number of women aged 15-49 married before age 15	Number of women aged 15-49 married before age 18	Number of women aged 15-49
Q1 (poorest)	5730 (2879491)	10165 (5101491)	12818 (6436980)
Q2	5317 (2671617)	9953 (4999971)	13360 (6708804)
Q3	4865 (2446537)	9634 (4836838)	13822 (6940737)
Q4	4102 (2059475)	8944 (4488657)	14242 (7151774)
Q5 (Richest)	3078 (1548376)	7733 (3880981)	15622 (7845003)
Religion			
Islam	21607 (10845110)	42282 (21224081)	62088 (31178680)
Hindu	1454 (7299009)	3885 (1952401)	6925 (3477688)
Christian	29 (14456)	86 (43052)	216 (108342)
Buddhist	31 (15913)	174 (87307)	628 (315598)
Others	0 (116)	1 (404)	5 (2298)
Illness and disability in the household			
Child/children with disability	3646 (1830211)	7021 (3524940)	9697 (4869685)
Family vulnerability (not mutually exclusive categories)			
Single parent	48 (91644)	73 (197461)	109 (297077)
Orphaned child in household	52 (118386)	77 (253569)	119 (381428)
Elder (70+) person in household	936 (1186362)	2215 (2685616)	4125 (4624742)
Geographic dimension			
Barisal	1534 (770863)	3010 (1510877)	4169 (2093590)
Chittagong	2916 (1463987)	7625 (3826525)	13378 (6717974)
Dhaka	7326 (3683872)	14608 (7331494)	22405 (11250844)
Khulna	3218 (1613908)	5980 (3001839)	8125 (4079938)
Rajshahi	7271 (3650552)	13063 (6559467)	17394 (8734703)
Sylhet	839 (422315)	2144 (1077736)	4393 (2206249)
Residence			
Rural	17130 (8613630)	33549 (16857118)	47452 (23829065)
Urban	5888 (2951604)	12605 (6329544)	21808 (10951433)

Sources: Data generated from MICS 2006.

Notes: • Numbers in parenthesis indicates the National figures.

Child marriage: Proportion of young women aged 15-19 years that are currently married/in union.
Marriage before age 15: Proportion of women aged 15-49 years that were first married/in union before their 15th birthday.
Numerator: Number of children aged 15-19 who report their age at first marriage as under age 15.
Denominator: All children aged 15-19 surveyed

Marriage before age 18: proportion of women aged 15-49 years that were first married/in union before their 18th birthday.
Numerator: Number of children aged 15-19 who report their age at first marriage as under age 18.
Denominator: All children aged 15-19 surveyed.

3.4 EDUCATION

Table 3.4.1: School attendance and correlates (by individual, households and geographic dimensions in 2006)

Bangladesh	Net primary school attendance rate (per cent) (MICS Indicator No. 55)
Total	81.3
Individual dimension	
Sex and age (in years)	
Male	
6 years	71.3
7 years	80.6
8 years	83.1
9 years	79.2
10 years	82.0
Female	
6 years	76.2
7 years	84.4
8 years	87.1
9 years	85.7
10 years	87.2
Household dimension	
Household size	
Less than 3	78.8
3-4 members	83.3
5-6 members	81.2
7+	79.7
Women's education	
None	75.5
Primary	85.8
Secondary +	89.6
Non-standard curriculum	77.2
Gender of the head of the household	
Male	78.91
Female	83.71
Wealth index quintiles	
Q1 (poorest)	73.4
Q2	80.6
Q3	82.8
Q4	86.8
Q5(Richest)	87.0
Religion	
Islam	80.9
Hindu	85.4
Christian	76.4
Buddhist	81.7
Others	54.7
Ethnicity	
Bangalee	81.4
Chakma	81.9
Saontal	53.5
Marma	78.2
Tripura	59.2
Garo	87.5
Others	64.5
Illness and disability in the household	
Child/children with disability	77.8
Family vulnerability (not mutually exclusive categories)	
Single parent	72.9

Bangladesh	Net primary school attendance rate (per cent) (MICS Indicator No. 55)
Orphaned child in household	73.2
Elder (70+) person in household	83.7
Geographic dimension	
Division	
Barisal	84.1
Chittagong	83.2
Dhaka	78.3
Khulna	87.0
Rajshahi	79.9
Sylhet	81.7
Residence	
Rural	81.5
Urban	81.7

Sources: Data generated from MICS-2006

Note: Primary school attendance/enrollment rate: The ratio of the number of primary school aged children who are enrolled in primary school to the total population of children of primary school age (6-10).

Numerator: Number of children of primary school age (6-10) who are currently attended /enrolled in primary school.
Denominator: All primary school age (6-10) children in the population.

Table 3.4.2 (a): Child education (primary): supply side and uptake variables by region 1990-2005

Year	No. of primary schools			No. of teachers			No. of students		
	Public	Private	Total	Total	Female	% of female	Total	Girls	% of girls
1990	37655	9586	47241	189508	39564	20.9	12051172	5388745	44.7
1995	37710	24944	62654	264376	72103	27.3	17133186	8078449	47.1
2000	37677	39132	76809	309341	104549	33.8	17667985	8635287	48.7
2005	37672	42725	80397	344789	124990	36.3	16225658	8134437	50.1

Sources: http://www.moedu.gov.bd

Table 3.4.2 (b): Child education (secondary): supply side and uptake variables by region 1990-2005

Year	No. of primary schools			No. of teachers			No. of students		
	Public	Private	Total	Total	Female	% of female	Total	Girls	% of girls
1990	295	10153	10448	122896	11880	9.7	2993730	1015745	33.9
1995	317	11695	12012	140050	19436	13.9	5115461	2402784	47
2000	317	15403	15720	174146	26290	15.1	7646885	4020237	52.6
2005	317	18183	18500	238158	48290	20.3	7398552	3868014	52.3

Sources: http://www.moedu.gov.bd

Table 3.4.2 (c): Child education (college): supply side and uptake variables by region 1990-2005

Year	No. of primary schools			No. of teachers			No. of students		
	Public	Private	Total	Total	Female	% of female	Total	Female	% of female
1990	198	650	848	18276	2476	13.5	824112	202322	24.6
1995	233	1041	1274	3 4878	6493	18.6	1273228	424553	33.3
2000	251	2176	2427	61415	12371	20.1	1725601	686139	39.8
2005	251	2899	3150	90401	17400	19.2	1367246	569337	41.6

Sources: http://www.moedu.gov.bd

Table 3.4.2 (d): Child education (madrasah): supply side and uptake variables by region 1990-2005

Year	No. of primary schools			No. of teachers			No. of students		
	Public	Private	Total	Total	Female	% of female	Total	Female	% of female
1990	3	5790	5793	81636	671	0.8	996996	76953	7.7
1995	3	5974	5977	85351	1488	1.7	1837013	553663	30.1
2000	3	7276	7279	108491	3746	3.5	3112205	1226209	39.4
2005	3	9211	9214	151967	13230	8.7	3453221	1648665	47.7

Sources: http://www.moedu.gov.bd

Table 3.5.3: Correlation between child outcomes and indicators of child poverty

Bangladesh	Bottom asset quintile (Q1)	At least one deprivation (Bristol)	Two deprivations	First four deprivations (Sh, S, W, I)	Last three deprivations (F, E, H)	Child had diarrhea	Orphan Child	Child labor	Child primary attendance rate
Bottom asset quintile (Q1)	1.00	0.068*	0.056*	0.024*	0.010*	0.020*	0.002	0.023*	-0.087*
At least one deprivation	0.068*	1.00	0.027*	0.008*	0.008*	-0.128*	0.064*	0.024*	0.290*
Two deprivations	00.056*	0.027*	1.00	-0.002	-0.002	0.049*	-0.017*	-0.006*	-0.075*
First four deprivations (Sh, S, W, I)	0.024*	0.008*	-0.002	1.00	0.261*	-0.003	-0.002	0.003	0.020
Last three deprivations (F, E, H)	0.010*	0.008*	-0.002	0.260*	1.00	-0.003	0.000	-0.002	-0.021*
Child had diarrhea	0.020*	-0.128*	0.049*	-0.003	-0.003	1.00	-0.024*	-0.010*	-0.123*
Orphaned Child	0.002	0.064*	-0.017*	-0.002	0.00	-0.024*	1.00	0.010*	-0.004
Child labour	0.023*	0.024*	-0.006*	0.003	-0.002	-0.010*	0.010*	1.00	0.017*
Child primary attendance rate	-0.087*	0.290*	-0.075*	-0.007*	-0.021*	-0.123*	-0.004	0.017*	1.00

Sources: Data generated from MICS-2006

* Correlation is significant at the 0.01 level (2-tailed).

Notes: **Correlation**: The correlation is one of the most common and most useful statistics. A correlation is a single number that describes the degree of relationship between two variables.

We use the symbol **r** to stand for the correlation. If **r** is close to 0, it means that there is no relationship between the variables. If **r** is positive, it means that if one variable increases the other variable also increases. If **r** is negative it means that if one variable increase, the other variable also decreases (often called an "inverse" correlation).

Table 3.5.4 (a): Regression between child outcomes and indicators of child poverty logistic regression

Dependent Variable = At least one severe deprivation (W)

$W = \alpha+\beta_1 R+ \beta_2 W+ \beta_3 M+ \beta_4 Ar+ \beta_5 H$

R = Region, W = Wealth index, M = Mother's education level, Ar = Area, H = Household head sex.

Dependent variable encoding

Original value	Internal value
At least one severe deprivation	1
Otherwise	0

Categorical variables coding

		Frequency	Parameter coding				
		(1)	(2)	(3)	(4)	(5)	(1)
Region	Barisal	1760	1.000	.000	.000	.000	.000
	Chittagong	3568	.000	1.000	.000	.000	.000
	Dhaka	4292	.000	.000	1.000	.000	.000
	Khulna	2230	.000	.000	.000	1.000	.000
	Rajshahi	2791	.000	.000	.000	.000	1.000
	Sylhet	2131	.000	.000	.000	.000	.000
Wealth	Poorest	2606	1.000	.000	.000	.000	
	Second	3326	.000	1.000	.000	.000	
	Middle	3544	.000	.000	1.000	.000	
	Fourth	4028	.000	.000	.000	1.000	
	Richest	3268	.000	.000	.000	.000	
Mother's education level	None	6404	.000	1.000	.000		
	Primary	4482	.000	.000	1.000		
	Secondary	5074	.000	.000	.000		
Area	Rural	12114	.000	1.000			
	Urban	4004	.000	.000			
Sex of household head	Female	890	1.000				
	Male	15882	.000				

Variables in the equation

	B	S.E.	Wald	df	Sig.	Exp(B)
Constant	-.222	.006	1544.542	1	.000	.801

Variables in the equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Household Size	Hh size	-.123	.010	155.769	1	.000	.885
Sex of household head	gender (1)	.251	.030	68.038	1	.000	1.285
Mother's education level	melevel3 (1)	.997	.040	635.932	1	.000	2.710
	melevel3 (2)	.880	.021	1710.341	1	.000	2.411
	melevel3 (3)	.505	.023	497.860	1	.000	1.657
Wealth quintile	wealth (1)	4.683	.044	11363.679	1	.000	108.069
	wealth (2)	4.157	.043	9468.162	1	.000	63.908
	wealth (3)	2.818	.042	4541.488	1	.000	16.741
	wealth (4)	1.408	.043	1077.062	1	.000	4.087
Place of residence	area (1)	-.340	.040	71.539	1	.000	.712
	area (2)	-.423	.019	478.536	1	.000	.655
Place of region	HH7 (1)	.037	.034	1.173	1	.279	1.038
	HH7 (2)	.162	.030	29.761	1	.000	1.176
	HH7 (3)	-.242	.029	68.976	1	.000	.785
	HH7 (4)	.042	.033	1.658	1	.198	1.043
	HH7 (5)	-.245	.030	66.063	1	.000	.783
	Constant	-3.141	.056	3131.957	1	.000	.043

Sources: Data generated from MICS 2006.

Table 3.5.4 (b): Regression between child outcomes and indicators of child poverty logistic regression

Dependent Variable = At least two severe deprivation(X)
$X = \alpha+\beta_1 R+ \beta_2 W+ \beta_3 M+ \beta_4 Ar+ \beta_5 H$

Dependent variable encoding

Original value	Internal value
Otherwise	0
At least one severe deprivation	1

Categorical variables coding

		Frequency	Parameter coding				
		(1)	(2)	(3)	(4)	(5)	(1)
Region	Barisal	1760	1.000	.000	.000	.000	.000
	Chittagong	3568	.000	1.000	.000	.000	.000
	Dhaka	4292	.000	.000	1.000	.000	.000
	Khulna	2230	.000	.000	.000	1.000	.000
	Rajshahi	2791	.000	.000	.000	.000	1.000
	Sylhet	2131	.000	.000	.000	.000	.000
Wealth	Poorest	2606	1.000	.000	.000	.000	
	Second	3326	.000	1.000	.000	.000	
	Middle	3544	.000	.000	1.000	.000	
	Fourth	4028	.000	.000	.000	1.000	
	Richest	3268	.000	.000	.000	.000	
Mother's education level	None	6404	.000	1.000	.000		
	Primary	4482	.000	.000	1.000		
	Secondary	5074	.000	.000	.000		
Area	Rural	12114	.000	1.000			
	Urban	4004	.000	.000			
Sex of household head	Female	890	1.000				
	Male	15882	.000				

Variables in the equation

	B	S.E.	Wald	df	Sig.	Exp(B)
Constant	-1.982	.009	53206.365	1	.000	.138

Variables in the equation

		B	S.E.	Wald	df	Sig.	Exp (B)
Household Size	Hh size	.739	.014	2675.989	1	.000	2.093
Sex of household head	gender (1)	-.143	.047	9.409	1	.002	.867
Mother's education level	melevel3 (1)	-.047	.075	.389	1	.533	.954
	melevel3 (2)	.839	.039	474.141	1	.000	2.314
	melevel3 (3)	.531	.041	165.946	1	.000	1.700
Wealth quintile	wealth (1)	4.387	.080	3043.581	1	.000	80.380
	wealth (2)	3.183	.080	1599.274	1	.000	24.128
	wealth (3)	2.081	.081	655.250	1	.000	8.011
	wealth (4)	1.374	.084	269.016	1	.000	3.950
Place of residence	area (1)	-.996	.053	352.700	1	.000	.369
	area (2)	-.875	.026	1167.130	1	.000	.417
Place of region	HH7 (1)	-.771	.049	246.412	1	.000	.462
	HH7 (2)	-.341	.038	80.298	1	.000	.711
	HH7 (3)	.153	.035	18.969	1	.000	1.166
	HH7 (4)	-.070	.042	2.725	1	.099	.932
	HH7 (5)	-.192	.037	26.986	1	.000	.825
	Constant	-7.123	.098	5305.592	1	.000	.001

Sources: Data generated from MICS 2006.

Table 3.5.4 (c): Regression between child outcomes and indicators of child poverty logistic regression

Dependent Variable = At least one less severe deprivation (Y)

$Y = \alpha+\beta_1R+ \beta_2W+ \beta_3M+ \beta_4Ar+ \beta_5H$

Dependent Variable Encoding

Original value	Internal value
Otherwise	0
At least one severe deprivation	1

Categorical variables coding

		Frequency	Parameter coding				
		(1)	(2)	(3)	(4)	(5)	(1)
Region	Barisal	1760	1.000	.000	.000	.000	.000
	Chittagong	3568	.000	1.000	.000	.000	.000
	Dhaka	4292	.000	.000	1.000	.000	.000
	Khulna	2230	.000	.000	.000	1.000	.000
	Rajshahi	2791	.000	.000	.000	.000	1.000
	Sylhet	2131	.000	.000	.000	.000	.000
Wealth	Poorest	2606	1.000	.000	.000	.000	
	Second	3326	.000	1.000	.000	.000	
	Middle	3544	.000	.000	1.000	.000	
	Fourth	4028	.000	.000	.000	1.000	
	Richest	3268	.000	.000	.000	.000	
Mother's education level	None	6404	.000	1.000	.000		
	Primary	4482	.000	.000	1.000		
	Secondary	5074	.000	.000	.000		
Area	Rural	12114	.000	1.000			
	Urban	4004	.000	.000			
Sex of household head	Female	890	1.000				
	Male	15882	.000				

Variables in the equation

	B	S.E.	Wald	df	Sig.	Exp (B)
Constant	2.194	.009	55267.900	1	.000	8.969

Variables in the equation

		B	S.E.	Wald	df	Sig.	Exp (B)
Household Size	hh size	-.066	.014	21.729	1	.000	.936
Sex of household head	gender (1)	-.207	.040	26.980	1	.000	.813
Mother's education level	melevel3 (1)	.924	.057	260.473	1	.000	2.519
	melevel3 (2)	1.317	.031	1769.547	1	.000	3.732
	melevel3 (3)	.718	.027	731.081	1	.000	2.049
Wealth quintile	wealth (1)	4.488	.091	2459.412	1	.000	88.960
	wealth (2)	3.308	.052	4080.539	1	.000	27.319
	wealth (3)	2.944	.044	4420.467	1	.000	18.988
	wealth (4)	1.166	.026	1948.263	1	.000	3.208
Place of residence	area (1)	-.256	.093	7.623	1	.006	.774
	area (2)	-.455	.025	330.471	1	.000	.635
Place of region	HH7 (1)	-.353	.049	52.659	1	.000	.703
	HH7 (2)	-.053	.040	1.732	1	.188	.948
	HH7 (3)	.087	.041	4.614	1	.032	1.091
	HH7 (4)	.190	.045	17.493	1	.000	1.209
	HH7 (5)	-.220	.042	26.966	1	.000	.803
	Constant	.536	.060	80.601	1	.000	1.709

Sources: Data generated from MICS 2006.

Table: 3.5.4 (d) Regression between child outcomes and indicators of child poverty logistic regression

Dependent Variable = No severe deprivation (z)

$Z = \alpha + \beta_1 R + \beta_2 W + \beta_3 M + \beta_4 Ar + \beta_5 H$

Dependent variable encoding

Original value	Internal value
Otherwise	0
No severe deprivation	1

Categorical variables coding

		Frequency	Parameter coding				
		(1)	(2)	(3)	(4)	(5)	(1)
Region	Barisal	1760	1.000	.000	.000	.000	.000
	Chittagong	3568	.000	1.000	.000	.000	.000
	Dhaka	4292	.000	.000	1.000	.000	.000
	Khulna	2230	.000	.000	.000	1.000	.000
	Rajshahi	2791	.000	.000	.000	.000	1.000
	Sylhet	2131	.000	.000	.000	.000	.000
Wealth	Poorest	2606	1.000	.000	.000	.000	
	Second	3326	.000	1.000	.000	.000	
	Middle	3544	.000	.000	1.000	.000	
	Fourth	4028	.000	.000	.000	1.000	
	Richest	3268	.000	.000	.000	.000	
Mother's education level	None	6404	.000	1.000	.000		
	Primary	4482	.000	.000	1.000		
	Secondary	5074	.000	.000	.000		
Area	Rural	12114	.000	1.000			
	Urban	4004	.000	.000			
Sex of household head	Female	890	1.000				
	Male	15882	.000				

Variables in the equation

	B	S.E.	Wald	df	Sig.	Exp (B)
Constant	.222	.006	1544.542	1	.000	1.248

Variables in the equation

		B	S.E.	Wald	df	Sig.	Exp (B)
Household Size	hhsize	.123	.010	155.769	1	.000	1.130
Sex of household head	gender (1)	-.251	.030	68.038	1	.000	.778
Mother's education level	melevel3 (1)	-.997	.040	635.932	1	.000	.369
	melevel3 (2)	-.880	.021	1710.341	1	.000	.415
	melevel3 (3)	-.505	.023	497.860	1	.000	.603
Wealth quintile	wealth (1)	-4.683	.044	11363.679	1	.000	.009
	wealth (2)	-4.157	.043	9468.162	1	.000	.016
	wealth (3)	-2.818	.042	4541.488	1	.000	.060
	wealth (4)	-1.408	.043	1077.062	1	.000	.245
Place of residence	area (1)	.340	.040	71.539	1	.000	1.405
	area (2)	.423	.019	478.536	1	.000	1.527
Place of region	HH7 (1)	-.037	.034	1.173	1	.279	.963
	HH7 (2)	-.162	.030	29.761	1	.000	.851
	HH7 (3)	.242	.029	68.976	1	.000	1.274
	HH7 (4)	-.042	.033	1.658	1	.198	.959
	HH7 (5)	.245	.030	66.063	1	.000	1.278
	Constant	3.141	.056	3131.957	1	.000	23.119

Sources: Data generated from MICS 2006.

ANNEX II

POLICY TEMPLATE

POLICY TEMPLATE

Table 1: Child outcome-related policy snapshot

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
Household income	1. The Constitution of Bangladesh PART II FUNDAMENTAL PRINCIPLES OF STATE POLICY: Article-15 (a, b)	FUNDAMENTAL PRINCIPLES OF STATE POLICY Article: 15. Provision of basic necessities.	**15. Provision of basic necessities**. It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens: *(a)* The provision of the basic necessities of life, including food, clothing, shelter, education and medical care; *(b)* The right to work, that is the right to guaranteed employment at a reasonable wage having regard to the quantity and quality of work.	The policy objective (article 15) is the basis of national development strategy and guides all sectoral development activities.	**Cabinet Division**
Household income	2. The Constitution of Bangladesh PART II FUNDAMENTAL PRINCIPLES OF STATE POLICY: Article-20 (1, 2)	FUNDAMENTAL PRINCIPLES OF STATE POLICY Article: 20. Work as a right and duty.	***20. Work as a right and duty.*** *(1) Work is a right, a duty and a matter of honour for every citizen who is capable of working and everyone shall be paid for his work on the basis of the principle "from each according to his abilities, to each according to his work".* *(2) The State shall endeavour to create conditions in which, as a general principle, persons shall not be able to enjoy unearned incomes, and in which human labour in every form, intellectual and physical, shall become a fuller expression of creative endeavour and of the human personality.*	Article 20 as State policy objective guides all sectoral development programmes impacting on household income.	**Cabinet Division**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
Household income	3. Bangladesh: Poverty Reduction Strategy Paper (PRSP-I)	BANGLADESH Unlocking the Potential National Strategy for Accelerated Poverty Reduction	In line with the constitutional obligation to fulfil the basic needs of all people, who can prosper in freedom in a free society, the objective of Bangladesh's Poverty Reduction Strategy is to reduce poverty substantially within the shortest *possible time*. The PRSP takes into consideration Bangladesh's previous official commitment to achieve the MDGs, as well as social targets set in the PAPR with the ADB and in the reports of the Independent South Asian Commission on Poverty Alleviation. By the year 2015, Bangladesh would achieve the following goals/targets promoting household income and well-being: • Remove the 'ugly faces' of poverty by eradicating hunger, chronic food insecurity, and extreme destitution. • Reduce the proportion of people living below the poverty line by 50 per cent. A projection of employment generation in the PRSP has been made for the period up to 2007-2008. Employment is projected to increase from 44.30 million people in FY03 to 58.08 million people in FY08, adding 13.78 million to the employed pool. Of these 9.03 million are expected to find employment in the rural areas while 4.75 million are expected to be absorbed into urban areas. During the PRSP period FY05-FY07, an estimated 8.02 million new jobs will be created–5.39 million in rural areas and 2.63 million in urban areas.	PRSP-I objectives are cross-cutting warranting multi-sectoral interventions as adopted by all development Ministries of Government in their short and long term development planning.	**General Economics Division, Planning Commission, Government of the People's Republic of Bangladesh.**
Child nutrition	1. The Constitution of Bangladesh PART II FUNDAMENTAL PRINCIPLES OF STATE POLICY: Article-18 (1)	Article 18. Public health and morality.	**18. Public health and morality.** (1) The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and of drugs which are injurious to health.		**Cabinet Division**
Child nutrition	2. BANGLADESH National Food and Nutrition Policy	National Food and Nutrition Policy 1997.	The main purpose of the Food and Nutrition Policy is to improve the nutritional status of the people significantly, particularly for vulnerable groups including the elderly, and thereby contribute to improved quality of life and national socio-economic development. **Objectives:** Some objectives of the National Food and Nutrition Policy are: • To increase production and availability of both staple and non-staple nutritious food, minimize post harvest losses; develop food preservation and distribution technologies at home and at the industrial level. To maximize availability of food for national	Nutrition and Children's well-being are crosscutting issues involving coordinated interventions by Ministries of: Health and Family Welfare, Food and Disaster Management, Education, Labour, Women and Children Affairs, etc. These ministries	**Ministry of Food and Disaster Management and Ministry of Health and Family Welfare; Government of the People's Republic of Bangladesh.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
			consumption in normal times, in times of disaster and also for export, when possible. • To improve the health and nutritional status of all people, especially children, women (adolescent girls, expectant and nursing mothers), and the elderly. • To consider the importance of the family unit to provide adequate physical, mental, emotional and social care for children and other vulnerable groups including the elderly; and strengthen the family unit as the basic unit of society. • To provide formal and non-formal nutrition education, especially to women and children. • To undertake all possible measures to increase income generating activities for poverty alleviation, particularly for women in rural households. • To develop an Action Plan with a timeframe to implement the policy.	and all other development agencies, with the guidance of the Planning Commission, undertake development programmes that include child nutrition for overall nutritional development.	
Child nutrition	3. Bangladesh National Plan of Action for Nutrition (NPAN)-1997	Bangladesh National Plan of Action for Nutrition (NPAN)-1997	**Goal:** The goal of the NPAN is to improve the nutritional status of the people of Bangladesh to the extent that malnutrition is no longer a public health problem by the year 2010, thereby improving the quality of life. **Objectives and targets:** 1. Develop human resources in nutrition by building institutional capacity in policy making, training, research and service to address nutrition problems. 2. Empower communities and households to understand nutritional problems and, thereby, to take appropriate measures to address those problems. 3. Ensure food security for all household members. Targets for increasing the consumption of particular foods and reducing malnutrition are as follows: a. reduce the prevalence of low birthweight to 20 per cent by 2000 and to less than 5 per cent by 2010. b. reduce severe and moderate Protein-Energy Malnutrition (PEM) (weight for age) in children under two: severe PEM to 25 per cent by 2000 and to <1 per cent by 2010; and moderate PEM to 25 per cent by 2000 and <10 per cent by 2010.		**Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
			4. Ensure food safety and food quality. 5. Protect, promote and support breastfeeding: a. to empower all women to breastfeed their children exclusively for 6 months and to continue breastfeeding well into the second year, supported by homemade energy-dense complementary food. b. to ensure the exclusive breastfeeding of infants by 80 per cent of mothers by 2000; and 95 per cent by 2010. 6. Ensure support for the socio-economically deprived and nutritionally vulnerable. 7. Reduce micronutrient deficiencies including nutritional anaemia, Vitamin A deficiency and iodine deficiency disorders (IDD). a. to reduce the prevalence of anaemia in under-five children to 50 per cent by 2000; and 25 per cent by 2010. b. to reduce the prevalence of night-blindness in children aged 6-71 months to <1 per cent by 2000; and eliminate by 2010. c. to reduce the prevalence of goiter in the entire population to 25 per cent by 2000; and <10 per cent by 2010. 8. Ensure proper assessment, analysis and monitoring of the nutrition situation using surveillance and evaluation procedures.		**Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.**
Child nutrition	4. Health Policy of Bangladesh	National Health Policy, 2000	The Health Policy has 15 goals and objectives, 10 policy principles and 32 strategies. The overall goal of the Policy is: To ensure that necessary basic medical utilities reach people of all strata as per Article 15 (A) of the Bangladesh Constitution, and develop the health and nutrition status of the people as per Section 18(A). The Policy also seeks to achieve the following objectives related to child nutrition: • To reduce the intensity of malnutrition among people, especially children and mothers; and implement effective and integrated programmes to improve the nutrition status of all segments of the population (Objective: 4); • To undertake programmes to reduce the rates of child and maternal mortality within the next 5 years and reduce these rates to an acceptable level (Objective: 5);		**Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
			• Nutrition and health education will be emphasised, as they are the major driving forces of health and Family Planning (FP) activities. There will be one nutrition and one health education unit in each upazila to reach every village (Strategy: 17).		
Child nutrition	5. Bangladesh: Poverty Reduction Strategy Paper (PRSP-I)	BANGLADESH Unlocking the Potential National Strategy for Accelerated Poverty Reduction	The PRSP, in line with Bangladesh's past official commitment to achieve the MDGs as well as social targets set in the PAPR with the ADB and in the reports of the Independent South Asian Commission on Poverty Alleviation, adopted the Strategic objective of achieving by the following objectives on child nutrition by the year 2015: • Reduce the proportion of malnourished children under five by 50 per cent and eliminate gender disparity in child malnutrition. The specific targets set for the PRSP period (2004 to 2008) are to: • Reduce severe PEM in children under two (U2PEM) from 12.6 per cent in 1995 to less than 5 per cent in 2006. • Reduce moderate U2PEM from 36 per cent in 1995 to 25 per cent in 2006. • Reduce incidence of low birth weight (LBW) from 50 per cent in 1995 to 15 per cent in 2006. • Reduce stunting from 43 per cent in 1995 to 35 per cent in 2006. • Reduce body mass index (BMI) from 60 per cent in 1995 to 40 per cent in 2006. • Reduce female U5 underweight, moderate or severe, as a percentage of male figure from 8 in 1990 to 0 in 2006. • Reduce female U5 severe underweight as a percentage of male figure from 26 in 1990 to 10 in 2006. • Reduce night blindness from 0.6 per cent of children (1-5 years) in 2003 to 0.2 per cent in 2006. • Reduce geographical disparity in child malnutrition. • Reduce prevalence of child malnutrition among the poor. • Reduce prevalence of anaemia in pregnant women from 70 per cent to 45 per cent in 2006 and in adolescent girls from 65 per cent to 25 per cent. • Reduce prevalence of iodine deficiency from 69 per cent of the population in 2003 to 25 per cent in 2006.		**Ministry of Food and Disaster Management, Government of the People's Republic of Bangladesh.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
	6. National Food Policy 2006	National Food Policy 2006	**Goal:** The goal of the food policy is to ensure a dependable food security system for all people of the country at all times. **Objectives:** The objectives of the food policy are: • To ensure adequate and stable supply of safe and nutritious food • To enhance the purchasing power of the people for increased food accessibility and • To ensure adequate nutritious food for all (especially women and children)	The policy objectives fit in well with GOB Agriculture Policy, Fisheries and Livestock Policy, etc. with implication on overall national development. Their interventions are interdependent for sustainable results.	**Ministry of Food and Disaster Management, Government of the People's Republic of Bangladesh.**
Child nutrition	7. National Plan of Action for Children (NPA)	3rd. National Plan of Action for Children (2005-2010)	The NPA for Children (2005-2010) seeks to achieve the relevant food and nutritional goals and targets of the Millennium Development Goals (MDG # 1, Target: 2, 4, 5). Within the framework of the relevant policies and programmes, the overall goal of the NPA is to improve the nutritional status of children and women. Among others, the specific objectives are to: • Increase food security of food insecure households. • Reduce the prevalence of low birth weight. • Reduce the prevalence of micronutrient deficiencies, including Vitamin A deficiency, iodine deficiency disorders and iron deficiency anaemia amongst children, adolescent girls, and women of childbearing age. • Reduce the prevalence of malnutrition amongst children under the age of five, with particular attention paid to children under two. • Improve infant and child feeding practices, including the initiation of breastfeeding immediately after delivery and exclusive breastfeeding for six months.		**Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh.**
Child health	1. Constitution of Bangladesh PART II FUNDAMENTAL PRINCIPLES OF STATE POLICY: Article-18 (1)	Article 18. Public health and morality.	**18. Public health and morality.** (1) The State shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and of drugs which are injurious to health.		**Cabinet Division**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
Child health	2. National Child Policy 1994	National Child Policy 1994	The National Children Policy, 1994 (NCP) seeks to "ensure the rights of safe birth and survival to all children" through prenatal and postnatal healthcare, essential obstetric services, and extended maternity leave for working mothers. Encouraging breastfeeding and supporting breastfeeding in the workplace also form a part of the NCP. Ensuring the health of all children through and expanded programme on immunization against six fatal diseases, prevention of diarrhoea and ARI, access to integrated healthcare for all children, raising awareness on personal hygiene, and educating mothers on child nutrition and development, also form a part of the NCP.		**Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh.**
	3. Health Policy of Bangladesh	National Health Policy, 2000	The Health Policy has 15 goals and objectives, 10 policy principles and 32 strategies. The majority of these seek to improve the status of child health directly or indirectly. The overall goal of the Policy is to ensure that necessary basic medical utilities reach people of all strata as per Article 15 (A) of the Bangladesh Constitution, and develop the health and nutrition status of the people as per Section 18(A). The Policy also seeks to achieve the following objectives entirely related to child health: • To undertake programmes to reduce the rates of child and maternal mortality within the next five years and reduce these rates to an acceptable level (Objective: 5) • To adopt satisfactory measures to ensure improved maternal and child health at the union level and install facilities for safe and clean child delivery in each village (Objective: 6) • To create awareness among every citizen of Bangladesh, and especially children and women and enable them, irrespective of cast, creed, religion, income, gender and geographical location, through media publicity, to obtain health, nutrition and reproductive health services on the basis of social justice and equality through ensuring everyone's constitutional rights (Principle: 1)		**Ministry of Health and Family Welfare**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
Child health	4. Bangladesh: Poverty Reduction Strategy Paper (PRSP-I)	BANGLADESH Unlocking the Potential National Strategy for Accelerated Poverty Reduction	The MDG targets include reducing the infant and under-five mortality rates by 65 per cent, and eliminating gender disparity in child mortality. In line with the constitutional obligation of developing and sustaining a society in which the basic needs of all people are met and every person can prosper in freedom and cherish the ideals and values of a free society, the vision of Bangladesh's Poverty Reduction Strategy is to substantially reduce poverty within the shortest possible time. The strategic goal in this area, in line with the MDGs, is to improve the health of children and mothers. The specific targets are as follows: • Reduce (NMR) per 1,000 live births (LB) from 41 in 2004 to 32 in 2006. • Reduce the IMR per 1,000 LB from 65 in 2004 to 47.9 in 2006. • Reduce the U5MR per 1,000 LB from 88 in 2004 to 70 in 2006. • Reduce the MMR per 100,000 LB from 320 in 2001 to 275 in 2006. • Reduce female U5MR as a percentage of male U5MR from 107 in 2000 to 102 in 2006. • Reduce incidence of child mortality among the poor (poor-rich ratio 1.86). • Reduce rural child mortality as a percentage of urban child mortality from 140 in 2000 to 120 in 2006. • Increase ANC coverage from 48.7 per cent in 2004 to 60 per cent in 2006. • Increase Post-Natal Care (PNC) coverage from 17.8 per cent in 2004 to 30 per cent in 2006. • Increase utilization of Essential Obstetric Care services from 26.5 per cent (risk group) in 2003 to 40 per cent in 2006. • All women must have access to Emergency Obstetric Care (EmOC), in case they experience complications. • Increase skilled birth attendance (SBA) at birth from 13.4 per cent in 2004 to 25 per cent in 2006. In addition, there are specific goals and targets for adolescent health to reduce adolescence pregnancy, provide reproductive health awareness and service to all adolescents, prevent transmission of STD including HIV/AIDS and reduce the negative health consequences of sexual abuse and exploitation.	The PRSP Policy of investing in people in health is correlated to, and interdependent on, other sectors such as Industry, Education, Rural Development, Food and Disaster Management, Health and Family Welfare for an intersectoral programme coordination mechanism.	**Cabinet Division** **Ministry of Health and Family Welfare**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
Child health	5. National Plan of Action for Children (NPA)	3rd. National Plan of Action for Children (2005-2010)	The NPA for Children (2005-2010) seeks to achieve the relevant health goals and targets of the Millennium Development Goals (MDG # 4, 5, 7). Within the framework of the government policies and programmes, the overall goal of the NPA is to improve the health of children and women. The major specific objectives of this document are to: • Reduce the infant mortality rate to 48, the neonatal mortality rate to 32, under-five child mortality rate to 70, and maternal mortality rate to 2.75 per 1,000 live births by 2006. • Maintain polio eradication status at polio eradication certification level by 2008, achieve elimination of neonatal tetanus nationally and in all districts by 2005 and reduce measles morbidity by 50 per cent by 2005 compared to 1999. • Reduce the prevalence of Hepatitis-B infection (HbsAg) among children aged 3-5 years by 80 per cent by 2010 compared to the prevalence of the pre-vaccine era. • Maintain a high level of immunization coverage (85 per cent of children under one year of age), 85 per cent for DPT, 80 per cent for measles and 85 per cent for polio by 2006. • Control diarrhoeal diseases by increasing the use of oral rehydration therapy (ORT) to 56 per cent. • Improve service provider management of severe and very severe cases of acute respiratory infection (ARI) cases from 60 per cent to 100 per cent by 2006. • Increase met need of emergency obstetric care to 40 per cent from 27 per cent, increase uptake of neonatal care (3 visits) to 60 per cent, increase skilled attendance at birth to 25 per cent from 12 per cent, increase postnatal care to 30 per cent from 16 per cent by 2006.		
Child Protection	1. Constitution of Bangladesh PART – III: FUNDAMENTAL RIGHTS Article 27	Article 27. Equality before law.	**27. Equality before law.** – "All citizens are equal before law and are entitled to equal protection of law."	Policy directives as contained in the Constitution of Bangladesh with an implacable binding on all sectors to protect and preserve the interest of children lawfully, and in the process of national development initiatives.	**Cabinet Division,** **Ministry of Women and Children Affairs.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
	2. Constitution of Bangladesh PART – III: FUNDAMENTAL RIGHTS Article 28	Article 28. Discrimination on grounds of religion, etc.-	**28. Discrimination on grounds of religion, etc.-** (1) The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex or place of birth. (4) Nothing in this article shall prevent the State from making special provision in favour of women or children or for the advancement of any backward section of citizens.	Under the Umbrella of the Constitution of Bangladesh, which is the supreme legal framework as well as highest policy directive, both the basic rights and livelihood needs of children beside investment in children's advancement and protection, have been ensured.	**Cabinet Division,** **Ministry of Women and Children Affairs.**
Child protection	3. ACT No. XXXIX of 1974 of the Parliament	THE CHILDREN ACT, 1974 and Children Rules, 1976	THE CHILDREN ACT, 1974 is the principal law on children. It consolidates and amends laws relating to the custody, protection and treatment of children and trial and punishment of youthful offenders. This Act, along with numerous provisions for the custody, protection and treatment of children, also provides for 'Juvenile Justice' when they come into conflict with law. Defining the Age of a child the Act says, *"... Child" means a person under the age of sixteen years, and when used with reference to a child sent to a certified institute or approved home or committed by a Court to the custody of a relative or other fit person means that child during the whole period of his detention notwithstanding that he may have attained the age of sixteen years during that period".*	The Policy Objective of the Children Act-1974, Children Rules-1976, which are the principal legislative instruments, have cross-cutting effects on other sectors of national development.	**Cabinet Division**
	4. National Child Policy 1994	**National Child Policy 1994**	The Ministry of Women and Children Affairs formulated a National Children Policy in December 1994 to protect juvenile interests, rights and welfare. To safeguard the interest of children and implement the policy directives, the National Children Council has been formed under the National children policy. The policy divided into eight chapters. • Chapter One states that it is essential to adopt an appropriate programme of action for the welfare of all children in the interest of the overall development of the country, and that everyone should participate in the task of helping every child grow into an able citizen. • Chapter two defines a child as one who has not passed the age of 14. • Chapter four speaks of the objectives of the policy. To ensure children's right to live, it is necessary to provide them with security of health, nutrition and person. To ensure their overall mental growth, it is necessary to educate them. Other objectives outlined in the policy are to help develop children's sense of moral, cultural and social values; to take necessary steps to help develop their		**Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
			family environment; to ensure special support for children with disabilities; to adopt policies to ensure maximum protection of children's rights with disability at national, social, family and personal levels; and to ensure legal rights of children in national, social and family activities.		
Child protection	**5. NPA against the Sexual Abuses and Exploitation of Children including Trafficking**	National Plan of Action against the Sexual Abuses and Exploitation of Children including Trafficking	The NPA is prepared as a matrix covering seven themes: Prevention, Protection, Recovery and reintegration, Perpetrators, Child Participation, HIV/AIDS, STIs and substance abuse, plus Coordination and Monitoring. Main issues are identified for each them and specific goals are set. The overall objective of the NPA is to protect children from any form of sexual abuse and exploitation, including trafficking.		**Ministry of Women and Children Affairs**
Child protection	**6. Bangladesh: Poverty Reduction Strategy Paper (PRSP-I)**	**BANGLADESH Unlocking the Potential National Strategy for Accelerated Poverty Reduction**	The Strategy visualizes the achievement of the following goal on child protection by the year 2015: • Reduce substantially, if not eliminate totally, social violence against the poor and the disadvantaged groups, especially violence against women and **children.** The PRSP adopted the following key targets to be achieved by 2007 in relation to protection of children: • Analysis of trends of child abuse, exploitation and violence. • Increase coverage of programmes for vulnerable children. • Increase rate of under-five birth registration from 8 per cent (in 2000) to 40 per cent in 2007. • Reduce the percentage of early marriage by 70 per cent during FY 2005 to FY 2007, Ensure juvenile justice reforms. • Increase awareness about safe migration, all forms of illegal trafficking and abduction. • Reduce all forms of ill-treatment and violence against children. • Protect children living on the street from all forms of abuse and exploitation. • Ensure safeguards for indigenous children. • Increase protection of children deprived of parental care. • Increase necessary support services for child victims. • Prevent the transmission of HIV/AIDS. • Ensure strict enforcement of law.	This Policy Objective calls for sector-wide approaches involving Health, Education, Social Welfare, Home Affairs, Labour, Water Resources etc. The PRSP also selected the Ministries of Women and Children Affairs, Law Justice and Parliamentary Affairs, Home Affairs, Labour and Employment, Social Welfare, Information, Youth and Sports, Local Government Division, etc. to take relevant and necessary responsibilities to protect children from abuse, exploitation and violence.	

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
Child protection	**7. National Plan of Action for Children (NPA)**	**3rd. National Plan of Action for Children (2005-2010)**	**The specific objectives of the NPA are to:** • Ensure protection of children from all forms of abuse, violence, discrimination and exploitation including trafficking • Build an enabling environment to secure the well-being of children, including those who are vulnerable. • Provisions of recovery and reintegration into society for child victims and children of adult victims of abuse, violence, discrimination and exploitation.		**Ministry of Women and Children Affairs**
Child protection	**8. Births and Deaths Registration Act 2004**	**Universal Births and Deaths Registration Act 2004**	Article 7 of the Convention on the Rights of the Child stipulates that every child has the right to a name, identity and nationality. Birth registration (BR) is a first and significant step in meeting child rights as it becomes the State's first official acknowledgement of the child's existence and the recognition of the child's status before the law. Birth registration also becomes the means to secure other child rights such as the access to services and state benefits such as immunization, health care and education. In addition, specifically for children, it ensures protection through legal age limits for employment, recruitment of armed forces, children in conflict with the law and child trafficking. The 2004 Births and Deaths Registration Act that replaced previous legislation from 1873 came into force on 3 July 2006. It provides for birth registration to adopt a cross sectoral approach by linking its activities to the health and education sector. The Act requires birth certificates to serve as proof of age and identity for services such as enrolment in educational institutions, issuance of passports and transfer of property. Certificates will also be requested for voter registration, issuance of driving licenses and passports, as well as for employment in government or non-government organizations. In addition, the Government of Bangladesh has decided to adopt a Universal Birth Registration strategy which provides for free registration for the following two years after the Act came into force. The strategy aims at registering all by the end of 2008. Registration of birth of children will: • *prevent early marriage; ensure all children's enrolment in school at the right age;* • *protect underage children from working, and* • *ensure special treatment for children in the juvenile justice system.*	The Policy objective has implication on other sectors such as Health and Family Welfare, Education, Food, Planning, etc. because national planning of development activities would need birth registration data for resource mobilization and useful utilization.	**Local Government Division, Ministry of Local Government, Rural Development and Cooperatives.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
Child education	1. Constitution of Bangladesh PART II FUNDAMENTAL PRINCIPLES OF STATE POLICY: Article-17(a, b, c)	Article 17. Free and compulsory education.	**17. Free and compulsory education**. - The State shall adopt effective measures for the purpose of (a) Establishing a uniform, mass-oriented and universal system of education and extending free and compulsory education to all children to such stage as may be determined by law; (b) Relating education to the needs of society and producing properly trained and motivated citizens to serve those needs; (c) Removing illiteracy within such time as may be determined by law	The Policy Objectives derived from the "Constitution of Bangladesh", Compulsory Primary Education Act-1990, and PRSP I have cross-cutting edge to have other sectors matching participation for promoting child education and well-being.	**Cabinet Division**
Child education	2. Act No. 27 of the Parliament, 1990	Primary Education (Compulsory) Act 1990 This Act may be called (Obligation to) Primary Education Act, 1990.	The Primary Education (Compulsory) Act 1990 made primary education free and compulsory for all children up to Grade 5, with "child" meaning any boy or girl between 6 and 10 years. The Act says, among other things, *(1) The Government may, by notification in the official Gazette, declare primary education obligatory in whatever area from whenever onwards.* *(2) The guardian of any child dwelling permanently in a area where primary education is obligatory shall, in the absence of justified reasons, get his child admitted for the purpose of receiving primary education in a primary education institute of the said area in the vicinity of his place of residence.*	The Act is a land mark legislation that provides legal guarantee to the children's right to education.	**Ministry of Primary and Mass Education, Government of the People's Republic of Bangladesh.**
Child education	3. Education for All: National Plan of Action (NPA I)	The National Plan of Action on Education (1991-2000) - Bangladesh	Following the World Conference on Education for All (WCEFA), meeting in Jomtien, Thailand in March 1990, Bangladesh prepared its first EFA: National Plan of Action (NPA I) covering the period 1991-2000. Using 1991, as the base-year, the NPA set its own goals for primary education, non-formal basic education and adult literacy to be achieved by 2000. The plan sets the following targets: 1. To raise the gross enrolment rate at the primary level from 76 per cent to 95 per cent. 2. To raise girl's gross enrolment rate at the primary level to 94 per cent. 3. To raise the completion rate at the primary level from 40 per cent to 70. per cent. 4. To raise the adult literacy rate from 35 per cent to 62 per cent. 5. To increase the female literacy rate from 24 per cent to 50 per cent by 2000. In line with EFA goals, NPA I covered five major basic education programme areas, namely Early Childhood Education and Development (ECED), Universalization of (Formal) Primary Education (UPE), Non-formal Basic Education (NFBE), Adult Education (AE) and Continuing Education (CE). Running through all the five was the Female Education and Gender Equity, described in a separate chapter.	The achievements of the NPA I can be summarized as follows: 1. Gross Enrolment Rate (GER) at Primary Education (PE) rose from 76 per cent (in 1991) to 92 per cent in 1995 and 96.5 per cent in 2000. 2. Completion Rate at PE rose from 40 per cent (in 1991) to 60 per cent in 1995 and 67 per cent in 2000. 3. Adult Literacy Rate (15-45 years) rose from 35 per cent (in 1991) to 47 per cent in 1995 and 64 per cent in 2000.	**Ministry of Primary and Mass Education, Government of the People's Republic of Bangladesh.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
	4. National Education Policy	National Education Policy 2000	The Education Policy of 2000 has the following key objectives related to child education: • Suggests a one-year course of pre-primary education to stimulate the child's interest in education and school. • Primary education should be universal, compulsory, free and of the same standard for everybody. • The duration of primary education is to be extended gradually to six years by 2003, seven years by 2006 and eight years by 2010. • The Rule of admission into class one at the age of 6+ will be made compulsory. • The ratio of the teacher and learners will be 1: 40 in primary and secondary level. • Dropout children aged 8-14 should be enrolled in non-formal education. • Secondary level education would consist of classes 9 to 12, instead of 6 to 10. • Provision for technical and vocational education in madrasah education system.		**Ministry of Education, Government of the People's Republic of Bangladesh.**
Child education	5. Education for All: National Plan of Action (NPA II) (Draft)	Education for All: National Plan of Action II (2003 – 2015) (Draft)	The DFA goals and strategies, achievements of NPA I and basic education needs of the country in 2001 provided the framework for NPA II. Moreover, the Government of Bangladesh (GOB) has made commitments at the World Education Forum (Dakar, April 2000) towards achievement of Education For All goals and targets for every citizen by the year 2015. In line with the objectives of the Dakar Framework for Action, Bangladesh has prepared another National Plan of Action for EFA (draft) with a specific set of goals to be achieved by 2015. The Ministry of Primary and Mass Education started work on developing the NPA II in early 2001 in the context of the aforesaid framework by using the UNESCO guidelines on preparation of national plans. The Plan was drafted in May 2003. The four major objectives of NPA II are to: (i) Institute a well organized and coordinated programme of early childhood care and education for the most vulnerable and disadvantaged children, using both formal and non-formal approaches, with an emphasis on family and community-based programmes		**Ministry of Primary and Mass Education, Government of the People's Republic of Bangladesh.**

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
			(ii) Bring all primary school-age children into school, particularly girls, those with disabilities and those in difficult circumstances and belonging to ethnic minorities, and enable them to complete primary education (already free and compulsory) of good quality; (iii) Establish programmes of appropriate learning and life-skills to meet the learning needs of all young people and adults, and ensure their access, participation and successful completion of relevant courses; (iv) Sustain and enhance the present near gender-parity in primary and above parity for girls in secondary education to achieve gender equity in education by 2005 and gender equality in 2015 by ensuring full and equal access of boys and girls to and achievement in basic education of good quality. The country has already undertaken a major programme "Primary Education Development Programme-II" (PEDP-II) on the basis of Dakar Framework and the proposed National Plan of Action (NPA-II).		
Child education	6. Bangladesh: Poverty Reduction Strategy Paper (PRSP-I)	**BANGLADESH Unlocking the Potential National Strategy for Accelerated Poverty Reduction**	Through adopting a comprehensive approach and by taking into account the country's past international and regional commitments and evolving national realities, the PRSP visualizes that, by the year 2015, Bangladesh would achieve the following goals related to child education: • Attain universal primary education for all girls and boys of primary school age. • Eliminate gender disparity in primary and secondary education. The key objectives and targets of the PRSP I are: **Primary Education**: to ensure that all children aged five, irrespective of their geographical, socio-economic, ethnic-linguistic, gender, physical and mental characteristics, as well as poor achievers, are brought into school and complete the primary education cycle. School attendance and the completion rate have to be improved substantially. Primary education has to be made available to all drop-outs and excluded boys and girls. The quality of primary education, including madrasha education, has to be improved so that the competency rate doubles by 2007. Finally, attention must be paid to maintain gender equality.		

Child outcome	What is the key national document/ plan that sets out the goals and strategy in this area?	What is the name of the key national policy, law, ministerial decree or directive in this area?	Policy objective. What exactly does the policy/law seek to achieve in relation to addressing the dimension of child poverty?	How does this policy objective fit in with objectives in other sectors or in the overall National Development Strategy?	Who is the Lead/Head implementing State agency?
			Secondary Education: increase access to secondary education by increasing gross enrolment rates by 50 per cent for all levels of secondary education and halve dropout; improve quality of education at the secondary level by enhancing the SSC and HSC pass rate to at least 65 per cent for both male and female students by the year 2008; ensure a gender balanced approach in the formulation of curricula by removing any negative images from the existing curricula and project a positive image of women and household activities; improve enrolment, attendance and completion rate among students from poor families by reducing their dropout rate by 50 per cent; and ensure sustainable gender parity in secondary and post-secondary education by making male-female student enrolment ratios equal, ensuring gender equality in completion rates, and making schools girl friendly.		

Table 2: Public expenditure and aid

(in million Tk.)

	Fiscal Year 2005-2006		Fiscal Year 2006-2007		Source of Data
	Revenue	Development	Revenue	Development	
Total public expenditure (Tk.)	562847.671 (a)	222625.763 (a)	598916.827 (b)	218832.5 (b)	(a)[1] (b)[2]
Public spending on cash transfers (and household income generation)[3] programmes (Tk.)	8594.00	6010.60	9625.80	6329.40	BER-2006 BER-2007 ADP-2005-06 RADP-2006-07 BER-2007
Public spending on nutrition (Tk.)[11]	33.163*[4]	1636.482*[5]	24.614*[6]	1175.256*[7]	IPHN[8], NNP[9], BNNC[10], RADP-2006-07
Public spending on child nutrition (Tk.)	30.163	1506.282	21.414	905.256	IPHN, NNP
Public spending on health (Tk.)	20642.634 [Actual spending (c) 19360.071]	20471.50 [Actual spending (c) 17679.443]	26948.396 ---------	22751.80 ---------	Revised Budget, 2005-06 & 2006-07 (c) MOHFW, 2006[12]
Public spending on maternal health (Tk.)[13]					
Public spending on child health (Tk.)[14]					
Public spending on education (Tk.)[15]	64103.30	29519.00	79947.84	29669.20	BANBEIS, 2006; ADP, 2005-06; Annual Revised Budget, 2006-07; RADP, 2006-07

1 Annual Revised Budget 2005-06. From **Annual Budget Book 2006-07**(Statement-6 & 8), Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh.

2 Annual Revised Budget 2006-07. From **Annual Budget Book 2007-08 (Proposed)**, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh.

3 Figures only include the amount of expenditure on cash transfer programmes.

4 The figures only include the sum of expenditures of major interventions of the Government in Nutrition sector (i.e., IPHN, NNP and BNNC). There are also nutritional interventions included in other programmes such as Essential Service Delivery and programmes of the Directorate General of Family Planning. Actual amount spent in those programmes particularly on nutrition could not have been possible to calculate.

5 Figure: Sum of Expenditures of IPHN, NNP & BNNC and other projects with Nutritional Intervention.

6 Figure: Sum of Expenditures of IPHN, NNP & BNNC.

7 Figure: Sum of Expenditures of IPHN, NNP & BNNC and other projects with Nutritional Intervention.

8 Institute of Public Health Nutrition (IPHN), DGHS, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.

9 National Nutrition Programme (NNP), Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.

10 Bangladesh National Nutrition Council, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh.

11 There is no particular source of this data. The figures used in the 'public spending on child nutrition' column have been constructed in consultation with the experts of the Institutions/Programmes that deal with/deliver services in the improvement of nutritional level of the people of the country. For example, experts of the Institute of Public Health Nutrition (IPHN) suggested that their activities/services are directly or indirectly designed for the improvement of the nutritional status of infants or children. Therefore, they suggested that the total budget of the Institute should be considered under the government's total expenditure on child nutrition. The same method has been used for NNP.

12 Public Expenditure Review of the Health Sector 2003/04 to 2005/06. Health Economics Unit (HEU), Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh; October 2007:17.

13 Data were not available.

14 Data were not available.

15 *These figures include the education expenditure of the Government of all levels (Primary, Secondary and Tertiary of all streams).*

	Fiscal Year 2005-2006		Fiscal Year 2006-2007		Source of Data
	Revenue	Development	Revenue	Development	
Gross official assistance from GOB for development (Tk.)	---------	126430 (52 per cent of the total ADP)	---------	148120 (57 per cent of the total ADP)	ADP, 2005-2006; ADP, 2006-2007
Gross official assistance from GOB for development on child nutrition, child health and education (Tk.)					
General budget support (Tk.)[16]	---------		---------		
ODA on cash transfers and household income generation programmes (Tk.)	---------	1254.10	---------	940.70	ADP, 2005-06; RADP-2006-07
ODA spending on child nutrition (Tk.)	---------	12508.8*[17]	---------	14308.2*[18]	ADP, 2005-06; RADP, 2006-07
ODA spending on health (Tk.)	---------	11645.2*[19]	---------	12357.50*[20]	ADP, 2005-06; RADP, 2006-07
ODA spending on education (Tk.)					

16 Data were not available.
17 Figure includes the ODA expenditure on nutrition and family planning.
18 Figure includes the ODA expenditure on nutrition and family planning.
19 Figure does not include ODA spending on medical education.
20 Figure does not include ODA spending on medical education.

Table 3: Total spending on supporting household income outcome by broad heads (in million Tk.)

	Year 2005/6 (Tk.)		Year 2006/7 (Tk.)		Total spending as per cent govt. spending year 2005/06	Total spending as per cent govt. spending year 2006/07	Source of data
	Rev.	Dev.	Rev.	Dev.			
Cash for human development programmes[21]		157250		183290			BER-2007[22]; ADP-2005-06 & 2006-07
Cash for work programmes[23]							
PRICE SUBSIDIES, tax allowances[24]	14837	19800	22862	17918			BBS, 2007[25]
Social pensions (old age and disability)	3260		3940				BER-2006; BER-2007
Maternity benefits[26]			170*[27]				DWA, MOWCA[28]
Child and family allowances[29]							

Table 4: Total spending on supporting child nutrition outcomes by broad heads (in million Tk.)

	Year 2005/6 (Tk.)		Year 2006/7 (Tk.)		Total spending as per cent govt. spending year 2005/06	Total spending as per cent govt. spending year 2006/7	Source of data
	Rev.	Dev.	Rev.	Dev.			
Community-based nutrition and health services (growth promotion, supplementary feeding)[30]							
Breastfeeding counseling		13.853		9.705			NNP[31]
Facility-based nutrition services (severe malnutrition treatment)[32]							
Micronutrient supplementation[33]	30.163	111.272	21.414	177.107			NNP; IPHN[34]
Targeted food aid[35]							

21 Figures include both Revenue and Development expenditure of the Government. They could not be separated as required in the table.
22 Bangladesh Economic Review 2007, Economic Adviser's Wing, Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh.
23 Data were not available.
24 Figures only include price subsidies of the Government and data for Tax Allowances were not available.
25 Statistical Pocket Book of Bangladesh 2007, Bangladesh Bureau of Statistics (BBS), Planning Division, Ministry of Planning, Government of the People's Republic of Bangladesh, April-2008.
26 Data for the remaining years were not available.
27 This amount is the allocation in the Annual Budget for FY 2007-08 under Maternity Voucher Scheme for Poor Mothers. Under this programme the government is to provide a maternity allowance of Tk. 300 per month to selected 45,000 poor pregnant mothers in 3000 unions. The Government's Ministry of Women and Children Affairs is to implement the programme through its Directorate of Women Affairs.
28 Department of Women Affairs, Ministry of Women and Children Affairs, Government of the People's Republic of Bangladesh.
29 Data were not available.
30 Data were not available.
31 National Nutrition Programme.
32 Data were not available.
33 Figures are the sum of expenditure of IPHN and NNP.
34 Institute of Public Health Nutrition.
35 Data were not available.

Table 5: Total spending on supporting child health outcomes by broad heads (in million Tk.)

	Year 2005/6 (Tk.)		Year 2006/7 (Tk.)		Total spending as per cent govt. spending year 2005/06	Total spending as per cent govt. spending year 2006/07	Source of data
	Rev.	Dev.	Rev.	Dev.			
Primary healthcare facilities	22.50	1100.00	22.00	795.00			ADP, 2005-06; RADP, 2006-07
Immunization programmes[36]							
Antenatal care programmes[37]							
Neonatal care programmes[38]							
Reproductive health and maternal care[39]		2847.50*[40]		5700.20*[41]			ADP, 2005-06; RADP, 2006-07

Table 6: Total spending on supporting child protection outcomes by broad heads (in million Tk.)

	Year 2005/6 (Tk.)		Year 2006/7 (Tk.)		Total spending as per cent govt. spending year 2005/06	Total spending as per cent govt. spending year 2006/07	Source of data
	Rev.	Dev.	Rev.	Dev.			
Alternative care (foster care, adoption services, residential care)[44]	15 .30	42.50	10	9.33			ADP, 2005-06 LG[42]; UNICEF[43]
Family support services[45]							
Child protective services[46]							
Juvenile justice[47]							

36 Data were not available.
37 Data were not available.
38 Data were not available.
39 Data for the Revenue Budget were not available.
40 Figure is the sum of ADP-2005-06 allocation in 2 Investment projects and 11 Technical Assistance projects.
41 Figure is the sum of RADP-2006-07 allocation in 3 Investment projects, 6 Technical Assistance projects and 1 Japan Debt Cancellation Fund project.
42 Local Government Division, Ministry of Local Government, Rural Development and Cooperatives, Government of the People's Republic of Bangladesh.
43 Child Protection Section, UNICEF, Dhaka, Bangladesh, August 2008.
44 Data were not available.
45 Data were not available.
46 Data were not available.
47 Data were not available.

Table 7: Total spending on supporting child education outcomes by broad heads (in million Tk.)

	Year 2005/6 (Tk.)		Year 2006/7 (Tk.)		Total spending as per cent govt. spending year 2005/06		Total spending as per cent govt. spending year 2006/07		Source of data
	Rev.	Dev.	Rev.	Dev.					
Pre-primary schooling[48]				Tk. 153.80 (FY 2008-09)					MOPME
Primary education	21242.962 (a)	16947.500 (a)	32036.877 (a)	17966.100 (a)					(a)[49]
Secondary education (Class VI to X of all Streams)	11970.5	6306.55*[50]	15437.9	4396.25*[51]	23.26		23.44		BANBEIS, 2006[52]; ADP-2005-06[53]; RADP-2006-07[54]
Lower secondary schooling[55]									
Secondary schooling									
Higher secondary schooling (Class XI-HSC/Equivalent of all Streams)[56]	7259.5*[57]								BANBEIS, 2006
Secondary and higher education[58] **(Class VI to XII)**	33332.2	7459.6	34794.1	9234.1	52.52 Rev.	27.07 Dev.	48.86 Rev.	24.39 Dev.	BANBEIS, 2006
Other – please list									
Medical education[59]	436.0		511.4						BANBEIS, 2006
Nursing education[60]	6.6		8.5						BANBEIS, 2006
Cadet college education[61]	189.3		201.3						BANBEIS, 2006

48 There are 37,672 government primary schools in Bangladesh. Pre-primary schooling programme is present in 26,000 of those schools. The number of students in those schools under the pre-primary schooling programme is 1.10 million. Public expenditure on the programme has been accounted under the umbrella budget of the Ministry of Primary and Mass Education until the FY 2007-2008. In the current budget (FY 2008-09) Tk. 153.80 has been allocated under the development budget for pre-primary schooling programme.

49 Annual Revised Budget 2006-07. Data taken from the Annual (Proposed) Budget Book of 2007-08. Finance Division, Ministry of Finance, Government of the People's Republic of Bangladesh.

50 The approximate figure is constructed taking the ADP allocations in the FY 2005-06 at this level of education (i.e., class VI to X).

51 The approximate figure is constructed taking the RADP allocations in the FY 2006-07 at this level of education (i.e., class VI to X).

52 Bangladesh Educational Statistics 2006. Bangladesh Bureau of Educational Information and Statistics (BANBEIS), December 2006.

53 Annual Development Programme 2005-2006. Planning Commission, Government of the People's Republic of Bangladesh.

54 Annual Development Programme 2007-2008. Planning Commission, Government of the People's Republic of Bangladesh.

55 There is no separate expenditure for this level. The amount is included in the expenditure of the secondary education.

56 Data for the other heads were not available.

57 The figure includes public expenditure on College (general) Education only.

58 In Bangladesh the expenditure of Secondary and Higher Secondary Education is allocated through the Directorate of Secondary and Higher Education.

59 Data for the Development Budget were not available.

60 Data for the Development Budget were not available.

61 Data for the Development Budget were not available.

Table 8.1.1: National programme inventory: Household income promotion

Child Outcome Area	Household Income Promotion
1 Programme Name	**Rural Maintenance Programme (RMP, Phase-III) (July 1995 to June 2006)**
2 Objectives	Traditionally, women in the rural communities of Bangladesh women have had little power or leadership role. RMP is an innovative project that used specific vocational training and employment to empower Bangladeshi women, as well as alleviating poverty by giving them the means to support their families independently. RMP first evolved in Bangladesh in 1983 with the help of the Canadian Government. It had two major parts: (a) Road Maintenance component and (b) Income Diversification component. Phase 1 and 2 of the programme were implemented through 1983 to 1995 under the then Ministry of Relief and Disaster Management. The third phase of the programme was implemented by the Ministry of Local Government Rural Development and Cooperatives. The specific objectives of the programme (phase III) were: 1) to create wage-based employment opportunities for rural destitute women throughout the year and thus alleviate their poverty; 2) to provide employment generation training, advocacy and other necessary assistance so that these women do not fall into poverty again; 3) to provide the regular maintenance of 84,000 kilometres of rural earthen roads using their labour.
3 Programme Type	1) Employment for rural destitute women in maintenance of earthen rural roads in their communities and providing each of them Tk. 450 per week as a wage (excluding compulsory savings; 2) Provide employment generation training, advocacy and other assistance to reduce poverty sustainably.
4 Reason for inclusion	1. Countrywide coverage (in 61 districts, 415 upazilas and 4,100 unions) 2. Large number of beneficiaries (employment opportunities for 42,000 rural destitute women) 3. Attaining MDG outcome (MDG #1).
5 Cost of Funding	
a Allocation (currency/year/region)	Total: 9262.869 million Tk. (Phase III).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	1. Local Government Engineering Department (LGED), Local Government Division, the Ministry of Local Government, Rural Development and Cooperatives, Government of the People's Republic of Bangladesh. (Implementing Agency) 2. CARE Bangladesh (Mangement) 3. CIDA, EU (Donor Agency).
b Agency role	1. LGED: Implementation. 2. CIDA, EU: Financial Support.
7 Mechanism and Beneficiaries	
a What is delivered	1. Engage rural destitute women in earthen roads maintenance work and provide each of them with Tk. 450 per week as a wage. 2. Provide training, advocacy and other assistance to reduce poverty sustainably. 3. Regular maintenance of 84,000 kilometres of rural earthen roads for better communication.
b Who benefits	42,000 rural destitute women and their household members have been benefited from this programme+C27 in the Phase III. (181,000 beneficiaries in the 3 phases).
8 Targeting	
a Intended beneficiaries	Rural poor, vulnerable and destitute women with no income source.
b Method	Women beneficiaries were selected on the basis of their vulnerability by the representatives of the Local Government (Chairmen and members of the union council). In general, 10 women were selected from each union.

Child Outcome Area	Household Income Promotion
c Disparities addressed	Traditionally, women in the rural communities of Bangladesh women have had little power or leadership role. RMP is an innovative project that used specific vocational training and employment to empower Bangladeshi women, as well as alleviating the poverty of their households by giving them the means to support their families independently.
9 Coverage	
a Geography	Countrywide coverage (in 61 districts out of 64, 415 upazilas and 4100 unions).
b Number of people covered	In Phase III a total of 42,000 rural destitute women were selected for the programme.
c Quality of coverage	The programme created employment opportunities for the most vulnerable rural women. The beneficiaries have also been provided with training, advocacy and other assistance. As a result, many of them have been able to alleviate their poverty in a sustainable way, managing their own savings and using these in their own income generating activities (IGAs). The women who participated in the programme developed basic management and business skills. They achieved greater self-confidence, self-reliance and security in their own lives. All women who spent at least two years in the programme were able to afford better accommodations and provide three meals a day for their families.
d Most vulnerable children	If the most vulnerable rural women are selected it is likely that their dependents, i.e., the most vulnerable children are also covered.
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning, Government of the People's Republic of Bangladesh.
c Impact of findings	
11 Implementation Challenges	1. Frequent revision of the project. In the implementation period of Phase III, the project had to be revised five times. As a result the implementation period and the total cost of the project increased (cost increased by 25 per cent of the original). 2. Selection of roads and beneficiaries: In general, 10 women from each union were selected to maintain 20 kilometres of earthen roads. It was sometimes difficult for C21rural women to go to the distant areas for work.

Table 8.1.2: National programme inventory: Household income promotion

Child Outcome Area	Household Income Promotion
1 Programme Name	**Rural Poverty Alleviation Programme (PODABIK, Phase II)** Duration: July 1998-June 2005.
2 Objectives	The Rural Poverty Alleviation Programme (PODABIK) is financed solely by the Government. The first phase of the programme was implemented through 1993 to 1998. Its objectives were: 1) to alleviate the poverty of the rural poor and landless households by organizing them in small informal cooperatives groups; 2) providing micro-credit against their IGAs for both male and female members, and 3) provide skills development training to the members for sustainable poverty alleviation.
3 Programme Type	The programme provided necessary skill development training to its members. It then provided them with micro-credit ranging from Tk. 5,000 to Tk. 10,000 against their IGAs.
4 Reason for inclusion	The programme is funded solely by the Government and promotes household income generation for the rural poor. The budgetary amount is large and, at the same time, the programme also addresses the Millennium Development Goals (MDG# 1).
5 Cost of Funding	
a Allocation (currency/year/region)	Total: 1706.60 million Tk. (solely GOB).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	Executive agency: Bangladesh Rural Development Board (BRDB), Rural Development and Cooperative Division, Ministry of Local Government Rural Development and Cooperatives.
b Agency role	Planning, financing and implementation.
7 Mechanism and Beneficiaries	
a What is delivered	In line with the goal, objectives and implementation strategy, the programme first formed small rural cooperative groups comprised of poor, destitute and landless household members of rural Bangladesh. Some 60 per cent of group members were women. It then arranged skills development training for the members, who were also allocated micro-credit against their own IGA.
b Who benefits, who does not	Poor, destitute and landless rural household members (both male and female).
8 Targeting	
a Intended beneficiaries	Both male and female members of poor, destitute and landless rural households who were entirely dependent on their physical labour and owned less than 0.50 acre of land.
b Method	Landless rural household who were entirely dependent on their physical labour and owned less than 0.50 acre of land were selected for the programme.
c Disparities addressed	60 per cent of the members were women.

Child Outcome Area	Household Income Promotion
9 Coverage	
a Geography	123 upazilas in 22 districts.
b Number of people covered	In the implementation period, 15,110 small rural cooperative groups were formed and there were 41,665 members who participated in the skills development and income generation training. These members also received micro-credit for IGA.
c Quality of coverage	
d Most vulnerable children	
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning, Government of the Peoples Republic of Bangladesh.
c Impact of findings	
11 Implementation challenges	

Table 8.1.3: National programme inventory: Household income promotion

Child Outcome Area	Household Income Promotion
1 Programme Name	**100 Days Employment Generation Programme**
2 Objectives	To overcome the impact of global food shortages and the price hike of the essentials on the poor and the lower middle class, the Government has established the 100 Days Employment Generation Programme to ensure employment of the rural unemployed poor across the country for 100 days across the whole year and in particular from mid-September to November (2 months, 15 days) and March and April (2 months). Two million people will get employment opportunities under this programme, which is designed as an employment guarantee programme for the unemployed poor.
3 Programme Type	It is an employment generation programme for the hardcore poor, seasonal unemployed people and marginalized farmers. The programme will create 200 million working days, with daily remuneration of Tk. 100 per person.
4 Reason for inclusion	Large number of beneficiaries, a large budget and support for the attainment of MDG outcome (MDG # 1). The budget suggests that. of all the safety net programmes launched to date, ths is the largest.
5 Cost of Funding	
a Allocation (currency/ year/ region)	Tk. 20,000 million has been allocated for the programme in the budget.
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	Ministry of Food and Disaster Management.
b Agency role	Planning and implementation.
7 Mechanism and Beneficiaries	
a What is delivered	Each of the programme beneficiaries (registered on the basis of several criteria) will get Tk. 100 a day for work under different projects. If no appropriate job is found for them within 15 days of receiving their registration cards, they will receive an unemployment allowance of Tk. 40 each day for the first 30 days, and Tk. 50 each day for the rest of the period.
b Who benefits, who does not	Expected to benefit two million unemployed poor across the country directly, and about ten million people indirectly.
8 Targeting	
a Intended beneficiaries	Rural hardcore poor but active people including marginal farmers living in the river erosion, flood prone, manga (a seasonal famine in the northern region), haor-baor (wetlands/ water-bodies) and char areas who remain unemployed generally for a period of five months from mid-September to November and March to April.
b Method	The programme beneficiaries are selected on the basis of the following key criteria: 1) rural hardcore poor including marginal farmers (owning >.5 acre of agricultural land, excluding the homestead) living in the river erosion, flood prone, manga (s seasonal famine in the northern region), haor-baor (wetlands/ water-bodies) and char areas; 2) unskilled unemployed poor people who intend to work; 3) those aged betwen 18 and 50 who have nationally issued Identity Cards; 4) only one male or member per family. People engaged in other safety net programmes cannot be included in this programme.
c Disparities addressed	Yes.

Child Outcome Area	Household Income Promotion
9 Coverage	
a Geography	Countrywide coverage (i.e. in all 64 districts) but preference will be given to people living in the river erosion, flood prone, manga (a seasonal famine in the northern region), haor-baor (wetlands/ water-bodies) and char areas.
b Number of people covered	Two million people directly, and about ten million people indirectly.
c Quality of coverage	
d Most vulnerable children	
10 Monitoring and Evaluation	
a Yes/no	This is a new programme and is subject to Monitoring and Evaluation.
b By who?	Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning.
c Impact of findings	
11 Implementation challenges	The 100 Days Employment Generation Programme is of unique character within the current budget and very extensive in nature. It is the first tim that a budget line has addressed the problems of the poor and of rural areas + C17 so meticulously.

Table 8.2.1: National programme inventory: Child nutrition

Child Outcome Area	Child Nutrition
1 Programme Name	**National Nutrition Programme (NNP) 2004-2010**
2 Objectives	**Overall: Reduce low birth weight, underweight, stunting, micronutrient deficiency (iron, iodine and vitamin A) Specific Objectives:** 1. Reduce the severe malnutrition rate in under-two children to <5 per cent (current rate-12.9 per cent). 2. Reduce the moderate malnutrition rate in under-two children to <30 per cent (current rate-36.3 per cent). 3. Increase the weight of at least half of all pregnant women by 9kg or more. 4. Reduce the percentage of children with llow birth weight (LBW) to <30 per cent. 5. Reduce the prevalence of anaemia in adolescent girls and pregnant women to one-third of the current rate. 6. Reduce and limit the prevalence of night-blindness in under-five children to 0.5 per cent. 7. Halve the current prevalence (43.1 per cent) of iodine deficiency.
3 Programme Type	1. Nutrition services: basic nutrition activities and food security activities. 2. Programme assistance and institutuional development.
4 Reason for inclusion	Coverage of beneficiaries, large budgetary allocation and addressing the MDG outcomes (MDGs 1 and 4).
5 Cost of Funding	
a Allocation (currency/year/region)	Total: Tk. 13,472 million Government: Tk. 1,132 million Donors: Tk. 12,340 million.
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies (add rows if needed)	**Implementation agency:** NNP, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh is playing the vital role in implementing the programme. There are also three more ministries and their departments involved in the implementation process. They are: Ministry of Agriculture, Ministry of Fisheries and Livestocks and Ministry of Women and Children Affairs. **Donor agency:** IDA, Netherlands and CIDA.
b Agency role	Implementation agency: Policy guideline and implementation. Donor agency: Credit administration.

Child Outcome Area		Child Nutrition
7	**Mechanism and Beneficiaries**	
a	What is delivered	A package of community based nutrition services.
b	Who benefits	Children, including adolescent girls, and women (particularly pregnant and lactating mothers).
8	**Targeting**	
a	Intended beneficiaries	1. Children under 5 years. 2. Pregnant & lactating women. 3. Adolescent girls.
b	Method	1. Growth monitoring. 2. Socio- economic status (hard core poor).
c	Disparities addressed	Children are given the supreme priority, and women (particularly pregnant and lactating mothers) and adolescent girls are also reached.
9	**Coverage**	
a	Geography	34 Districts of 6 Divisions.
b	Number of people covered	About 30 million beneficiaries are covered.
c	Quality of coverage	
d	most vulnerable children	Yes.
10	**Monitoring and Evaluation**	
a	Yes/no	Yes.
b	By who?	1. Independent Quality Assurance Group (IQUAG). 2. Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning.
c	Impact of findings	
11	**Implementation Challenges**	1. Fund disbursement. 2. Poor targeting. 3. Selection of implementing NGOs.

Source: NNP and UNICEF, Dhaka.

Table 8.2.2: National programme inventory: Child nutrition

Child Outcome Area	Child Nutrition
1 Programme Name	**Control of Iodine Deficiency Disorder through Universal Salt Iodization.**
2 Objectives	To Improve coverage of household consumption of adequately iodized salt >90 per cent by 2015.
3 Programme Type	Micronutrient supplementation to all age group.
4 Reason for inclusion	Coverage of beneficiaries, large budgetary allocation and also addressing MDG outcomes (MDGs 1 and 4).
5 Cost of Funding	Year of cost estimation 2007–2008.
a Allocation (currency/year/region)	**Total Allocation:** Tk. 41.24 million (Apx); **Government:** Tk. 20.80 million (Apx); **Donors:** Tk. 20.44 million (Apx).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	**Government agency**: 1. Bangladesh Small and Cottage Industries Corporation (BSCIC); 2. Institute of Public Health Nutrition. **Donor agency:** USAID.
b Agency role	**Government agency:** 1. Policy guideline, 2.Implementation, 3. Technical and logistic support to private sector, 4. External monitoring of quality iodized salt production by salt factories 5. Law enforcement. **Donor Agency:** Grant financial support.
7 Mechanism and Beneficiaries	
a What is delivered	Iodized salt.
b Who benefits, who does not	All age groups of a family.
8 Targeting	
a Intended beneficiaries	All age groups of a family.
b Method	Census data.
c Disparities addressed	Both girls and boys of all age groups are included.
9 Coverage	
a Geography	Nationwide coverage: 64 districts of 6 divisions.
b Number of people covered (# not covered)	Nationwide coverage of all age groups.
c Quality of coverage	Household consumption of iodized salt is 85 per cent (MICS 2006). But the coverage of adequately iodized salt is only 51 per cent (IDD/ USI survey 2004-5).
d most vulnerable children	Yes.
10 Monitoring and Evaluation	
a Yes/no	No.
b By who?	N/A.
c Impact of findings	
11 Implementation Challenges	1. To improve production of adequately iodized salt at factory level. 2. Sustain the cost sharing by private sector for public health intervention.

Reference: MICS 2006. IDD/USI survey 2004-5

Table 8.2.3: National programme inventory: Child nutrition

Child Outcome Area	Child Nutrition
1 Programme Name	**Vitamin A Supplementation Programme.**
2 Objectives	To reduce child mortality and morbidity rates and keep the prevalence of night blindness among children <5 years below 1 per cent.
3 Programme Type	Micronutrient supplementation to children aged 9 -59 months.
4 Reason for inclusion	Addressing MDG outcomes (to reduce child mortality and morbidity).
5 Cost of Funding	
a Allocation (currency/ year/ region)	**Total cost:** Tk. 173.743 million (Apx). **Government:** Tk. 115.093 million (Apx) - (Operational cost Tk. 44.00 million + Vitamin A capsule procurement Tk. 71.093 million). **Donors:**. Tk. 58.65 million (Apx).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	**Government agency:** Institute of Public Health Nutrition (IPHN); Expanded Programme on Immunization (EPI); Sub-national health departments; Bangladesh Television, Betar and Department of Mass communication; Donor agency: CIDA; The Micronutrient Initiative.
b Agency role	**Government Agency:** 1. Procurement of Vitamin A capsule; 2. Planning, advocacy, orientation, mass communication, micronutrient supplementation and monitoring; 3. Service delivery at ward level. Donor agency: Grant financial support.
7 Mechanism and Beneficiaries	
a What is delivered	Vitamin A capsule supplementation, behavioural change communication on nutrition.
b Who benefits, who does not	Children aged 9-59 months, post-natal mothers within six weeks of delivery.
8 Targeting	
a Intended beneficiaries	1. Children aged 9-11 months 2. Children aged 12-59 months3. Post-natal mothers.
b Method	GR survey.
c Disparities addressed	Both girls and boys are included.
9 Coverage	
a Geography	Nationwide coverage; 64 Districts of 6 Divisions.
b Number of people covered (# not covered)	Nationwide coverage of all children aged 9-59 months and post-natal mothers within six weeks of delivery.
c Quality of coverage	Vitamin A supplementation coverage: 80 per cent among children aged 9-11 months, 95 per cent coverage among children aged 12-59 months, and 35 per cent coverage among post-natal mothers (CES, 2007). Inclusion of vitamin A also increased the coverage of Oral Polio Vaccine (OPV) during NIDs.
d Most vulnerable children	Yes, included.
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning. [CES 2007, MICS 2006.]
c Impact of findings	
11 Implementation Challenges	1. Reaching hard to reach children. 2. Reaching post-natal mothers within six weeks of delivery where coverage of ANC, institutional delivery and PNC is still very low.

Source: Planning, Monitoring and Evaluation Section, UNICEF, Dhaka, Banladesh.
Reference: CES 2007, MICS 2006.

Table 8.3.1: National programme investory: Child health

Child Outcome Area	Child Health
1 Programme Name	**Health Nutrition and Population Sector Programme (HNPSP). Duration:** 2003-2010
2 Objectives	The major national commitment of the Government in this sector is the Health, Nutrition and Population Sector Programme (HNPSP) (2003-2010). Initiated in 1998, as the Health and Population Sector Programme (HPSP) and revised and renamed in 2003 to incorprate nutrition as a major component. Its goal is to modernize the country's health sector and facilitate progress towards the health related Millennium Development Goals (MDGs). That is why it aims at the sustainable development of health, nutrition, and reproductive health of all citizens of Bangladesh, especially children, women and vulnerable groups. The activities of HNPSP are divided into 38 different Operational Plans (OP), most of them directly or indirectly related to child health. In line with the MDGs and PRSP, some targets have been set for achievement between FY2006-07 to June 2010 under the HNPSP. These are: 1) reduce the Neonatal Mortality Rate from 32 to 21 per 1,000 life births and the Infant Mortality Rate (IMR) from 48 to 37 per 1,000 life births; 2) reduce the Maternal Mortality Rate (MMR) from 2.75 to 2.40 per 1,000 life births; 3) reduce the Total Fertility Rate (TFR) from 2.80 per cent to 2.20 per cent; 4) reduce the drop out rate for contraceptives from 49.4 per cent to 20 per cent; 4) increase the Contraceptive Prevalence Rate (CPR) from 58 per cent to 72 per cent; 5) reduce the population growth rate from 1.40 per cent to 1.20 per cent; 6) increase the number of Nursing Institutes from 44 to 50; 7) increase the average life expectency of women from 65 to 70 years; 8) sustain the cure rate for Tuberculosis at 85 per cent and above; 9) prevent the spread of HIV/AIDS; 10) reduce malnutrition among under-five children from 42 per cent to 30 per cent; 11) reduce the aneamia of pregnant women from 45 per cent to 30 per cent, etc.
3 Programme Type	Different forms of health services, including: Reproductive and Maternal Healthcare; EPI; Childhood Illness Management; School Health Programme; Communicable and Non-Communicable Disease Control; Micronutrient Supplementation, etc. for all citizens of Bangladesh, especially children, women and vulnerable groups.
4 Reason for inclusion	Countrywide coverage, Largest budgetary allocation in the health sector.
5 Cost of Funding	
a Allocation (currency/year/region)	Total: Tk. 324,503 million. Govenment: Tk. 216,568 million. Donors: Tk. 107,935 million. Source: (BER, 2008).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies (add rows if needed)	Government of Bangladesh (implementation agency): 1. Directorate General of Health Services, MOHFW; 2. Directorate General of Family Planning (DGFP), MOHFW, Ministry of Health and Family Welfare. Donor agencies: World Bank, DFID, EC, RNE (Embassy of the Kingdom of the Netherlands), SIDA, UNFPA, CIDA and KfW (Germany).
b Agency role	Implementation agency: financing, planning, operation and implementation; Donor agencies: financing.
7 Mechanism and Beneficiaries	
a What is delivered	Different forms of health services.
b Who benefits, who does not	All citizens of Bangladesh, especially children, women and vulnerable groups.
8 Targeting	
a Intended beneficiaries	All citizens of Bangladesh, especially children, women and vulnerable groups.
b Method	Services are delivered under 38 Operational Plans and ten different projects.
c Disparities addressed	Priority is given to children, women and vulnerable groups.

Child Outcome Area	Child Health
9 Coverage	Whole of Bangladesh: 64 districts, all upazilas and unions.
a Geography	All citizens of Bangladesh.
b Number of people covered	
c Quality of coverage	Yes.
d most vulnerable children	
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning, Government of the People's Republic of Bangladesh.
c Impact of findings	
11 Implementation Challenges	

Table 8.3.2: National programme inventory: Child health

Child Outcome Area	Child Health
1 Programme Name	**Expanded Programme on Immunization (EPI)**
2 Objectives	To reduce child mortality and morbidity from vaccine preventable diseases, and sustain immunization coverage for polio eradication, maternal and neonatal tetanus elimination and measles control.
3 Programme Type	Vaccination against seven killer diseases for children aged 0-11 months, children aged 0-59 months, pregnant women and women aged 15-49 years.
4 Reason for inclusion	Coverage of beneficiaries, large budgetary allocation and addressing MDG outcomes (MDGs 4 and 5).
5 Cost of Funding	
a Allocation (currency/ year/ region)	
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	**Government agency**: Directorate of Health Services (DGHS), MH&FW; Expanded Programme on Immunization (EPI);. Institute of Public Health Nutrition (IPHN); Bangladesh Television (BTV), Bangladesh Bater, Dept. of Mass Communication. **Donor agency**: UNICEF, WHO, GAVI.
b Agency role	**Government Agency**: Policy guideline, Implementation, Monitoring, supervision and evaluation. **Donor Agency**: Advocacy, planning, communication & social mobilization, training, monitoring and evaluation, resource mobilization, procurement support service.
7 Mechanism and Beneficiaries	
a What is delivered	Vaccination against sevenkiller diseases (Diphtheria, tetanus, pertusis, polio, measles, Hepatitis B, tuberculosis), Vitamin A
b Who benefits	Children aged 0-11 months, 0-59 months and women 15-49 years old, including pregnant women.

Child Outcome Area	Child Health
8 Targeting	
a Intended beneficiaries	1. Children aged 0-11 months. 2. Children aged 0-49 months. 3. Women aged 15-49 years old, and pregnant women.
b Method	1. GR Survey. 2. Census Data.
c Disparities addressed	Both girls and boys are included irrespective their race, region, and socioeconomic status.
9 Coverage	
a Geography	Nationwide coverage: all 64 districts of the country.
b Number of people covered	4 million children aged 0-11 months, 22 million children 0-49 months, 7 million women, and 5 million pregnant women each year.
c Quality of coverage	BCG coverage: 98 per cent; DPT3 coverage: 87 per cent; OPV3 coverage: 93 per cent; Measles coverage: 81 per cent. Children fully immunized by 12 months: 76 per cent (Source: CES 2007).
d Most vulnerable children	Yes, covered.
10 Monitoring and Evaluation	
a Yes/no	No. (No external monitoring and evaluation system).
b By who?	Although no external monitoring and evaluation system exists, the Programme is subject to Monitoring and Evalution by the Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning, Government of the People's Republic of Bangladesh.
c Impact of findings	
11 Implementation Challenges	1. Reaching hard to reach areas children. 2. Shortage of field workers, and filling vacant posts. 3. Reducing dropout rates.

Reference: CES 2007, MICS 2006.

Table 8.3.3: National programme inventory: Child health

Child Outcome Area	Child Health
1 Programme Name	**Integrated Management of Childhood Illness (IMCI) & Newborn Health**
2 Objectives	F-IMCI: • To reduce the morbidity and mortality associated with major childhood diseases and conditions. • To promote child growth and development by preventing diseases and promoting healthy practices. C-IMCI. • To improve access and availability of community-based services. • To improve behaviour and care practices of families and communities.

Child Outcome Area	Child Health
3 Programme Type	**F-IMCI**: • Increasing the skills of health providers, particularly doctors, paramedics and nurses at various levels, for case management and counselling in an integrated way. • Improving health systems in terms of regular supply of drugs, supportive supervision, regular reporting, effective referral and management information systems (MIS). • Introduction of referral care in the district and sub-districts hospitals C-IMCI. • Improving five key care practices (essential newborn care; feeding (IYCF); nutrition (micro-nutrients); early childhood development; and prevention of drowning, plus caring and care-seeking at family level. • Strengthening community case management by basic health workers, training of informal health providers, counselling • Community mobilization and participation. • Increasing local government involvement. • Selection of low performing areas with a focus on the poorIMCI Pre-Service Education (PSE): Introducing IMCI in the medical, paramedical and nursing curriculum.
4 Reason for inclusion	Coverage of beneficiaries, large budgetary allocation and also addressing MDG outcomes (MDG Target 4).
5 Cost of Funding	Year of cost estimation 2008.
a Allocation (currency/year/region)	Total Allocation: $3,917,913 approx Government: $19,118 (revenue budget) Donors: WHO: $111,892; UNICEF: $3,424,262 Non government organizations: $362,641.
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies (add rows if needed)	Government agency: Ministry of Health and Family Welfare; Directorate of Health Services; Directorate of Family Planning; Donor agency: UNICEF; WHO ; AusAID; CIDA.
b Agency role	Government Agency: 1. Policy guidelines; 2. Implementation; 3. Supervision, M&EDonor Agency: 1. Technical assistance in planning and implementation; 2. Advocacy, community & Social mobilization; 3. Capacity development, Training; 4. M&E; 5. Resource mobilization; 6. Procurement.
7 Mechanism and Beneficiaries	
a What is delivered	• Improved skills of health workers to manage neonatal and childhood illnesses. • Improved and effective health systems. • Increased availability of quality child care services. • Improved family and community care and care seeking practices.
b Who benefits	• Neonates. • Children under five. • Mothers.

Child Outcome Area	Child Health
8 Targeting	
a Intended beneficiaries	1. Neonates. 2. Children under five. 3. Mothers.
b Method	1. GR survey. 2. Census data. 3. PRA (identification of poor and vulnerable/marginalised).
c Disparities addressed	1. Gender (Boys & Girls). 2. Poor and marginalized. 3. Hard to reach areas.
9 Coverage	
a Geography	274 upazilas, 41 districts, 6 divisions.
b Number of people covered	Estimated average population of 41 districts; estimated total population of Rajshahi, Dhaka and Sylhet divisions.
c Quality of coverage	Average, with scope for further improvement through the strengthening of government systems.
d Most vulnerable children	Yes.
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	ICDDR,B; [References: 1. Follow up after Training, 2006-07 study by ICDDR,B; 2. Summary Report IMCI Early implementation phase, 2003 by IMCI working group; 3. Review of F-IMCI implementation, 2005, by JSI.
c Impact of findings	
11 Implementation Challenges	1. Shortage of trained MOHFW staff. 2. Weak supervision and monitoring. 3. MIS to be made fully functional. 4. Poor caring and care seeking practices and low utilization of facilities. 5. High rate of home delivery: lack of skilled attendants at birth and essential neonatal care. 6. Maintaining quality of interventions alongside the rate of expansion.

Table 8.4.1: National programme inventory: Child protection

Child Outcome Area	Child Protection
1 Programme Name	**Birth Registration Project**
2 Objectives	Birth registration is a key factor in child protection. This makes it possible to establish children's ages, to protect their rights and to implement plans to ensure that they receive the education and health care, such as regular immunizations, that they need. The other crucial element in child protection is giving communities information, education and training in children's rights and the means to ensure that young people do not become the victims of discrimination or exploitation. Girl children and adolescents face specific risks of sexual abuse and exploitation, and in Bangladesh there is a particular challenge to protect women from acid-throwing. According to the previous 'Birth and Death Registration Act-1873,' it had been mandatory to register the birth of each child born in Bangladesh. Yet the rate of such registration was only 10 per cent. As the scope for using Birth Certificates was very limited, people did not see birth registration as important. As a result the intended goal of the Act was not achieved. At the same time children were particularly vulnerable to child marriage, child labour, underage criminal prosecution and other abuses. Birth Registration could, therefore, provide children with an official identity, helping to protect them from such vulnerabilities. In this situation, and with the objective of universal birth registration, the Government of Bangladesh introduced a new act 'The Birth and Death Registration Act-2004' that came into force on 3 July, 2006. To implement the Act, the Government undertook a Universal Birth Registration Programme to register the birth of every citizen by the year 2008. The specific objectives of the programme could be summarized as follows overall: To support the establishment of a functional universal birth registration system in Bangladesh. Specific: 1) to ensure birth registration for all citizens of Bangladesh by 2008; 2) to ensure that birth certificates are used as proof of age, a protection tool and as an access mechanism to other relevant rights/services; 3) to strengthen the capacity of registrars and other duty bearers on birth and death registration; 4) to initiate and continue registration through the routine immunization system; 5) to support Ministries and Agencies to create relevant laws/rules/policies that are compatible with the Birth and Death Registration Act 2004; 6) to ensure the supply of the required administrative materials for birth registration; 7) to expand the electronic birth registration system and to establish a central database at national level; 8) to raise awareness on Birth and Death Registration through mass media campaigns.
3 Programme Type	Birth registration of all children by 2008, and providing each child with a birth certificate as a document that would protect their rights.
4 Reason for inclusion	Country-wide coverage and a large budgetary allocation.
5 Cost of Funding	
a Allocation (currency/ year/ region)	Total: Tk. 425 million. Government: Tk. 0.00 million. Donors: Tk. 425 million. [Financial Year 2005-2006] (Source: MoLG Website).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	**Government agency**: Local Government Division, Ministry of Local Government, Rural Developmnet & Co-operatives, Government of People's Republic of Bangladesh (Implementing Agency). **Donor/Funding agency**: UNICEF.
b Agency role	**Implementing agency**: Planning, implementation, operation, monitoring, supervision and evaluation of the project;supply of materials for birth registration and consolidation activities; delivery of training to people engaged in birth registration work; publicity to increase public awareness; collection of information about birth and registration. **Donor/Funding Agency**: Provision of technical, financial and other support to the Government in the planning, implementation, operation, monitoring, supervision and evaluation of the project; capacity building of government counterparts.

Child Outcome Area	Child Protection
7 Mechanism and Beneficiaries	
a What is delivered	Infrastructure for a functional birth registration (BR) system: BR materials, BR information system (computers and software), BR orientations, trainings etc.
b Who benefits, who does not	Children and adults of all ages and geographical regions of the country.
8 Targeting	
a Intended beneficiaries	1. Children (in particular vulnerable children i.e., refugee children, children living in brothels, street/working children and indigenous children); 2. Adults.
b Method	NR (universal Birth registration); 2. From 0 to 18.
c Disparities addressed	Preference is given to children of all ages. Compulsory birth registration will help the preparation of age-based population statistics and national development planning. Under the Birth and Death Registration Act, 2004, a birth registration certificate is compulsory for school admission, for passports, employment and other services, which will contribute indirectly to poverty reduction. It will also improve the availability of statistics on women. Birth registration will ensure the legal rights of girl children and women and this will help to stop early marriage and will help to prepare age-based development planning.
9 Coverage	
a Geography	Nationwide Coverage [in all (64) Districts of six Divisions of Bangladesh].
b Number of people covered	Focus on children: 56 per cent of population = 78.4 million children. Adults and elderly people of all ages would also be covered.
c Quality of coverage	To date, 40 per cent of the population has been registered.
d most vulnerable children	Yes (birth registration of vulnerable children is ongoing).
10 Monitoring and Evaluation	
a Yes/no	Not subject to any external monitoring and evaluation system.
b By who?	Although there is no external monitoring syste, it is subject to Monitoring and Evaluation by Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning.
c Impact of findings	N/A.
11 Implementation Challenges	1. Prioritization of the registration of children. 2. Setting up a national electronic birth registration system through the development of birth registration information system software, expansion of computer availability and training of duty bearers. 3. Meeting the demand for birth registration. 4. Government commitment at central level.

Table 8.4.2: National programme inventory

Child Outcome Area	Child Protection
1 Programme Name	**Empowerment of Adolescents.**
2 Objectives	Overall objective of the Project is to create a culture of respect for children's protection rights through development of child rights based and gender appropriate policies, advocacy, change of societal attitudes, strengthened capacity in government and civil society responses to protection issues, and the establishment of protective mechanisms against abuse, exploitation and violence. Specific objective: to support adolescents to access peer education for life skills, including HIV/AIDS and livelihood options to protect themselves from exploitation, violence, and abusive practices, including dowry and child marriage; to establish support mechanisms for adolescents in selected areas involving their community members and community leaders; to advocate for establishing adolescents rights; to conduct research, studies and enhance the knowledge based on adolescents related issues, including the situation of adolescents of ethnic minority groups including Chittagong Hill Tracts.
3 Programme Type	Adolescents empowerment and participation: social change.
4 Reason for inclusion	Supporting child outcomes by improving access to and use, equity and efficacy of social services as well as protection from risk, adversity and chronic poverty.
5 Cost of Funding	
a Allocation (currency/year/region)	Total Allocation: Tk. 440.93 million.
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies (add rows if needed)	**Government Agency**: Ministry of Women and Children Affairs, Gobernment of the People's Republic of Bangladesh (Implementing Agency); Donor/Financing Agency: UNICEF (with 90 per cent EC funding); NGOs: BRAC and CMES.
b Agency role	**Implementing Agency**: Planning, implementation, operation, monitoring, supervision and evaluation of the Project. **Donor/Financing Agency**: Provide technical, financial and other support to the Government in the planning, implementation, operation, monitoring, supervision and evaluation of the Project; NGOs: Implementation of Project.
7 Mechanism and Beneficiaries	
a What is delivered	Life-skills, livelihood package and adolescent participation; community participation and enabling environment for adolescents; capacity building pf partners; research and monitoring.
b Who benefits, who does not	Adolescent boys and girls, parents community leaders, Government and NGO officials.
8 Targeting	
a Intended beneficiaries	1. Adolescent boys and girls. 2. Parents. 3. Communities. 4. Government and NGO officials.
b Method	Categorical assessment (children age 10-19).
c Disparities addressed	Target group has distinct needs that are different from other age groups of children. Around 70 per cent of the beneficiaries are girls.

Child Outcome Area	Child Protection
9 Coverage	
a Geography	27 Districts of 6 Divisions.
b Number of people covered	Around 70000 adolescents from rural areas are covered through 2680 adolescent centres – around 70 per cent are girls.
c Quality of coverage	70000 adolescents are directly benefiting from the project.
d Most vulnerable children	Yes. Around 70 per cent of the beneficiaries are girls.
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	John Hopkins University and Such Local Research Agency [Reference Baseline survey report of Kishore Abhijan 2007].
c Impact of findings	
11 Implementation Challenges	1. Working with parents and communities proved to be challenging. 2. Government commitment. 3. Behavioural monitoring is challenging.

Source: UNICEF, Dhaka.

Table 8.4.3: National programme inventory: Child protection.

Child Outcome Area	Child Protection
1 Programme Name	**Protection of Children at Risk [Street Children and Children without Parental Care (orphaned and vulnerable children)].**
2 Objectives	**Overall**: To protect street children and children without parental care from abuse, exploitation and violence and improve their life conditions, promoting a protective environment and child protection mechanisms. **Specific**: 1) to develop the capacity to establish reintegration mechanisms for street children within the family and community; 2) to ensure the protection of children living on the streets and build the capacity of stakeholders; 3) to enhance and strengthen basic drop-in centre services for children living on the streets in six divisional cities; 4) to strengthen psycho-social and life skills support services; 5) to enhance the capacity of children living on the street for market-driven jobs that ensure a sustainable livelihood by providing non-formal education and livelihood skills training. **Children without parental care**: 1) to build institutional capacity on proactive social work and develop minimum institutional care standards for children in institutions, which should be seen as the last resort; 2) to develop community-based care mechanism, with institutionalization seen as a measure of last resort.
3 Programme Type	Care and access to basic services.
4 Reason for inclusion	Supporting child outcomes by improving access to and use, equity and efficacy of social services as well as protection from risk, adversity and chronic poverty.
5 Cost of Funding	
a Allocation (currency/year/region)	Total Allocation: Tk. 194.18 million. Government of Bangladesh: Tk. 44.81 million. Donors: Tk.149.37 million.
b Captured in Part A (yes/no)	
c (If yes to b) proportion of total	

Child Outcome Area	Child Protection
6 Agencies	
a Participating agencies	**Government agency**: Department of Social Services, Ministry of Social Welfare, Government of People's Republic of Bangladesh. (Implementing Agency); Donor/Funding agency: UNICEF; NGOs: five National and local NGOs in selected intervention areas.
b Agency role	**Implementing Agency**: Planning, implementation, operation, monitoring, supervision and evaluation of the Project. **Donor/Funding Agency**: Provide technical, financial and other support to the Government in the planning, implementation, operation, monitoring, supervision and evaluation of the Project; Capacity building of government counterparts. **NGOs**: Operate DICs for street children, Operate open air schools, Prepare children for community based integration, Promote case management for children and proactive social work.
7 Mechanism and Beneficiaries	
a What is delivered	Support services for children development and protection.
b Who benefits, who does not	1. Vulnerable children living on the street, i.e. a) those who live and work on the street day and night without parents or family; b) who work and live on the street day and night with family; c) who work on the street and return to another family (not their own); d) who work on the street and return to their own family. 2. Children without parental care living in institutions.
8 Targeting	
a Intended beneficiaries	1. Vulnerable children living on the street, i.e. a) those who live and work on the street day and night without parents or family; b) who work and live on the street day and night with family; c) who work on the street and return to another family (not their own); d) who work on the street and return to their family. 2. Children without parental care living in institutions.
b Method	Categorical assessment; as per the criteria for identification (observation and personal contact).
c Disparities addressed	Priority is given to homeless, rootless children.
9 Coverage	
a Geography	6 districts 6 divisional cities.
b Number of people covered	389,892 children livingon the street, with institutional support for safe custody/home for 50,000 children. Also children without parental care (# unknown).
c Quality of coverage	The focus is mainly on the cities where such children are concentrated, as well as the areas where the institutions are located.
d Most vulnerable children	Yes, the programme is designed to protect street children and children without parental care who are most vulnerable to abuse, exploitation and violence, in particular girl children who are much more vulnerable.
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	INCIDIN. (Assessment of institutions is ongoing).
c Impact of findings	(Assessment of institutions is ongoing).
11 Implementation Challenges	1. Promoting community-based integration and de-institutionalization. 2. Developing child protection system: coordination, referral and monitoring mechanism. 3. Increasing prevention by providing support to families (cash transfers, referral and better access to services).

Table 8.5.1: National programme inventory: Education

Child Outcome Area	Education
1 Programme Name	**Primary Education Development Programme II (PEDP II) Implementation Period: 2004-2009**
2 Objectives	Despite many achievements in the primary education sector over the past decade, major improvements are still needed in order for all children to receive the benefit of quality education. The major challenges are access, equity and the quality of education. As a result of all these factors, children's achievement levels are far below the national targets. Only about half of all primary school graduates achieve the minimum national curriculum competencies. As a result of this situation, and following the completion of all the PEDP I projects (including IDEAL), PEDP-II was launched in September 2004 by the Government of Bangladesh. The programme aims to ensure the quality of primary education for every child in the country by increasing primary school access, participation and completion. It also aims to improve the quality of students' learning achievements, while ensuring the Primary School Quality Level standard. PEDP II represents a major operationalizing of a key part of the Government's Education for All (EFA) and poverty reduction agenda, which are linked with the Millenium Development Goals (MDGs). The specific objectives of the programme are: 1) To improve the quality of primary education in Bangladesh through the introduction of Primary School Quality Level (PSQL) standards 2) To make primary education accessible for all children in Bangladesh 3) To increase enrolment, attendance and the rate of completion of primary education cycle 4) To adopt a child-centred approach in the classroom 5) To fully integrate the PEDP activities within the organizational and operational systems of MoPME and the DPE 6) To undertake institutional reforms in education management, and its effective decentralization and the devolution of decision making 7) To strengthen and build the capacity of the school management system at all levels 8) To ensure accountability and transparency at all levels9) To supply textbooks and teaching and learning materials free of cost10) To strengthen the role of the community, and especially parents, in the running and support of their schools.
3 Programme Type	The PEDP-II covers four components: 1) quality improvement through organizational development and capacity building; 2) quality improvement in schools and classrooms; 3) quality improvement through infrastructure development; and 4) improving and supporting equitable access to quality schooling.
4 Reason for inclusion	Countrywide coverage, highest beneficiaries and big Budgetary Allocation and also Attains MDG (MDG # 2 & 3).
5 Cost of Funding	
a Allocation (currency/ year/ region)	Total: Tk. 74,929.70 million. **Government of Bangladesh**: Tk. 24,973.30 million. Donors: Tk. 49,956.40 million. (Source: ADP, 2008-09).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies	**Government agency**: Directorate of Primary Education, Ministry of Primary and mass Education, Government of the People's Republic of Bangladesh. (Executing Agency) and Local Government Engineering Department (LGED). **Donor agencies**: ADB (Lead Agency), World Bank, NORAD, SIDA, CIDA, EC, DFID, The Netherlands, UNICEF, AusAid, JICA.
b Agency role	**Directorate of Primary Education**: 1. Overall implementation, 2. Provide technical support in all aspects, 3. Social mobilization and behavior change communication. **LGED**: Civil works; **Donor agencies**: Provide financial assistance from a consortium of 11 donors, led by the Asian Development Bank.

Child Outcome Area	Education
7 Mechanism and Beneficiaries	
a What is delivered	1. Civil Works (Construction of school and upazila education offices, upazila resource centres, maintenance and repair of schools including supply of furniture). 2. Provide machinery and equipment, including computer and accessories. 3. Provide training, organize meetings, workshops and seminars and study tours abroad. 4. Curriculum revision, provision of textbooks, supplementary reading materials, teaching learning materials, weighing machine, etc. 5. Surveys, studies, national assessment and evaluation. 6. Innovation grants for schools. 7. Social mobilization. 8. Capacity building of DPE personnel, including teachers/ AUEOs/ UEOs/ PTI and URC Instructors.
b Who benefits, who does not	Primary school age children (6+ to 10+), parents, guardians, teachers, and DPE officials who are associated with the primary education development programme.
8 Targeting	
a Intended beneficiaries	PEDP-II will be implemented in all 64 districts, covering approximately 17.7 million children and 280,000 teachers in 61,000 schools. The intended Beneficiaries of the programme are: 1. All primary school age (6+ to 10+) children of Bangladesh. 2. Parents, guardians. 3. Teachers and others stakeholders.
b Method	1. Baseline Survey of PEDPII. 2. M&E routine report, child survey report. 3. EMIS report4. Follow on PEDP I target groups.
c Disparities addressed	The programme addresses the following disparities: 1. Appoint 60 per cent female teachers in primary schools. 2. Reduce gap between rural and urban areas of education interventions. 3. Create facility to include all children in main stream primary education including special need children. 4. Stipend programme for poor rural children. In addition, UNICEF, an implementation partner. will support initiatives for educationally disadvantaged groups of children: a groundbreaking study analyzing the educational situation of disadvantaged children, including those in extreme poverty, with disabilities, working children and those from ethnic minorities and other vulnerable groups. The study will also examine current practices for inclusive education.
9 Coverage	
a Geography	Countrywide coverage. (All) 64 districts of 6 divisions of the country.
b Number of people covered (# not covered)	PEDP-II will be implemented in all 64 district,s covering approximately 17.7 million children and 280,000 teachers in 61,000 schools.

Child Outcome Area	Education
c Quality of coverage	**Key Performance Indicators (KPIs) of PEDP II** Current public expenditure on education is increased to at least 2.8 per cent of GNP by 2010. Primary Education expenditure per pupil increased to 10 per cent of GNP by 2010. Apparent (gross) intake rate of new entrants in primary Grade 1 as a percentage of the population of the official entry age 103 per cent by 2010. Gross Enrolment Ratio (GER) 107 per cent by 2010. Net Enrolment Ratio (NER) 88 per cent by 2010. Pupil-teacher ratio 1:46 by 2010. Survival rate to Grade 5 (percentage of the pupil cohort reaching and completing Grade 5) 82 per cent by 2010. The number of disabled children out of school reduced by 30 per cent by 2010. Student absenteeism reduced to 20 per cent by 2010, with no discrepancy between boys and girls. Education achievement of girls improved to at least the same level as boys by 2010. The number of pupils achieving acceptable levels of literacy and numeracy (as measured by National Assessment instruments) increased by 50 per cent by 2010. The transition rate from Class 5 to Class 6 increased to 40 per cent, with gender parity, by 2010. 30,000 new and suitably furnished classrooms constructed during PEDP-II Textbooks available from the first day of the new school year. All teachers trained to at least Certificate in Education (C. in Ed.) standard.
d Most vulnerable children	Yes.
10 Monitoring and Evaluation	
a Yes/no	Yes. National Assessment Cell (NAC): National Assessment Cell has been established at DPE under the direct supervision of Monitoring & Evaluation division. Administered firm has submitted final draft report of National Assessment Test 2006.
b By who?	A UK-based organization 'Oxford Policy Management' has been commissioned for the results-based monitoring of PEDPII activities. In the other hand, all the study conducted by the different research organization. A National Assessment Cell (NAC) has been established at DPE under the direct supervision of Monitoring & Evaluation division. Administered firm has submitted final draft report of National Assessment Test 2006.
c Impact of findings	Findings were using in MTR and Joint Annual Review Meeting (JARM) and also based on findings, prepare Annual Operation Plan (AOP).
11 Implementation Challenges	1. Capacity building of institutes (DPE/ NAPE/ PTI/ URC/) as well as schools. 2. Capacity building of some DPE officials. 3. Non functioning of the procurement process.

Source: Name of the available references for M&E reports
1. Contact EMIS cell for any kinds of information.
2. Baseline survey 2005 of DPE.
3. School survey 2006 of DPE.
4. School Survey 2007 of DPE.
5. National Assessment of Pupils of grade 3&5.

Mr. Ratan Kumar Roy
Director,
Monitoring & Evaluation Division, Directorate of Primary Education (DPE)
Mirpur – 2, Dhaka, Bangladesh.
Tel: 02-8018126
Also: UNICEF, Dhaka and the website: http://www.mopme.gov.bd/PEDP%20II%20(06-07).htm

Table 8.5.2: National programme inventory: Education

Child Outcome Area	Education
1 Programme Name	**Primary Education Stipend Project (PESP) (Duration: July 2002-June 2008)**
2 Objectives	1) To increase the enrolment rate of all primary level school age children of poor families; 2) To increase the attendance rate of children enrolled students in primary school; 3) To reduce the trend of drop-out rate of children enrolled in primary school; 4) To establish equity in financial assistance to all primary school age children; 5) To enhance the quality of primary education.
3 Programme Type	Every year, around 5.5 million students receive stipends from this programme.
4 Reason for inclusion	This is the largest programme in this sector in the country. It has many beneficiaries, a large budgetary allocation and aims to attain MDG outcome relatd to children.
5 Cost of Funding	
a Allocation (currency/year/region)	Total: Tk. 33,123.12 million, funded solely by the Government of Bangladesh.
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies (add rows if needed)	**Executing agency**: Directorate of Primary Education, Ministry of Primary and Mass Education, Government of the People's Republic of Bangladesh.
b Agency role	Planning, financing and implementation.
7 Mechanism and Beneficiaries	
a What is delivered	Cash assistance through a stipend programme to poor primary school pupils and their families throughout rural Bangladesh. Households of qualifying pupils will receive Tk. 100 taka (about $1.76) per month for one pupil (not to exceed Tk.1,200 annually) and Tk. 125 per month for more than one pupil (not to exceed Tk. 1,500 annually).
b Who benefits, who does not	Children from poor families throughout rural Bangladesh (excluding metropolitan cities, district towns and pourasavas).
8 Targeting	
a Intended beneficiaries	The targeted beneficiaries of the PESP are an estimated 5.5 million pupils from the pooresthouseholds, who are enrolled in eligible primary schools in all rural areas of Bangladesh (469 upazillas).
b Method	The identification of 40 per cent of pupils enrolled in grades 1-5 from the poorest households, and their selection for participation in the PESP, will be conducted at the school level by the School Management Committees (SMC) with assistance from the head teachers. The list of proposed stipend recipients will be reviewed and approved by the Upazilla Primary Education Officer (UPEO) and counter-signed by the Upazilla Nirbahi Officer (UNO). To qualify for the stipend, selected pupils must maintain 85 per cent monthly attendance and attain a minimum of 50 per cent in the annual exam administered for each grade. To continue to participate in the programme, a school must demonstrate at least 60 per cent pupil attendance, and 10 per cent of its grade 5 pupils must sit for the Primary School Scholarship Exam.
c Disparities addressed	Yes. Only primary school students from the rural poor households are included in the programme.

Child Outcome Area	Education
9 Coverage	
a Geography	469 upazillas of the country.
b Number of people covered (# not covered)	PESP to cover 5.5 million students from more than 65,051 Government, Non-government, Community, Satellite primary schools and Ebtedayee Madrassahs.
c Quality of coverage	
d Most vulnerable children	Yes.
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning.
c Impact of findings	
11 Implementation Challenges	

Source: Ministry of Primary and Mass Education: http://www.mopme.gov.bd/Stipend%20Project%20(06-07).htm **The Bangladesh Primary Education Stipend Project: A Descriptive Analysis** A study prepared under the management and guidance of Carolyn Winter (World Bank). This study was commissioned and supported by the Partnership for Sustainable Strategies on Girls' Education, an international, inter-agency group dedicated to improving educational opportunities for girls in the developing world. Partner agencies include the World Bank, the British Department for International Development, The Netherlands, The Nike Foundation, UNESCO and UNICEF. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2004/03/29/000160016_20040329173239/Rendered/PDF/282570PAPER0BangladeshStipend.pdf

Table 8.5.3: National programme inventory: Education

Child Outcome Area	Education
1 Programme Name	**Reaching Out of School Children (ROSC), Implementation Period: July 2004-June 2010**
2 Objectives	The Government of Bangladesh has recently completed a National Plan of Action for Education for All (2001-2015) that embraces all of the goals of Education for All. A Primary Education Development Programme was launched in 2003 to reach commitments made in regard to the Education for All and Millennium Development Goals. But this Primary Education Development Programme does not incorporate the non-formal education system that caters for the education of about 10 per cent of children who do not have access to formal education in Bangladesh, mainly because of poverty. The Reaching Out of School Children (ROSC) project aims to address this gap. ROSC aims to contribute to the country's long term objective of poverty reduction through the development of human capital. Its key objective is to reduce the number of out of school children through improved access to quality education in support of the government's national Education for All goals. The duration of the ROSC project is six years (2004-2010). In line with PEDP II, the key objective of this project would be to use demand-side mechanisms to support the Government in efforts to achieve its National Education for All (EFA) goals. In particular the project aims to: 1) Provide access to primary education and ensure the retention of disadvantaged children who are currently out of school. 2) Improve the quality and efficiency of primary education specially for these children. 3) Strengthen the capacity of, and build, learning centres and their related organization.

Child Outcome Area	Education
3 Programme Type	The project mobilizes stakeholders and raises awareness about primary education in general, and the project in particular, through appropriate media and communication campaigns. It motivates out of school children to enter schools through community mobilization. Only those children who have never been enrolled in any school, or who have dropped out of school more than a year ago, are eligible to enter the ROSC school / learning centres. The project provides education allowances for these children to support the continuation and completion of schooling. The project also provides grants to the school / learning centres to improve the overall quality of education and service provided. The project also strives to establish a sound structure for the management and implementation of the project and strengthens the capacity of service providers to deliver quality services and the capacity of the community and other relevant stakeholders to monitor and manage the project. It facilitates the establishment of a network of participating service providers, supported by a network coordinating body, and complements government efforts for the policy reforms needed to develop a comprehensive education sector.
4 Reason for inclusion	The education programme includes the most vulnerable children who are subject to school drop out and exclusion.
5 Cost of Funding	
a Allocation (currency/ year/ region)	Total: Tk. 3,830.19 million. Government of Bangladesh: Tk. 236.84 million. Donors: Tk. 3,593.35 million.
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	
6 Agencies	
a Participating agencies (add rows if needed)	The ROSC project is co-financed by the Government of Bangladesh, the World Bank and SDC. The Directorate of Primary Education (DPE) under the Ministry of Primary and Mass Education is responsible for the project, which is being steered by a ROSC Committee at the Ministry level and implemented by the ROSC Unit under the Directorate of Primary Education.
b Agency role	Executive agency: Directorate of Primary Education (DPE): planning, finance and implementation. Donor agencies: financial support.
7 Mechanism and Beneficiaries	
a What is delivered	It is envisaged that the project will ensure access to quality primary education for 0.5 million out of school children; increase the completion and transition rates for these children; achieve classroom conditions for these children that are comparable to formal schools; evaluate the effectiveness of demand-side intervention to address problems of quality and access to primary education; and identify strategies for mainstreaming non formal education.
b Who benefits, who does not	0.5 million out of school children in 60 upazillas in 34 districts of 6 divisions that are relatively disadvantaged in terms of net enrolment rate, primary cycle completion rate, level of poverty and gender situation.
8 Targeting	
a Intended beneficiaries	0.5 million out of school children in 60 upazillas in 34 districts of 6 divisions that are relatively disadvantaged in terms of net enrolment rate, primary cycle completion rate, level of poverty and gender situation.
b Method	
c Disparities addressed	Yes, It is being implemented in 60 upazillas in 34 districts of 6 divisions that are relatively disadvantaged in terms of net enrolment rate, primary cycle completion rate, level of poverty and gender situation.

Child Outcome Area	Education
9 Coverage	
a Geography	The project is being implemented in 60 upazillas in 34 districts of 6 divisions that are relatively disadvantaged in terms of net enrolment rate, primary cycle completion rate, level of poverty and gender situation.
b Number of people covered	It is envisaged that project will ensure access to quality primary education for 0.5 million out of school children.
c Quality of coverage	
d Most vulnerable children	Yes. The programme is entirely designed for the most vulnerable children.
10 Monitoring and Evaluation	
a Yes/no	
b By who?	
c Impact of findings	
11 Implementation Challenges	

Source: Ministry of Primary and Mass Education: http://www.mopme.gov.bd/ROSC%20(06-07).htm http://www.sdc.org.bd/en/Home/Education/ROSC

Table 8.5.4: National programme inventory: Education

Child Outcome Area	Education
1 Programme Name	**Female Secondary School Assistance Project, Phase-II. (FSSAP-II) Revised Implementation Period: July-2005 to December-2008.**
2 Objectives	1) To increase secondary school enrolment of girls through continuing financial assistance, with the aim of expanding girls education. 2) To organize teacher education and training for qualitative improvement in secondary education. 3) To create intensive mass awareness about girls' education and acquire its social acceptance. 4) To provide special facilities for girls' education in inaccessible and disadvantaged areas and by the poorest of poor girls. 5) To make the environment of the institutions safe, healthy and attractive for girls by providing water supply and sanitation facilities through increased community participation. 6) To enhance the efficiency of project personel by providing training to ensure smooth and timely implementation of the various programmes of the Project. 7) To develop an effective management system for secondary education at upazila level. 8) Above all, to help the empowerment of women.
3 Programme Type	Cash grant, book allowances and examination fee (for SSC) and tuition fees for all girls in secondary schools (5.171 million girls).
4 Reason for inclusion	The programme is designed entirely for girl children to increase their enrolment in higher secondary education. It is also a step towards the Millennium Development Goals (MDG3).
5 Cost of Funding	
a Allocation (currency/ year/region)	Total: Tk. 5,029.90 million. Government of Bangladesh: Tk. 5,029.90 million. (Source: ADP-2008-09).
b Captured in Part A (yes/no)	Yes.
c (If yes to b) proportion of total	

Child Outcome Area	Education
6 Agencies	
a Participating agencies	Executing Agency: Ministry of Education.
b Agency role	Implementation.
7 Mechanism and Beneficiaries	
a What is delivered	Financial assistance: to expand the girls education cash grant, book allowances and examination fee (for SSC) and tuition fees for all girls in secondary schools (5.171 million girls). Teacher training and education: organize teacher education and training for qualitative improvement in secondary education.
b Who benefits, who does not	Appx 5.171 million girls at the secondary education level.
8 Targeting	
a Intended beneficiaries	Girl students of secondary level education.
b Method	
c Disparities addressed	Yes. The programme is designed entirely to increase the secondary school enrolment of girls through continuing financial assistance, with the aim of expanding girls education.
9 Coverage	
a Geography	119 Selected upazilas of 61 Districts of Bangladesh.
b Number of people covered	Appx 5.171 million girls.
c Quality of coverage	• Female enrolment, as a percentage of total enrollment, increased from 33 per cent in 1991 to 48 per cent in 1997 and about 56 per cent in 2005. • Secondary School Certificate pass rates for girls in the project area increased from 39 per cent in 2001 to 58 per cent in 2006. • 66,000 members of school management committees have been trained in school management accountability, with a focus on education quality and a conducive learning school environment. • 6,666 schools – many more than originally targeted – are currently participating in the programme, through a cooperation agreement with the Ministry of Education. • Indirect benefits of the project included delays in the age of marriage and reduced fertility rates, better nutrition, and more females employed with higher incomes.
d Most vulnerable children	Yes. The programme is designed entirely to increase the secondary school enrolment of girls through continuing financial assistance, with the aim of expanding girls education.
10 Monitoring and Evaluation	
a Yes/no	Yes.
b By who?	Implementation Monitoring and Evaluation Divisin (IMED), Planning Commission.
c Impact of findings	
11 Implementation Challenges	

Source: Ministry of Education, World Bank website: http: / / www . worldbank . org. bd / WBSITE / EXTERNAL / COUNTRIES / SOUTHASIAEXT / BANGLADESHEXTN / 0, contentMDK: 21227882~menuPK: 295791~pagePK: 1497618~piPK:217854~theSitePK: 295760,00.html

Abbreviations

ADB	Asian Development Bank
AE	Adult Education
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BB	Bangladesh Bank
BBF	Bangladesh Breastfeeding Foundation
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BCG	Bacillus Calmette Guérin
BDHS	Bangladesh Demographic and Health Survey
BINP	Bangladesh Integrated Nutrition Project
BLFS	Bangladesh Labour Force Survey
BSCIC	Bangladesh Small and Cottage Industries Corporation
BMI	Body Mass Index
BNNC	Bangladesh National Nutrition Council
BR	Birth registration
BSCIC	Bangladesh Small and Cottage Industries Corporation
CBN	Cost of Basic Needs
CE	Continuing Education
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CIDA	Canadian International Development Agency
CIDD	Control of Iodine Deficiency Disorder
CIU	Central Intelligence Unit
CLS	Child Labour Survey
C-IMCI	Community Based Integrated Management of Childhood Illness
CMNS	Child and Mother Nutrition Survey
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
DCI	Direct Calorie Intake
DFID	Department for International Development (UK)
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Service
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis and Tetanus
DSS	Department of Social Services
EC	European Commission
EU	European Union
ECED	Early Childhood Education and Development
EFA	Education for All
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
GDP	Gross Domestic Product
GOB	Government of Bangladesh
HbsAg	Hepatitis B surface Antigen
HDRC	Human Development Research Centre
HH	Household
HIES	Household Income and Expenditure Survey
HIV	Human Immunodeficiency Virus
HNPSP	Health, Nutrition and Population Sector Programme
ICN	International Conference on Nutrition
IDD	Iodine Deficiency Disorders
IDU	Injecting Drug Users
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPHN	Institute of Public Health Nutrition
IDA	International Development Association
IU	International Unit
IYCF	Essential Newborn Care, Feeding
JICA	Japan International Cooperation Agency
KUK	Kishore Unnayan Kendra (Juvenile Correction Centre, Tongi, Gazipur)
LBW	Low Birthweight
LGED	Local Government Engineering Department
LTU	Large Taxpayers Unit
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare
MOLGRD	Ministry of Local Government, Rural Development & Cooperatives
MOWCA	Ministry of Women and Children Affairs
NASP	National AIDS/STD Programme
NBR	National Board of Revenue
NCP	National Children Policy
NFBE	Non-formal Basic Education
NGO	Non-governmental Organization
NID	National Immunization Days
NMR	Neonatal Mortality Rate
NNP	National Nutrition Programme
NPA	National Plan of Action
NPAN	National Plan of Action for Nutrition
NT	Neonatal Tetanus
NWT	National Working Team
OP	Operational Plans
ORT	Oral Rehydration Therapy

PAF	Programme Accelerated Fund
PEDP	Primary Education Development Programme
PEM	Protein-Energy Malnutrition
PKSF	Palli Karma Shahayak Foundation
PMS	Poverty Monitoring Survey
PMU	Programme Management Unit
PPP	Purchasing Power Parity
PRSP	Poverty Reduction Strategy Papers
PSE	Pre-Service Education
RED	Reach Every District
RMP	Rural Maintenance Programme
RNE	Embassy of the Kingdom of the Netherlands
ROSC	Reaching Out of School Children
SEACT	Sexual Abuse and Exploitation of Children including Trafficking
SIDA	Swedish International Development Cooperation Agency
SMEs	Small and Medium Enterprises
SNP	Safety Net Programmes
SSNP	Social Safety Net Programmes
STD	Sexually Transmitted Disease
TFR	Total Fertility Rate
TR	Test Relief
U2PEM	Under-Two Protein Energy Malnutrition
U5MR	Under-Five Mortality Rate
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPE	Universalization of (Formal) Primary Education
VAS	Vitamin A Supplementation (VAS)
VAT	Value Added Tax
VGD	Vulnerable Group Development
VGF	Vulnerable Group Feeding
WCEFA	World Conference on Education For All
WHO	World Health Organization

UNICEF Bangladesh
BSL Office Complex
1, Minto Road, Dhaka 1000
Bangladesh

Telephone: 88 02 9336701-10
Email: dhaka@unicef.org
Website: www.unicef.org.bd

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