

# ANALYSIS OF THE SITUATION OF CHILDREN AND WOMEN IN BANGLADESH 2015





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OF CHILDREN AND WOMEN IN  
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## ACKNOWLEDGEMENTS

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The Interministerial Committee that accompanied the development of the Situation Analysis was co-chaired by Mr Ashadul Islam, Additional Secretary (UN) of the Economic Relations Division and included representatives of the Ministry of Finance, the Ministry of Education, the Ministry of Women's and Children's Affairs, the Ministry of Health and Family Welfare, the Ministry of Social Welfare, the Ministry of Chittagong Hill Tract Affairs, the Ministry of Primary and Mass Education, the Ministry of Information, the Ministry of Planning, the Ministry of Local Government, Rural Development and Cooperatives, the Ministry of Law, Justice and Parliamentary Affairs, the Ministry of Home Affairs, the Planning Commission and the Statistics and Informatics Division. The final Situation Analysis report was validated by senior Government counterparts from the same ministries.

Special thanks to Ms Kay Dorji who undertook the desk review, conducted the consultations and produced the final report.

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## FOREWORD

Over recent decades Bangladesh has achieved major improvements in the lives of children, adolescents and women in a relatively short time span. The country has done well to reach the Millennium Development Goal (MDG) targets on underweight children and hunger, gender parity in primary and secondary education, child and maternal mortality and access to safe drinking water and basic sanitation facilities, underpinned by rapid economic growth with Gross Domestic Product (GDP) growth rates ranging from 6.0 to 6.5 per cent over the past 5 years. However, considerable inequalities persist in terms of human development indicators, with under-5 mortality rates at 79 and 35 per 1,000 live births and stunting levels at 53 per cent and 27 per cent for the poorest and richest quintiles respectively. Furthermore, significant challenges remain relating to neonatal mortality which has been declining at a much slower pace than under-five mortality, high levels of stunting, the quality of education, pervasive violence against children in communities and schools as well as low levels of birth registration, gender-based discrimination and lack of opportunities for girls and women. Populations living in urban slums with limited access to quality and affordable services and populations living in locations vulnerable to the effects of climate change are particularly at risk of poor social outcomes.

UNICEF supported the development of this Analysis of the Situation of Children and Women against the backdrop of Bangladesh's transition towards the status of a lower-middle-income country as well as the global transition towards the Sustainable Development Goals (SDGs). Both these changes at national and global levels set the scene for UNICEF's upcoming 2017-20 Country Programme with the Government. Together with a series of other knowledge products, the Situation Analysis enabled UNICEF Bangladesh to formulate an evidence-based Country Programme that reflects the reality of the current country context in Bangladesh and addresses key barriers and bottlenecks to the fulfilment of the rights of children and women. The Situation Analysis used available data – in particular data emerging from the 2012/13 Multiple Indicator Cluster Survey and the 2014 Demographic and Health Survey, other research as well as analysis included in the 2014 UNICEF Mid-Term Review report, to identify trends and causes of key deprivations affecting children. This included analysis from an equity perspective, with a focus on gender inequality and the differential impact deprivations have on girls and boys. The development of the Situation Analysis was designed as a collaborative process, accompanied by an Interministerial Committee representing key Government ministries for child rights and was subsequently validated by senior Government counterparts.

The Situation Analysis reviews Bangladesh's progress towards fulfilling children's rights to food and nutrition, health and survival, education as well as protection. The structural causes underlying disparities in child rights include the need for systems and institutional strengthening at national and sub-national levels, a need for a culturally sensitive transformation in existing gendered social norms to eliminate harmful practices; the persistence of widespread poverty and a need to direct more attention to quality services in disadvantaged areas lagging behind in human development, including urban slums and hard-to-reach areas; inadequate knowledge and awareness on good household practices and Bangladesh's heightened vulnerability to disaster and ensuing emergencies.

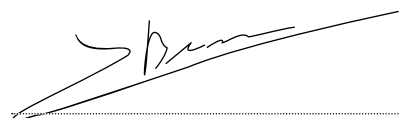
The country context in Bangladesh is changing rapidly in many different ways. In terms of demography, the current adolescent population of over 36 million aged 10 to 19 exceeds the population of children aged 0 to 9. Therefore, the country urgently needs to invest in the realization of their rights, focusing on some of the persistent gender inequities leading to challenges such as high child marriage and teenage pregnancy rates, and to provide access to quality learning as well as employability and life skills for adolescent girls and boys to be competitive in the labour market.

Furthermore, Bangladesh's position as one of the countries most vulnerable to climate change exposes it to the risk that the effects of climate change will threaten the significant achievements Bangladesh has made over the last 20 years on poverty reduction and achieving the MDGs. Given that children tend to be disproportionately affected by the harmful effects of climate change, it will be crucial to invest in climate change adaptation and social services that are resilient to disruptions caused by natural disasters and other climate-related events.

Bangladesh is also witnessing rapid and large-scale urbanization, with more than 50 million people currently living in urban areas and projections suggesting that in 30 years half the country's population will reside in urban areas. Adequate provision of quality basic services that meet the needs of this growing urban population will be key to avoid the deepening of inequities.

Finally, children with disabilities are often invisible in mainstream development programming, which is compounded by a lack of quality data on the number of children with disabilities. There is a need to enhance interventions for children with disabilities through early detection, inclusive education and social protection to ensure that they are not left behind.

Against the backdrop of these emerging challenges, UNICEF will continue to support the Government of Bangladesh in its journey to ensure that the rights of all children and adolescents are realised by addressing the underlying causes of inequities and by working towards a society with equal opportunities for all children.



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# Table of Contents

<b>ACRONYMS AND ABBREVIATIONS</b> .....	<b>8</b>
<b>EXECUTIVE SUMMARY</b> .....	<b>11</b>
<b>CHAPTER 1: INTRODUCTION</b> .....	<b>34</b>
1.1 Objectives and Conceptual Framework of the Situation Analysis .....	36
1.2 Methodology and Structure of the Situation Analysis .....	37
<b>CHAPTER 2: DEVELOPMENT SITUATION OF BANGLADESH</b> .....	<b>38</b>
2.1 Demographic Profiles and Trends .....	40
2.2 Recent Socioeconomic Development Trends and Context of the Post-2015 Development Agenda .....	42
2.2.1 Bangladesh’s Economic Development: A Brief Summary .....	42
2.2.2 Bangladesh’s Human Development: A Brief Summary .....	44
2.3 The Role of Socio-Cultural Norms and Values with Regard to Children and Women in Bangladesh .....	46
2.4 Key Crosscutting Development Themes Emerging as Priorities for Children and Women in Bangladesh in 2017-2021 .....	47
2.4.1 Strengthening Systems and Institutions .....	47
2.4.2 Embedding Effective Planning and Monitoring at the Local Level .....	49
2.4.3 Mainstreaming Gender and Empowering Women .....	50
2.4.4 Empowering Adolescents .....	55
2.4.5 Ending Child Marriage .....	57
2.4.6 Improving Social Services and Opportunities for Children and Women in Urban Slums .....	61
2.5 Other Key Development Considerations Affecting Children and Women in Bangladesh .....	65
2.5.1 Disability .....	65
2.5.2 Vulnerability to Disaster .....	67
2.5.3 Hard to Reach Areas .....	68

<b>CHAPTER 3: THE POLICY AND GOVERNANCE CONTEXT FOR CHILDREN'S LIVES</b>	<b>70</b>
3.1 International Commitments on Child Rights and Gender Equality	73
3.2 National Legislation and Child Rights Policies	74
3.3 Issues of Data	80
3.4 Other Key Actors on Behalf of Children and Women	80
<b>CHAPTER 4: THE RIGHT TO FOOD AND ADEQUATE NUTRITION</b>	<b>82</b>
4.1 Introduction	82
4.2 Nutrition Institutions, Systems and Governance	84
4.3 Key Indicators of Children's and Women's Nutritional Status	87
4.4 Root and Underlying Causes of Key Nutrition Challenges	92
4.5 Recommendations to Improve Children's and Women's Nutritional Status	93
<b>CHAPTER 5: THE RIGHT TO HEALTH AND SURVIVAL</b>	<b>94</b>
5.1 Health	94
5.1.1 Introduction	94
5.1.2 Health Institutions, Systems and Governance	96
5.1.3 Key Indicators of Children's and Women's Health Status	100
<i>Neonatal, Infant and Child Mortality</i>	100
<i>Maternal and Reproductive Health</i>	102
<i>Adolescent Health</i>	106
<i>Children With Disabilities</i>	106
<i>Early Childhood Care and Development</i>	107
<i>Common Childhood Illnesses</i>	108
<i>Childhood Issues of Injuries and Injury Prevention</i>	109
<i>Non-Communicable Diseases</i>	110
5.1.4 Root and Underlying Causes of Key Health Challenges	111
5.1.5 Recommendations to Improve Children's and Women's Health Status	112
5.2 Water, Sanitation and Hygiene (WASH)	112
5.2.1 Introduction	112
5.2.2 WASH Institutions, Systems and Governance	117
5.2.3 Key Indicators of Children's and Women's WASH Status	120
<i>Safe Water</i>	120
<i>Improved Sanitation</i>	121
<i>Effective Hygiene</i>	122
5.2.4 Root and Underlying Causes of Key WASH Challenges	124
5.2.5 Recommendations to Improve Children's and Women's WASH Status	124
5.3 HIV and AIDS	126
5.3.1 Introduction	126
5.3.2 HIV and AIDS Institutions, Systems and Governance	130
5.3.3 Key Indicators of Children's and Women's AIDS Status	132
5.3.4 Root and Underlying Causes of Key HIV and AIDS Challenges	134
5.3.5 Recommendations to Improve Children's and Women's HIV and AIDS Status	135



<b>CHAPTER 6: THE RIGHT TO EDUCATION AND DEVELOPMENT FOR CHILDREN . . .</b>	<b>136</b>
6.1 Introduction . . . . .	136
6.2 Education Institutions, Systems and Governance . . . . .	141
6.3 Key Indicators of Children’s and Women’s Education Status . . . . .	143
6.3.1 Early Childhood Care and Development . . . . .	143
6.3.2 Pre-Primary Education . . . . .	144
6.3.3 Primary Education . . . . .	145
6.3.4 Literacy Rates and Second Chance Education/Non Formal Education . .	146
6.3.5 Secondary Education . . . . .	147
6.4 Root and Underlying Causes of Key Education Challenges . . . . .	147
6.5 Recommendations to Improve Children’s and Women’s Education Status. . . .	148
<b>CHAPTER 7: THE RIGHT TO BE RESPECTED AND PROTECTED . . . . .</b>	<b>150</b>
7.1 Introduction . . . . .	150
7.2 Protection Institutions, Systems and Governance . . . . .	152
7.3 Key Indicators of Children’s and Women’s Protection Status . . . . .	156
7.3.1 Birth Registration . . . . .	156
7.3.2 Violence Against Children . . . . .	157
7.3.3 Violence Against Women . . . . .	160
7.3.4 Child Marriage . . . . .	162
7.3.5 Child Labour . . . . .	163
7.3.6 Sexual Abuse of Children . . . . .	163
7.3.7 Sexual Exploitation of Children . . . . .	165
7.3.8 Trafficking of Children and Women . . . . .	165
7.3.9 Protection Issues for Refugee and Ethnic Minority Populations . . . . .	166
7.3.10 Children in Contact With the Law . . . . .	168
7.3.11 Children With Disabilities . . . . .	168
7.3.12 Children Living on the Streets and Children Without Parental Care. . . .	169
7.4 Root and Underlying Causes of Key Protection Challenges . . . . .	170
7.5 Recommendations to Improve Children’s and Women’s Protection Status . . .	171
<b>CHAPTER 8: CONCLUSION: THE WAY FORWARD . . . . .</b>	<b>172</b>
Bibliography . . . . .	174
Annex 1: List of Persons Interviewed . . . . .	186
Annex 2: Capacity and Role Pattern Analysis Matrix – Nutrition . . . . .	187
Annex 3: Capacity and Role Pattern Analysis Matrix – Health . . . . .	192
Annex 4: Capacity and Role Pattern Analysis Matrix – WASH . . . . .	195
Annex 5: Capacity and Role Pattern Analysis Matrix – HIV and AIDS . . . . .	199
Annex 6: Capacity and Role Pattern Analysis Matrix – Education . . . . .	201
Annex 7: Capacity and Role Pattern Analysis Matrix – Protection . . . . .	207
List of Figures: Root, Underlying and Immediate Causes of Child Marriage . . . .	60
List of Tables: Indicator values for urban, rural and poorest urban population based on MICS 2012-2013 (%) . . . . .	63

## ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Anti Retroviral Therapy
BBS	Bangladesh Bureau of Statistics
BCO	Bangladesh Country Office
BENAP	Bangladesh Every Newborn Action Plan
BRAC	Bangladesh Rural Advancement Committee
BSMMU	Bagabandhu Sheikh Mujib Medical University
C4D	Communication for Development
CCT	Conditional Cash Transfer
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CLTS	Community Led Total Sanitation
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of People With Disabilities
CSR	Corporate Social Responsibility
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHS	Demographic and Health Survey
DNI	Direct Nutrition Interventions
DNSO	District Nutrition Support Officer
DPE	Directorate of Primary Education
DPHE	Department of Public Health Engineering
DPO	Disabled Persons' Organisation
DRR	Disaster Risk Reduction
ECCD	Early Childhood Care and Development
EiE	Education in Emergencies
EPI	Expanded Programme of Immunisation
EVA	Especially Vulnerable Adolescent
FDI	Foreign Direct Investment
GDI	Gender Development Index
GDP	Gross Domestic Product
GENAP	Global Every Newborn Action Plan
GII	Gender Inequality Index
GNI	Gross National Income
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System

HPNSDP	Health, Population and Nutrition Sector Development Plan
ICN2	Second International Conference on Nutrition
ICT	Information and Communication Technology
IDD	Iodine Deficiency Disorder
IDU	Injecting Drug User
IFA	Iron Folic Acid
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPHN	Institute of Public Health Nutrition
LBW	Low Birth Weight
LGD	Local Government Division
LLP	Local Level Planning
LSBE	Life Skills Based Education
M&E	Monitoring and Evaluation
MARA	Most at Risk Adolescent
MDGs	Millennium Development Goals
MIC	Middle Income Country
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonatal and Child Health
MoE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MoLGRD&C	Ministry of Local Government, Rural Development and Cooperatives
MoPME	Ministry of Primary and Mass Education
MoRES	Monitoring Results for Equity Systems
MoSW	Ministry of Social Welfare
MoWCA	Ministry of Women's and Children's Affairs
MPDR	Maternal and Perinatal Death Review
MPI	Multidimensional Poverty Index
MTR	Mid Term Review
NAPE	National Academy for Primary Education
NAR	Net Attendance Ratio
NASP	National AIDS/STD Programme
NER	Net Enrolment Rate
NFE	Non Formal Education
NGO	Non-Government Organisation
NIPORT	National Institute of Population Research and Training

NNS	National Nutrition Service
NUPRP	National Urban Poverty Reduction Programme
ODA	Official Development Assistance
OHCHR	Office of the High Commissioner for Human Rights
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PEDP	Primary Education Development Programme
PMTCT	Prevention of Mother to Child Transmission
ppb	Parts per billion
PPE	Pre Primary Education
PSU	Policy Support Unit
PWID	People Who Inject Drugs
RED	Reach Every District
RMG	Readymade Garment
SAARC	South Asia Association for Regional Cooperation
SACOSAN	South Asia Conference on Sanitation
SBA	Skilled Birth Attendant
SCANU	Special Care Newborn Unit
SCE	Second Chance Education
SDGs	Sustainable Development Goals
SLIP	School Level Improvement Plan
TFR	Total Fertility Rate
U5MR	Under-5 Mortality Rate
UESD	Utilisation of Essential Service Delivery
UHC	Universal Health Coverage
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UPEP	Upazila Primary Education Plan
UPR	Universal Periodic Review
VAW	Violence Against Women
WASA	Water Supply and Sewerage Authority
WASH	Water Sanitation and Hygiene

# Executive Summary

The Analysis of the Situation of Children and Women in Bangladesh 2015 represents an updated depiction of the status of realisation of the rights of children and women in the country. Not only does it inform the new UNICEF Country Programme 2017-2020, but it also consolidates evidence on persistent inequities and makes the most disadvantaged and vulnerable young children more visible for the purposes of policy decision making, legislation, budgeting and national research.

In all, the Situation Analysis attempts to begin to answer the question: Where and how can UNICEF have the most impact on development progress for children, adolescents and women in Bangladesh? It thus forms a basis for adjusting UNICEF programme interventions and strategies to ensure that programmes and policies remain relevant to the lives of girls and boys as well as women, and especially to the most vulnerable and disadvantaged among these groups. In turn, this will ensure that programmes and policies are likely to achieve the desired impact.

The Situation Analysis is influenced by a number of wider national and global factors, foremost among them Bangladesh's commitments under the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of Persons with Disabilities (CRPD). Likewise, it has been developed against the backdrop of the country's ambitious transition toward middle-income status by 2021, as well as the new global framework for development through the post-2015 Sustainable Development Goals (SDGs).

New knowledge and information from more than 250 sources on the status of children and women in Bangladesh, particularly from the Multiple Indicator Cluster Survey (MICS) 2012-2013 and Demographic and Health Survey (DHS) 2014, have further enriched the process. Moreover, these have been supplemented by interviews with key partners and UNICEF staff to elicit their perspectives and contribute to the analysis of role patterns and common capacity gaps among duty bearers at all levels.

## THE DEVELOPMENT SITUATION OF BANGLADESH

Overall, Bangladesh has achieved remarkable development progress in a comparatively short period, and is well-poised as the post-2015 era of the Sustainable Development Goals (SDGs) opens. Progress has been particularly impressive in terms of reducing head-count poverty and under-5 mortality rates (U5MR); official figures indicate that the country has met both the relevant Millennium Development Goal (MDG) targets. Other areas of positive progress include primary school enrolment, gender parity in primary and secondary education, a significant reduction in open defecation, and improved immunisation coverage.

Despite this important progress, equitable results for children, who comprise 40 per cent of the population, and for women continue to be a significant concern. Therefore, the question of whether Bangladesh is achieving progress with equity remains key. Overall, Bangladesh is classified as a country of “high inequity,” with a Gini coefficient of 0.32. Wide disparities at sub-national levels also are evident in the effective coverage of basic social services at disaggregated levels, as is highlighted throughout the Situation Analysis, by rural/urban location, by geographic region, by gender, and by wealth, among other factors. For example, nearly 1 in 3 of the country’s sub-districts, or upazilas (29 per cent), are classified as “most deprived,” as are nearly 1 in 4 districts.

Yet without concerted efforts to address the trend of unequal growth, Bangladesh will lose a unique opportunity to harness the potential for accelerated economic growth resulting from the demographic dividend due to reduced fertility in the country. For example, GDP per capita has grown by a factor of 5 between 1980 (US\$206) and 2014 (US\$1,044), but the share of wealth controlled by the poorest segment of the population has fallen, from 6.5 per cent in 1992 to 5.2 per cent in 2010 – suggesting that the poor are getting poorer, with significant implications for children and women.

Estimates on poverty rates differ due to methodological variations but remain high, ranging from 31.5 per cent of the population (based on a poverty line of US\$1.09/day) to 43.3 per cent (based on US\$1.25/day); the latter figure is nearly double the rate for South Asia as a whole. Concomitantly, 87 per cent of the national work force – largely comprising men – is in informal employment, where working conditions often are insecure and far short of decent work. Women’s overall labour force participation, while increasing, remains low, at only 36 per cent. Meanwhile, up to 16 per cent of the working-age population is abroad, generating remittances equivalent to more than one-tenth of GDP.

The fast rate of economic development, propelled by national ambitions of becoming a middle-income country by 2021, risks outpacing the country’s human development and social change. Bangladesh’s performance in the global Human Development Index shows a 46 percent improvement between 1990 and 2013, but even so, it remains near the bottom of the “medium human development” category.

## SIX KEY CROSS-CUTTING PRIORITIES

In light of this, six key crosscutting and interlinked development themes are emerging as priorities for the realisation of children’s and women’s rights in Bangladesh during 2017-2021, and form the “spine” of the Situation Analysis. These are:

- Strengthening systems and institutions
- Embedding effective planning and monitoring at the local level
- Mainstreaming gender and empowering women
- Empowering adolescents
- Ending child marriage
- Improving social services and opportunities for children and women in urban slums

A considerable number of laws and acts protect the rights of children in Bangladesh; however, implementation of policy can be slow. Civil service reform remains critical, with clear codes of conduct, strengthened capacity development, and sufficient budgets for effective social development. In addition, the involvement of women and youth will be especially crucial in strengthening of the role of citizens in ensuring government accountability. The Government commitment to introduce child-focused budgeting in the fiscal year 2015-

2016 represents a particularly important opportunity for system strengthening, as does the modelling and scaling up of effective service delivery.

At the same time, however, the status of children also has been found to remain deeply rooted in social norms, attitudes and practices: individuals younger than age 18 are not always considered as children, which deeply affects the realisation of children's rights. Importantly, social perceptions and expectations of childhood continue to vary according to age, gender, social class, wealth, disability and other factors. Communication for development strategies that can be used to address these perceptions, attitudes and norms are steadily being mainstreamed within sectoral and cross-sectoral programmes of governmental and other partners at national and sub-national levels.

Meanwhile, requirements new data and information are increasingly being linked to evidence-based decision making. Already, Bangladesh is a leader in applying UNICEF's Monitoring Results for Equity Systems (MoRES) approach to development, resulting in the reduction of identified development bottlenecks and improved coverage of interventions in 20 of the most socioeconomically deprived districts in the country.

Local-level planning can particularly be useful in addressing development bottlenecks; strengthening the supply of services and improve their quality; and raising economic efficiency through enhancing accountability. It can allow greater representation in decision making, while also relieving managers in central Ministries of routine tasks; ultimately, it can enhance a more responsive government and involves a redefinition of structure, governance and procedures.

More broadly, local-level planning also represents a key component of the critical investments needed to strengthen the overall planning process in Bangladesh, which also encompasses evidence-based planning, "bottom-up" planning and integrated planning; for example, "bottom-up" planning already has been supported by UNICEF in 60 *upazilas* in the country. Strengthening overall planning also is linked to the need for establishment of Divisional- and district-level planning and monitoring units, as well as capacity development of relevant stakeholders.

In terms of mainstreaming gender, Bangladesh has made important strides for women with regard to increased access to services, including through rural infrastructure development; enhanced educational outcomes; and rising labour force participation through the ready-made garment industry. Key improvements also have been noted at the policy level, including adoption of the Domestic Violence Act and the national Policy for the Advancement of Women, as well as establishment of the National Council for Women and Child Development.

Nonetheless, various social and legal norms around gender continue to strongly influence whether women can be educated or employed in decent work, whether they can participate in civic activities, and under what conditions they bring "honour" or "shame" to themselves and their families. All this results in low social value for the girl child, and hence, overall reduced life chances for adolescent girls; for boys, they are most likely to be withdrawn from school to engage in child labour.

Reflecting the serious impediments to gender equality and women's empowerment that exist, Bangladesh is ranked 107<sup>th</sup> in the Gender-related Development Index, significantly lower than the global average, and 115<sup>th</sup> in the Gender Inequality Index. The Committee for the Elimination of All Forms of Discrimination Against Women (CEDAW Committee), in its latest Concluding Observations, has noted both a lack of key data as well as the persistence of discriminatory laws.



Protection issues for girls and women in Bangladesh thus continue to be acute. The trafficking of girls and women, particularly for sex work, remains widespread. Many women have been found to continue in abusive relationships because of their fear of loss of shelter and lack of economic options. Lack of safety in public spaces manifests in adolescent girls often being harassed and abused on the way to school; violence against girls and women is frequently condoned, such that two-thirds of women in the country experience physical violence by their husbands.

Malnutrition issues and exposure to unhealthy practices also are widespread among girls, with limited information and services on adolescent health in particular, as well as high rates of adolescent birth because of the prevalence of child marriage. Lastly, women and girls particularly face low representation and participation in both public and personal decision making, along with limited opportunities for financial empowerment. Furthermore, the gendered nature of the labour market is linked to girls' low participation in technical and vocational education and training, which further sets them at a disadvantage to join the paid labour force.

Some considerations for addressing gender inequalities in Bangladesh include targeted gender priorities with a cross-sectoral focus, such as promoting gender-responsive adolescent health, including delayed and safer pregnancy; providing integrated health services, menstrual hygiene management and puberty education; and reducing adolescent anaemia. Issues of access, retention, completion, quality, life skills and employability will need to be addressed to advance girls' secondary education.

Numerous opportunities exist to deepen gender mainstreaming in UNICEF programmes. These include: (1) Promoting maternal health, including ease, accessibility, quality and dignity of care in areas such as safe delivery, skilled birth attendants, emergency obstetric care, and women's knowledge and information; (2) Enhancing maternal nutrition, particularly prevention of anaemia; (3) Improving access to safe drinking water, especially in the home, and easier access by women/girls for procuring and using water; and (4) Improving access to adequate sanitary facilities nearby/in the home and school, particularly as it affects women's safety, dignity and health. Critically, girls, boys, men and women can all be engaged through communication for development strategies to promote participation and voice, for awareness generation, behaviour and social change, and demand creation.

In education, gender-related priority areas may include: (5) Achieving gender equality in primary education, including regular attendance and improved learning outcomes; (6) Addressing school-related gender-based violence (GBV); and (7) Addressing educational differentials by gender for children with disabilities. Lastly, in protection it will be important to focus on such areas as (8) Preventing and addressing GBV and sexual abuse of children and women; (9) Address the nature of gender differences in child labour; and (10) Supporting the Government to deliver more effective social protection benefits to girls and women.

Further, key gender considerations for emerging areas of programming include gender differentials in urban poverty, linked to rapid urbanisation and related vulnerabilities, along with new approaches to planning and response to climate change, Disaster Risk Reduction and resilience building from a gender "lens." Understanding and responding to the rights and needs of minority groups and communities (e.g., *hijras*, ethnic and religious minorities) will be critical to support diversity and challenge social exclusion. Lastly, the potential for identifying challenges and opportunities in terms of digital safety can help to provide safer digital access to young girls and boys at risk of bullying or exploitation for unlawful activities.

With regard to empowering adolescents, emerging challenges include an acute lack of information, skills and services that respond to their distinctive needs, again compounded by deeply embedded attitudes, beliefs, social norms and practices. Adolescents' mental



health and adolescent girls' exposure to gender-based violence are particularly important, as is nutrition, given that 1 in 3 adolescent girls is underweight. Nonetheless, important opportunities exist for productive work with adolescents, to promote quality learning, better preparation for work and civic engagement; to foster healthy behaviours; and to encourage better protection from becoming victims of violence. In this regard, adolescent clubs and adolescent radio listeners groups, the latter supported by the Ministry of Information, offer significant potential to help adolescents participate and contribute to policy decisions that affect their lives.

Some progress has been recorded in the prevention of child marriage, with the median age of marriage shifting from 14 among women in their late 40s to 16.6 among women in their early 20s. Nonetheless, critical challenges remain, exacerbated by poverty, adverse social norms, and vulnerability to natural disaster. Bangladesh is ranked 3<sup>rd</sup> globally in the number of child marriages and 4<sup>th</sup> in early childbearing. Nearly two-thirds of all girls are still married before age 18, with 1 in 4 becoming mothers before that age<sup>1</sup>. A widespread practice is the falsification of birth certificates, or families may go to neighbouring villages to marry their daughters, where the registrar, for example, is more lenient and more willing to register an illegal marriage.

Although the issue of child marriage is longstanding, ending this practice now has more urgency, given that it has been proposed as a specific target for the new Sustainable Development Goal (SDG) to empower women and girls and achieve gender equality and that it is an issue that is hampering Bangladesh's socio-economic development. Only then can the main principles of the post-2015 development framework – human rights, poverty eradication, gender and other forms of equity, and social justice – be fulfilled in Bangladesh. In all, targeted interventions such as conditional cash transfers offer key protection opportunities for girls with regard to child marriage. Strengthening enforcement of child marriage laws also is linked to overall strengthening of institutions and systems. Lastly, enhanced awareness on the legal definition of a child, along with positive behaviour and social change, will be important to overcome barriers including social norms that reinforce gender roles and result in girls' ultimate disadvantage.

Meanwhile, rapid urbanisation in Bangladesh is putting enormous pressure on existing infrastructure and basic civic facilities. Dhaka is ranked as the 11<sup>th</sup>-largest urban centre in the world, a mega-city with a population of more than 14.2 million; its population more than doubled between 1991 and 2011, and is expected to increase by another 86 per cent by 2030. Moreover, more than 1 in 3 Dhaka residents live in one of the city's 5,000 slums, with slum populations increasing at almost double the rate of urban areas in general. Virtually all future population growth in the country expected to be in urban areas, posing a huge development challenge, including for delivery of quality services for children and women. Already, numerous indicators of children's socioeconomic status, including stunting, child marriage and improved sanitation, are worse in urban slums than in rural areas.

Lastly, three more broad development factors also deserve a detailed mention as affecting children and women in Bangladesh: (1) disability, where progress has been improving but slow, with a lack of disaggregated data on the size of the population affected by disabilities; (2) vulnerability to disaster (flooding, waterlogging, riverbank erosion, cyclones, earthquakes waterlogging, riverbank erosion), and to climate-related risks, all of which leave children and women in particular need of strengthened resilience; and (3) living in hard-to-reach areas, given the country's challenges of geographic remoteness and isolation, which are a major driver of social stagnation. All three exacerbate inequities and provide important crosscutting development areas requiring special attention in the coming years.

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1 BDHS 2011.

## RIGHTS-BASED THEMATIC ANALYSES

The thematic analyses in this Situation Analysis focus on the right to food and adequate nutrition; the right to health and survival, including issues of water and sanitation and HIV/AIDS; the right to education; and the right to be respected and protected. Overall, the analysis particularly indicates a range of strengths and areas for improvement in all sectors with regard to institutions, systems and governance, compounded by frequent political violence. Many of the areas for improvement relate to insufficient sub-national (district/*upazila*) management and technical capacities, fragmentation of national-level responsibilities, low accountability/transparency, and weak coordination and monitoring. At the same time, effective governance during the upcoming Seventh Five Year Plan 2015-2020 presents a unique opportunity to take Bangladesh to the next level, where no child is left behind, particularly the most disadvantaged and vulnerable; specifically, it offers opportunities to prioritise investment into rights-oriented interventions.

### ***The Right to Food and Adequate Nutrition***

Nutrition represents a multisector area of particular challenge and an increasingly important development issue in the post-2015 era. Nutritional challenges begin straight from conception for children in Bangladesh, and encompass both quality of nutrition as well as feeding/dietary practices, exacerbated by limited dietary diversity, particularly among the poorest families. More than 1 in 4 infants (26 per cent) weigh less than 2,500 grams at birth and are considered to have low birth weight, which is an indicator of the newborn's chances for survival, growth, long-term health and psychosocial development.

Overall, Bangladesh still suffers from two key sets of nutrition issues: the first is a high burden of child and maternal undernutrition, while the second relates to a rapid increase in overweight and obesity and in nutrition-related non-communicable diseases, including hypertension, diabetes, heart disease, cancer and osteoporosis. In addition, undernutrition already costs the country an estimated US\$1 billion in lost productivity every year, and even more in health costs.

Key root causes for continuing nutrition challenges included the traditional low priority given to the issue in the political economy and in public sector budgeting; insufficient attention to community-based nutrition; challenges in detection/management of acute malnutrition; traditional cultural beliefs, norms and household practices that adversely impact the nutritional status of a household; and household food insecurity and poverty. The generally low status of women and adolescents contributes to inequitable household access to food and an inter-generational cycle of undernutrition.

Progress on key nutrition indicators has been mixed, in particular as a result of the impact of several of the crosscutting issues identified above (social norms, climate change). While improvements have occurred in reducing the level of stunting in under-5 children, for example, this level nevertheless remains very high (36 per cent) and is accompanied by slower reductions in underweight and wasting. Those children whose mothers have secondary or higher education or who are from the richest wealth quintile are the least likely to be underweight and stunted; notable disparities also exist between rural and urban children. Even so, stunting still affects children in nearly a quarter of the wealthiest households, illustrating the challenges still to be overcome.

The proportion of children aged 6-23 months receiving a minimum acceptable diet has improved only marginally, from 21 to 23 per cent, while exclusive breastfeeding has declined sharply since 2011, from 64 to 55 per cent. In addition to the prevalence of undernutrition already noted among adolescent girls, undernutrition remains significant among women, at 17 per cent in 2013, and also puts the urban poor at high risk. Hygiene-related practices remain extremely low, with very few caregivers washing their hands before feeding a child.

A strong policy mandate exists with regard to food and nutrition issues, but inter-Ministerial coordination mechanisms require significant further strengthening. Other challenges to system building include a need for strengthening of information, human resource capacity and supply chain management alike. Systemic/institutional arrangements are in place but often are inadequately resourced, exacerbated by insufficient sub-national management and technical capacities. Critically, nutrition-specific interventions are not being fully complemented by nutrition-sensitive interventions in other relevant sectors.

Overall, ensuring that all children and women in Bangladesh enjoy optimum nutrition to lead healthy and productive lives can be achieved only by prioritising nutrition services and key target groups, scaling up nutrition-specific and nutrition-sensitive interventions, and strengthening the enabling environment for concerted, multisector action on nutrition. All nutrition-relevant sectors – health, education, WASH, child protection, agriculture, food, social protection et al. – will need to align around nutrition as a fundamental component of human and economic development. Recommendations include:

<b>Policy/Strategy</b>	Support establishment of an effective multisector leadership and coordination mechanism
<b>Institutions/ Governance</b>	<p>Support institutional strengthening to effectively address malnutrition, including sustaining and adequately resourcing coordination institutions</p> <p>Adopt a convergence and equity approach for multisector and multi-stakeholder responses</p> <p>Strengthen and scale up a full set of Direct Nutrition Interventions</p> <p>Scale up nutrition-sensitive interventions, particularly in areas of WASH, reproductive health/family planning, adolescents, social protection, education and agriculture, to further address some of the underlying and root causes of malnutrition</p> <p>Prioritise gendered approaches to support nutrition interventions in all sectors and at all levels</p>
<b>Programme, Including Gender/ Adolescents/ Child Marriage/ Urban Slums</b>	<p>Build a stronger focus and investment in infant and young child feeding as a core nutrition component</p> <p>Support strengthened household access to foods of appropriate quality/diversity, including through enhanced engagement with and oversight of food and beverage companies</p> <p>Increase attention to/resource allocation for nutrition in urban slums/hard-to-reach areas, to close acute equity gaps</p> <p>Support capacity development of human resources at national and sub-national levels, as well as sub-national-level technical assistance in planning and implementation</p> <p>Develop and resource interventions that address overweight and nutrition-related non-communicable diseases</p> <p>Intensify and expand multi-level C4D efforts at household and community levels to increase knowledge, information and demand for quality services, as well as for behaviour and social change (including in norms), to adopt and maintain Infant and Young Child Feeding (IYCF) practices</p>
<b>M&amp;E/Data/ Knowledge Management/ Innovation</b>	<p>Support technical assistance at sub-national level in information management</p> <p>Advocate for the development of effective monitoring, evaluation and accountability of public as well as private-sector actors, as well as establishment of a national nutrition information system to regularly track key indicators; encourage citizen involvement in accountability processes</p>

## ***The Right to Health and Survival***

A number of Bangladesh's health indicators, particularly with regard to infant and under-5 mortality rates and to maternal mortality, have improved significantly in recent decades. According to Government figures, the country has achieved its MDG4 target of 48 deaths per 1,000 live births.

Overall, however, the challenges remains enormous: still, 1 in every 27 children dies before reaching his/her first birthday, and 1 in every 22 children does not survive to her/his fifth birthday, with largely preventable health causes. Significant inequities in health outcomes exist across geographical regions and between different wealth quintiles. In urban areas, particularly wide differentials exist in health service utilisation and outcomes between slum and non-slum areas.

Critically, the current burden of deaths for children under 1 year of age occurs within the first month of life, and particularly among newborns. Moreover, the proportion of neonatal deaths to overall under-5 deaths has increased from 39 per cent in 1989-93 to 60 per cent in 2007-2011, largely due to a rapid reduction in post-neonatal mortality. Thus, further reducing neonatal mortality represents an urgent priority to improve the realization of rights for children in Bangladesh.

Meanwhile, despite Bangladesh's good progress on maternal mortality, about 5,200 women die yearly due to complications of pregnancy, delivery and the postpartum period. Most maternal deaths are due to delivery by unskilled birth attendants at home and to lack of comprehensive emergency obstetric care from a skilled provider at a facility; only about 43.5 per cent of births overall are delivered by skilled personnel, reaching as low at 2.8 per cent in some hard-to-reach areas. It is estimated that for each maternal death, 14 perinatal deaths occur, while three-fourths of the babies born to women who die, also die within the first year of life. Significant inequities exist across regions and among wealth quintiles.

Coverage of ANC, by a doctor, nurse or midwife, remains low, with only 58.7 per cent of women receiving ANC from any skilled provider during the pregnancy. Notably, about two-thirds of mothers (65.7 per cent) received ANC at least once during the last pregnancy, but only 1 in 4 (24.7 per cent) received the recommended number of 4 ANC visits. This is strongly associated with urban residence, as well as mother's education and wealth.

Of urgent concern for adolescent health, as noted above, are issues arising from violence against girls, Child marriage and undernutrition, as well as access to separate and appropriate sanitary facilities in schools. Critically, adolescents and young people are not sufficiently aware of the consequences of unprotected sexual activity, sexually transmitted diseases, HIV/AIDS or treatment available to them. Young women aged 15-19, with lower rates of contraceptive use than older women, report the highest age-related rate of unmet need for contraception.

Overall, the rights of children with disabilities to quality health care are not yet realised in the country. While notable progress also is being made in prevention of impairments, the main causes of preventable disabilities in Bangladesh continue to be related to undernutrition of mothers and children; disease, delivery and congenital conditions; and accidents. Most quality health services for children with disabilities are specialised and not mainstreamed.

Access to Early Childhood Care and Development (ECCD) services for 0 to 4-year-olds in Bangladesh remains to be further developed, with much of the attention focused on pre-primary education services for slightly older children. Stronger efforts are needed to significantly expand the coverage of ECCD services for this younger age group and to gather additional information, while also ensuring sustainability of efforts, given that only

63.9 per cent of children aged 36-59 months are developmentally on track across four key development indicators. Parenting education and support also require significant strengthening. Disturbingly, drowning has emerged as the leading cause of death among children aged 1-4 years.

Health system governance remains large and complex, challenging effective stewardship. This requires the addressing of issues in policy formulation, strategic planning and effective coordination, and particularly in light of an expected shift to Universal Health Coverage within the next 20 years. Bifurcation of overarching health responsibilities between the Directorate General of Health Services and Directorate General of Family Planning, both within the Ministry of Health and Family Welfare, hinders effective coordination and integrated, cost-effective service delivery, with fragmented planning and budgeting resulting in duplication and inequitable resource allocation. Centralised fund management and disbursement for district health systems further affects allocative efficiency.

Skilled human resources represent a particularly serious issue in all areas of the country that constrains development results in health. Like many countries, however, in Bangladesh the workforce challenge is not just about shortfalls in numbers of health workers; of equal importance is their distribution (rural/urban, primary vs. tertiary) and, critically, the quality of their performance. In particular, Bangladesh is lagging far behind in terms of the ratio of nurses and midwives to population, at less than half the global average for low-income countries. In addition, vacancies and absenteeism of service providers – coupled with especially poor infrastructure for mother, newborn and child health services in hard-to-reach areas, interpersonal communication skills of service providers for effective social mobilization, and community engagement – all place a burden on the system to render timely and quality services and improve utilization rates.

The human right to health means that every child, every adolescent and every woman has the right to and can demand the highest attainable standard of physical and mental health, including access to all health services. It means that hospitals, clinics, medicines and doctors' services must be accessible, available, and of good quality for everyone, on an equitable basis, where and when needed. To advance further toward this goal in Bangladesh, recommendations include:



<b>Policy/Strategy</b>	Support for increased resource allocations to hard-to-reach areas and urban slums to close the equity gap
<b>Institutions/ Governance</b>	Support for building of the decentralised capacity of the health system, including enhancement of planning capacities; institutionalisation of quality assurance, social mobilization and community engagement; and promotion of a strong monitoring and evaluation culture  Increased focus on adequacy of numbers of skilled human resources at health facilities
<b>Programme, Including Gender/ Adolescents/Child Marriage/Urban Slums</b>	Promotion of low-cost, high-impact interventions Promotion of neonatal health as an urgent priority Increased focus on adolescent health, including strengthened counselling about suicide prevention and sexual/reproductive health in particular, including in adolescent clubs Incorporation of the prevention of child injuries into ECCD and C4D strategies Support to ensure sustainability is strongly reflected in programme/project design Intensify C4D efforts to create demand for quality services, as well as promote life-saving, healthy and preventive behaviours and conducive social norms for maternal, newborn and child health
<b>M&amp;E/Data/ Knowledge Management/ Innovation</b>	Demonstration of successful health models in areas of emerging challenges, e.g., neonatal interventions, drowning prevention, early disability detection and intervention services Behavioural data generation to demonstrate progress in achievement of programme objectives

In terms of water, sanitation and hygiene (WASH), Bangladesh has emerged as a leader in Asia in experimenting with and implementing innovative approaches to rural sanitation in particular, with the result that there has been a dramatic reduction in open defecation, from 34 to 3 per cent. At the same time, while Bangladesh is reported to have high rates of access to improved drinking water sources, at 97.9 per cent, only 56 per cent use improved sanitation facilities. Moreover, these figures mask stark variations in coverage and quality within geographic areas, communities, schools and even households.

Key challenges in the sector include water quality and year-round access, inadequate sanitation facilities, and poor handwashing practices, all of which severely affect children's well-being and physical and mental development. Lack of knowledge about WASH impact on health and nutrition is significant. Other factors, including poverty, rapid urbanisation, declining water levels, and vulnerability to climate change/natural hazards, compound a challenging situation; the WASH situation in urban slums is particularly precarious, characterised by low access and a need for significantly strengthened sludge and solid waste management practices. Overall, more than 20 per cent of Bangladesh's area is rated as very or extremely hard to reach with water and sanitation services, covering some 28.6 million people.

With regard to the WASH sector's considerable links to and effects on nutrition, a strong correlation has been found between household drinking water with under-5 child stunting,

wasting and underweight. For example, 57 per cent of children from households with unimproved drinking water sources are stunted, wasted or underweight, compared to 31 per cent in households with improved drinking water sources. Strong correlations also have been found between severe stunting or underweight and use of unimproved sanitation.

Critically, it has been recognised Bangladesh suffers from the worst case in the world of arsenic contamination of water, with a diverse disease burden from this known carcinogen. About 1 in 4 households have water with arsenic content above international standards, such that nearly 20 million people drink arsenic-contaminated water; 800,000 water points are contaminated. It has been estimated that arsenic is responsible for 42,000 deaths a year in the country. An estimated 3 in 5 water sources in the country also supply an excess of the national standard for manganese; evidence also shows that high manganese levels in water impair the intellectual development of children.

High levels of knowledge with regard to the benefits of handwashing frequently does not translate into practice: Despite high-level knowledge, for example, during school demonstrations only 28 per cent of students washed both hands with soap.

Menstrual hygiene in schools for adolescent girls remains a key challenge, with impacts on health and on school absenteeism among girls. Most surveyed students used old cloth (82 per cent), but reported good cloth washing practices, with only 5 per cent washing cloth with only water. Only about 6 per cent of schools had a separate toilet for girls with facilities for menstrual management.

Up to 1 in 4 girls reported that they miss school during menstruation, often for three to five days per month; this equates to up to 20 per cent of school time, which has a demonstrated detrimental impact upon learning – and subsequently, opportunities – for girls. The lack of adequate segregated, clean and functional facilities, and the almost-complete absence of menstrual hygiene facilities, often is regarded as a reason for parents to remove their daughter from school, reducing their development opportunities and increasing the likelihood of child marriage.

The WASH situation in public facilities is highly challenging: While about 4 in 5 schools have functional improved drinking water sources and functional improved toilets, in less than half of schools, for example, were the toilets actually accessible to pupils. Only 6 per cent of schools have a separate toilet with menstrual hygiene management facilities, although menstrual hygiene is a key issue for adolescent girls. A critical lack of functioning toilets in hospitals also has been noted. Moreover, in urban hospitals fewer than 2 in 5 staff drinking water sources were improved, while 5 per cent of all hospitals have no water source whatsoever for staff, and 7 per cent have no water source for patients/caregivers.

In terms of institutions, systems and governance, the Government has made strong commitments to achieving WASH targets and has designated a clear lead sector agency. At the same time, the existence of WASH sector policies, guidelines, Acts and plans is challenged by poor dissemination and implementation, and the low but steadily increasing WASH budget faces funding gaps in research and development, operation and maintenance, sanitation and hygiene. Sector coordination, monitoring and reporting require significant strengthening among the five Ministries responsible for WASH-related policies; again, a centralised system of administration and funding prevails, resulting in weak sub-national capacities for WASH delivery. Thus, the need for Government institutional strengthening remains key in light of the traditional following of a “project” intervention outlook, although moves are under way toward a more forward-thinking, scalable sectoral overview.

Access to safe water and access to decent sanitation are human rights, both included within the human right to an adequate standard of living and explicitly recognised in 2010 by the



United Nations General Assembly and the Human Rights Council. These human rights are in themselves essential for life and dignity, but are also the foundation for achieving a wealth of other human rights, including the right to health and the right to development. Around the world, the real challenge now is to translate these human rights obligations into meaningful action on the ground. For Bangladesh to further achieve this, recommendations include:

<b>Policy/Strategy</b>	<p>Promotion of WASH sector coordination and harmonisation of policies, particularly including a harmonised approach for arsenic mitigation</p> <p>Additional priority to Integrated Water Resources Management</p>
<b>Institutions/ Governance</b>	<p>Institutional capacity development at national and sub-national levels</p> <p>Strengthening of overall sector monitoring and reporting system, with an increased focus on equity</p> <p>Support for a nationwide water quality surveillance and reporting system</p> <p>Support for equitable resource allocation for hard-to-reach and water quality-challenged areas; sanitation and hygiene; and urban slums</p>
<b>Programme, Including Gender/ Adolescents/Child Marriage/Urban Slums</b>	<p>Sectoral approach to scaling up of WASH delivery</p> <p>Intensified efforts for provision of WASH facilities, including menstrual health management facilities, in schools and health centres</p> <p>Intensified efforts on hygiene promotion and other C4D activities, including the use of safe water, improved sanitation and handwashing with soap at critical times for improving utilization rates, behaviour and social change; this also may include incorporation of WASH messages into health structures</p> <p>Piloting of a “100 per cent” approach to improved WASH services (safe drinking water, hygienic sanitation) in selected urban slums, potentially employing public-private partnerships</p> <p>Strengthening of linkages between improved sanitation, handwashing and solid waste management</p> <p>Improved emergency preparedness, including piloting of more disaster-resilient designs of water and sanitation facilities and strengthening of local-level capacity, coordination and preparedness mechanisms</p> <p>Intensified support for increased involvement of women in planning, implementing and operation and maintenance of WASH services</p> <p>Support for mandatory provision of facilities for persons with disabilities with regard to public water supplies and toilets</p>

<p><b>M&amp;E/Data/ Knowledge</b></p> <p><b>Management/ Innovation</b></p>	<p>Promotion of climate-resilient WASH technologies</p> <p>Increased support for research on new technologies to address challenges relating to water quality, year-round access, operation and maintenance, and scaling up of pilot initiatives on alternative technologies</p> <p>Real-time data generation to capture changes in knowledge, practices and norms change processes</p> <p>Building of a strengthened evidence base on the health impact of arsenic, manganese, salinity and faecal contamination for more effective advocacy</p>
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Lastly, new HIV infections among adults and children have declined substantially worldwide, but not in Bangladesh. Although HIV prevalence in the general population in Bangladesh is low, at 0.1 per cent, a 25 per cent increase in new HIV cases in the country has been reported. Moreover, reported new infections have increased by a factor of about 1.5 within the last five years alone. Bangladesh is thus one of four countries in the Asia-Pacific region where the epidemic continues to increase. HIV has been identified in 60 out of the country's 64 districts, but about 3 in 4 newly identified cases are concentrated in 12 districts.

Higher rates of infection are particularly being recorded among key population groups: HIV prevalence among people who use drugs, female and male sex workers, males who have sex with males, and transgender people stood at 0.7 per cent overall, seven times higher than the nationwide prevalence rate. A concentrated epidemic exists in Dhaka among people who inject drugs, while an epidemic also may be emerging among female sex workers in border towns and needs careful attention.

Women comprise about 1 in 3 adults living with HIV. Critically, migrants now constitute from 25 to 40 per cent of annual cases; a significant increase likewise is reported in infections among spouses of migrants. Other emerging risk groups include non-PWIDs injecting drug users, clients of sex workers, and especially vulnerable adolescents (EVA). Additional groups among whom higher vulnerability is suspected but supporting evidence is not strong include garment, tea garden and transport workers; refugee and displaced persons; and some ethnic minority populations.

Limited coverage of services and low rates of HIV testing both contribute to an overall low case detection rate. Overall, limited treatment facilities exist for people living with HIV in Bangladesh, and mechanisms to ensure quality of treatment service provision are largely absent. Capacity is extremely limited to provide more complex HIV treatment needs. Key gaps in HIV counselling and testing include poor distribution of counselling and testing centres across the country; lack of national guidelines for counselling and testing, along with cumbersome testing procedures; and considerable "lag time" between HIV testing and availability of test results. Further illustrating the limitations of coverage, only about 1 in 4 eligible adults and 1 in 3 eligible children are on anti-retroviral therapy.

HIV surveillance and detection among adolescents and young people in the country is particularly in need of strengthening. Critically, a major drop in coverage appears to lie in access to HIV counselling and testing services by adolescents, associated with policy

barriers in age of consent to medical services among adolescents and legal barriers that criminalise behaviours of key populations; AIDS-related stigma and discrimination; and the limited capacity of service providers to scale up interventions for adolescents. Taboos with regard to open discussion about HIV and AIDS, sex and sexuality, sexually transmitted infections, drug use, child sexual abuse and exploitation all inhibit the degree to which HIV risky behaviours can be addressed, particularly among adolescents.

Although one of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission, comprehensive knowledge among of HIV among women and adolescent girls in Bangladesh remains alarmingly low. Only 55.8 per cent of women aged 15-49 years had heard of AIDS, while only 23.2 per cent know at least two ways to prevent HIV. Some recent surveys show a slight decline in knowledge of HIV prevention methods between 2011 and 2014. Overall, only 6.6 per cent of women had comprehensive knowledge with regard to HIV transmission, while only about 17.7 per cent of young people of both sexes aged 15-24 have such comprehensive knowledge, the lowest in the Asia-Pacific region.

The National AIDS Committee was formed in 1985, four years before identification of the first HIV case in Bangladesh. The National AIDS/STD Programme is the main Government body responsible for overseeing and coordinating HIV prevention, treatment and care efforts. However, the programme is not adequately staffed and not fully technically capacitated; staff turnover is frequent, and funding also is irregular. Among international partners, the funding situation for HIV and AIDS is declining because of reduced priority given to the issue, with some major international support ending altogether. Likewise, mainstreaming HIV into Government multisector programmes has shown very slow progress; for example, prevention of mother-to-child transmission (PMTCT) has not been adequately mainstreamed into maternal and child health care.

Taken together, these issues present key constraints to effective planning and coordination of the national response, as well as to service delivery, availability of commodities, and issues of accountability. The low HIV prevalence in Bangladesh, low population estimate of people living with HIV, and competing health and social development challenges also all continue to represent risks to sustaining the current national AIDS response.

The rights of children, adolescents and women in Bangladesh are inextricably linked with the spread and impact of HIV on individuals and communities. A lack of respect for human rights fuels the spread and exacerbates the impact of the disease, while at the same time HIV undermines progress in the realisation of human rights for all. This link is apparent in the disproportionate incidence and spread of the disease among certain population groups in the country, including most-at-risk and extremely vulnerable adolescents, with profound implications for sustainable development. To further strengthen an equitable HIV response on behalf of children, adolescents and women, the following recommendations include:

<p><b>Policy/Strategy</b></p>	<p>Address policy and legal barriers to access to and use of HIV interventions, particularly by adolescents</p> <p>Support leveraging of the national budget, international funding and partnerships to scale up HIV interventions for children, adolescent key populations at risk of HIV, and HIV-positive pregnant women in high-risk populations</p>
<p><b>Institutions/ Governance</b></p>	<p>Support strengthening of NASP capacity in terms of human resources to manage the HIV response, coordinate multiple HIV stakeholders as well as non-HIV partners, and facilitate various advisory and coordination committees</p>
<p><b>Programme, Including Gender/ Adolescents/Child Marriage/Urban Slums</b></p>	<p>Support further mainstreaming of PMTCT into maternal, neonatal and child health care, including training of health workers</p> <p>Support universal testing of Syphilis and HIV at ANC with a goal of elimination of vertical transmission</p> <p>Promote provider-initiated HIV testing and counselling, particularly for exposed infants and children (including children affected by AIDS) in child health care settings and networks of people living with HIV</p> <p>Intensify C4D focus on uptake of protection, care and support practices for adolescents and youth; create awareness of and increase demand for quality services; address negative social norms, stigma and discrimination toward infected and affected youth and adults; and foster self-efficacy based on new knowledge acquisition that is critical for behavioural transformations</p> <p>Promote innovation in prevention, care and treatment, including the use of ICTs to address the identification, enrolment and retention of adolescents and women in high-risk populations in HIV programmes</p>
<p><b>M&amp;E/Data/ Knowledge Management/ Innovation</b></p>	<p>Support strengthened HIV M&amp;E and knowledge management, including standardised monitoring and reporting tools/systems on HIV and AIDS among adolescents/most-at-risk adolescents and children; support for a more effective, regular platform for sharing knowledge on HIV and AIDS-related matters; and investigation of further vulnerability and risk among adolescents exposed to new pathways of addiction</p>

### ***The Right to Education***

Overall, education indicators are improving, albeit sometimes slowly. Attendance in early childhood education remains very low, comprising only about 1 in 10 children. An inadequate understanding of child rearing and child development, especially the importance of early stimulation and learning, is compounded by insufficient development of ECCD services and inadequate relevant data. Pre-primary education is increasing but still low; slightly more than 40 per cent of children overall have the readiness to attend primary school. Among the poor, however, enrolment is far lower, at only 11 per cent. Only 1 in 3 children of primary school entry age have actually entered Grade 1 on time. Key early learning and pre-primary issues include an acute need for specialised human resource development, along with an

overall need for strengthened strategic planning and coordination in the sub-sector and enhanced parenting education.

Bangladesh has made significant progress in primary education for both girls and boys by increasing enrolment, closing the gender parity gap, and reducing the dropout rate, which nonetheless remains high. The Millennium Development Goal target for gender parity is considered to be achieved and now stands in favour of girls. About three-quarters of children attend primary school, and almost all reach the last grade of primary education. More than 7.9 million primary school children benefit from Government stipends for the disadvantaged, which are intended to target 40 per cent of the poorest families in the country, as well as children with disabilities. Further, decentralised school-level improvement planning has contributed to creating enabling school environments. Even so, children in the poorest households are twice as likely to suffer from education deprivation compared to those from the wealthiest households.

Strengthening learning outcomes represents the greatest challenge of primary education in Bangladesh, and an area that requires even further attention. Unqualified teachers and inadequate infrastructure, including numerous other factors, continue to affect the quality of learning in classrooms. In addition, while a nearly universal pass rate prevails from primary school, the pass mark is set at a low 33 per cent, so that it is recognised that the pass rate does not necessarily reflect the extent to which children are acquiring the expected competencies. In all, poor performance below grade levels represents a major cause of school dropout and repetition.

Teacher supervision, monitoring and accountability requires particular strengthening, given that Bangladesh has not had a system of pre-service primary teacher education/training. Most schools also run double shifts, which reduces contact hours of teachers and pupils in Bangladesh to only about half the international norm. Many primary schools also are still not able to maintain the standard student-teacher ratio of 46:1.

Critically, more than 1 in 4 children – some 6.2 million – are out of school, particularly in urban slums and hard-to-reach areas. As many as 45 per cent of children are out of school in the worst-performing sub-districts; this proportion not only clearly indicates poverty and deprivation in general, but also the need for strengthened quality of primary education. Bangladesh also has the highest proportion of children out of school at lower secondary level in the South Asian region. Nevertheless, precise information on second chance education/non-formal education (SCE/NFE) coverage is difficult to obtain. Illiteracy remains a major issue in Bangladesh and a significant constraint on development, signifying a key lost opportunity and the urgent need for additional emphasis on SCE/NFE; for example, 1 in 3 women who have completed primary education are still illiterate. National strategic direction and ownership of SCE/NFE represents a central issue.

At the same time, population trends because of declining fertility in Bangladesh – whereby growth will slow in the population younger than age 14 in the coming decades – will have important implications for education. Thus, education facilities may need to be adapted and reoriented to address the needs of older, secondary school-age children, whose numbers will still be rising. However, currently fewer than half of children of secondary school age attend secondary school or higher, while 33.7 per cent are still attending primary school. Convergence among different streams of secondary education (mainstream, vocational and religious) requires further support. Empowerment of adolescents to protect themselves from vulnerable circumstances and harmful social practices also will be critical, through the integration of Life Skills Based Education (LSBE) into the secondary school curriculum.

Despite some recent achievements, the concept and practice of inclusive education remain at a nascent stage of development in the country. Awareness and understanding of inclusive

education is limited, and does not fully encompass children with physical/intellectual disabilities as well as children with key social disabilities, e.g., poor or ethnic minority children. The mainstream school system particularly requires significant strengthening to meet the diverse needs of children with disabilities; a key issue is that of barriers to access and assistive devices.

Overall, strategic education priorities outlined in the national Vision 2021 remain relevant, and the long-awaited National Education Policy 2010 features cornerstones of inclusive learning opportunities for all; an integrated, unified system in which all students are exposed to shared knowledge; equity of approach to the school environment; and quality of learning. A new policy also exists to extend primary education from Grade 5 to Grade 8. However, no consensus yet exists on how to realise these and other education policies, with the expansion of primary education in particular expected to involve significant recurrent and capital expenditures.

Also in primary education, however, the Primary Education Development Plan 3 (PEDP3) offers a model of a largely successful sector-wide approach (SWAp) between donors and Government. In turn, it has contributed to a sense of momentum in the education sector and provided an opportunity to introduce more innovation and equity-focused design of interventions. Still, important delays in expenditure of the PEDP3 budget have occurred, affecting quality and involving substantial cost. The approved school effectiveness framework also presents a good decentralised planning model for school development planning that links school- and primary-level implementation plans to drive local-level planning; again, however, implementation is problematic. Critically, the primary education system remains highly fragmented; at all levels of education, inadequate and uneven coordination for effective management and monitoring poses a particular challenge.

Access to quality education is a fundamental human right and remains essential for the exercise of all other rights. It promotes individual freedom and empowerment and yields important development benefits; moreover, it is a powerful tool by which economically and socially marginalised people can participate fully as citizens. Yet millions of children, adolescents and adults in Bangladesh continue to be deprived of lifelong educational opportunities, many as a result of poverty. To move forward toward equitable education opportunities for all, recommendations include:

<p><b>Policy/Strategy</b></p>	<p>Support improved coordination at all levels for effective management and monitoring of the education sector</p> <p>Implement recommendations of National Policy on ECCD</p> <p>Support development of a SWAp-like mechanism to promote harmonised ECCD strategies for 3- to 6-year-old children</p> <p>Support the development of a national vision for SCE/NFE</p> <p>Support a secondary education SWAp to promote expanded secondary NFE/SCE</p>
<p><b>Institutions/ Governance</b></p>	<p>Support strengthened institutional capacities for sustainability of national programmes</p> <p>Support strengthened decentralised planning and decision making, school development planning and school quality standards</p> <p>Support regular resource allocations to ECCD in annual development plans</p>



	<p>Support the introduction of pre-service and strengthened in-service teacher training; continuous academic support and supervision at school cluster level; and strengthened child-centred classroom teaching/learning practices</p> <p>Support the development of an expanded NFE to Grade 8 and link with skills development/technical and vocational education and training (TVET)</p> <p>Support a flexible SCE/NFE model for working children</p>
<p><b>Programme, Including Gender/ Adolescents/Child Marriage/Urban Slums</b></p>	<p>Include hard-to-reach areas in programming</p> <p>Support further quality infrastructure development (WASH facilities et al.) to encourage the enrolment of girls and children with disabilities</p> <p>Support the strengthened quality of early learning and primary schools in urban slums, as well as linkages with SCE/NFE</p> <p>Support strengthened access to secondary education with expanded NFE</p> <p>Develop a partnership with the private sector for SCE/NFE apprenticeships, also serving as a catalyst for the prevention of child marriage</p> <p>Intensify implementation of C4D interventions to improve education sector priorities, including parenting education, reduction in dropout rates, enrolment rates, child-centred pedagogy and improved learning outcomes in relation to early childhood development and for those with disabilities; C4D will contribute to addressing the behavioural and social dimensions of education programmes through community engagement and social norm change among families and communities to create demand for quality education. Behaviour and social change principles will also be used to guide critical inputs into life skills education (e.g., individual decision-making, value development et al.)</p>
<p><b>M&amp;E/Data/ Knowledge Management/ Innovation</b></p>	<p>Track the internal efficiency of PPE programmes and support a PPE-related MIS</p> <p>Track the overall transition to secondary education and, in particular, girls' survival to secondary school completion to prevent child marriage</p> <p>Data generation to demonstrate contribution of C4D interventions, particularly on community engagement, including strengthening the role of School Management Committees</p>

## ***The Right to Be Protected and Respected***

Numerous issues of child protection, many of which often disproportionately affect adolescents, are found across the country. Overall, many key bottlenecks again relate to social norms, wherein the perception of what constitutes a “child” differs from the one implicit in the Convention on the Rights of the Child.

Persistent low rates of birth registration – such that some 10 million children younger than age 5 do not officially exist – make it difficult to protect children from child marriage and child labour. Many parents do not see the importance of reporting birth and obtaining certificates for their children within 45 days; they do so only when they need a birth certificate to prove the child’s identity and age, which is usually at the time of school enrolment at age 6.

Violence against children (VAC), including corporal punishment as an “educational” and disciplinary measure, remains widespread, with 66 per cent of children experiencing physical punishment; 1 in 4 children were subjected to severe punishment. Suicide remains the ultimate form of violence among children themselves, particularly adolescent girls, among whom more than 1 in 5 deaths are due to suicide.

Likewise, violence against women (VAW) remains the most extreme form of the continuing low status of women and girls. A nationwide survey identified that some 87 per cent of married women had experienced any type of violence by their current husband, although levels of reporting incidents remain very low. Nearly 1 in 10 women subjected to violence as an adult also had experienced violence as a child. Importantly, discrimination or violence against third-gender *hijra*, many of them adolescents, also is notable in the country.

The most common form of violence against women in Bangladesh is psychological violence, experienced by 90 per cent of women; this includes controlling behaviours such as trying to restrict a woman’s contact with her family of birth, insisting on knowing where she is at all times, often being suspicious that the woman is unfaithful, or being verbally abusive. Substantial proportions of women also experience physical, sexual and economic violence. Dowry remains a common form of violence against women, although prohibited by law; dowry demands that are not met may result in horrific consequences for the young bride, including stove burning, beating and acid attacks. Compared to other South Asian countries, Bangladesh also displays a much higher percentage of ever-married girls aged 15-19 who experience physical violence by their husbands or partners, at 40 per cent. However, most adolescent girls in particular who experience violence do not seek help.

As highlighted throughout the Situation Analysis, child marriage, while declining, continues to be widespread, with more than 1 in 3 girls aged 15-19 years already married. At the same time, sexual abuse of both girls and boys represents a largely neglected issue and requires urgent attention, affecting up to 16 per cent of girls and 7 per cent of boys. Girls who suffer rape and girls who consent to non-marital sexual relationships are similarly considered permanently “stained;” critically, rape taken to mean loss of “purity” and “honour” applies only to girls, and often is directly linked with child marriage. Meanwhile, both girls and boys also engage in sex work and are subject to sexual exploitation, an issue not only confined to brothels and the streets but also encompassing new forms of exploitation related to social media. Likewise, human trafficking, frequently resulting from poverty, is believed to be extensive both within Bangladesh and to other countries, including for sex work; convictions are difficult to obtain.



Meanwhile, millions of children in Bangladesh are denied an education and vulnerable to violence and abuse because of the persistence of child labour, particularly in Dhaka, where the proportion of working adolescents is more than three times the national average. At the same time, the magnitude of the current issue is somewhat obscured by the lack of a recent survey.

Refugee children, particularly Rohingya children, as well as ethnic minority children in hard-to-reach areas, face acute protection challenges. In addition, most of the services being developed in support of a comprehensive child protection system in Bangladesh also cannot yet address the various barriers faced by children with disabilities, representing an important equity gap. In addition, the Committee on the Rights of the Child has expressed concern over an apparently rising number of children living or working on the streets in urban centres, particularly Dhaka; recent data are lacking.

In all, child protection involves multiple complex systems, and Bangladesh has witnessed a large number of initiatives to safeguard and protect the rights of children. These include legislative reforms and strengthened coordination among various Ministries, departments and institutions. The passage of the Children Act 2013 in particular represents an important shift from a responsive child protection to a more proactive, rights-oriented effort supporting a continuum of care with more family- and community-based alternatives. The Government also has gradually developed a significant social protection and social welfare programme, with numerous programmes that affect children and women; nonetheless, efficient coverage of child-sensitive social protection programmes is far from universal, including among the extreme poor.

Overall, however, acute child protection institutional capacity issues exist, including in monitoring and accountability, with significant gaps in human resource. Similarly, the lack of Government resources has been a barrier to progress in piloting the transformation of institutions with the introduction of gatekeeping, minimum standards and revised guidelines. A critical risk exists that implementation of the Children Act 2013 will remain limited because of (1) a lack of dissemination and understanding by concerned professionals; (2) slow development of the Rules of the Act; and (3) unprepared systems, a need for strengthened political will, and resistance to undertake needed child protection system reforms. Meanwhile, various provisions in other existing legislation – in particular, the Child Marriage Restraint Act 1929 and the minimum age of criminal responsibility – require further harmonisation with international standards. At sub-national level, a key challenge is to extend the coverage of Community Based Child Protection Committees, which are helping to ensure that children at risk and in need of special protection are identified and referred to services at an early stage.

All children, adolescents and women have the right to be protected from violence, abuse and exploitation. While the direct impact of a society's failure to adequately protect its children is difficult to quantify and the impact on poverty is not directly documented, it is recognised that abuse, violence and exploitation of children are fundamental social problems that have implications not only for the well-being and rights of children, but also for the long-term well-being and stability of society as a whole. Creating a truly protective system is a highly complex undertaking. With that in mind, recommendations include:

<b>Policy/Strategy</b>	Support continuation of legal reform with regard to protection issues Support development of a Plan of Action to end child marriage by 2041
<b>Institutions/ Governance</b>	Facilitate strengthened coordination between health and birth registration sectors Coordinate, plan, develop capacity and release budget to help enforce the 2013 Children Act, ensuring a continuum of care, including availability of quality services, nationwide
<b>Programme, Including Gender/ Adolescents/Child Marriage/Urban Slums</b>	Provide children and adolescents with skills to cope with/manage risks and challenges and to seek appropriate support Educate families, caregivers and parents on their child's development and provide parenting skills Accelerate and extend implementation of C4D activities to strengthen social mobilisation and community engagement for social and behaviour change, abandonment of harmful social norms/practices, and adherence to the CRC Work with men and boys to reduce violence Promote greater protection for children with disabilities, especially girls; specifically invest in the education system to implement measures to eliminate physical punishment and inclusive education for children with disabilities
<b>M&amp;E/Data/ Knowledge</b>	Support increased accountability of duty bearers through a strengthened monitoring system
<b>Management/ Innovation</b>	Data generation to demonstrate contribution of C4D interventions, particularly analysing qualitative data on knowledge, behaviour and norms change process

## THE WAY FORWARD

Bangladesh has achieved major improvements in the lives of children, adolescents and women in recent decades – and has managed to achieve these successes in a relatively short time, and with comparatively small budgets in the social sector. Thus, Bangladesh's girls and boys, adolescents and women are generally better off today than their peers from a few decades ago. While considerable challenges remain, these are being increasingly recognised and addressed by the Government, communities, parents, families, the international community, and children themselves. Bangladesh must be encouraged to foster an ever-stronger commitment to development of its children. In so doing, the country can move a long way toward realising its ambitious hopes and vision.

Even so, from the analysis above it is clear that many of the development challenges that continue to face Bangladesh arise from the same or similar root causes, and that constraints to realisation of the full spectrum of rights among all of the country's children, adolescents and women remain profound.

Key structural causes of major disparities include, among others, (1) an acute need for systems/institutional strengthening, including at sub-national levels, to address insufficient capacities for equity-based planning, implementation, coordination and monitoring; (2) a strong need for a culturally sensitive transformation in social norms to eliminate harmful practices, and to ensure respect for the rights of all women, adolescents and children; (3)

the persistence of widespread poverty despite national economic progress, which continues to influence the life choices of many families; (4) a need to direct more substantive attention to quality services in disadvantaged areas lagging in human development, including urban slums and hard-to-reach areas; (5) inadequate knowledge and awareness, particularly at family level, on good household practices and their benefits; and (6) Bangladesh's continuing heightened vulnerability to disaster and ensuing emergencies.

At the same time, most of these challenges are complex, warranting comprehensive policies and robust implementation over a sustained period of time. This suggests that an integrated approach to Bangladesh's development needs among children and women would best serve the country in many cases. Priority will need to be given to the six emerging themes highlighted across all sectors, namely, systems/institution strengthening; promotion of local-level planning; mainstreaming gender; enhancing attention to adolescents; ending child marriage; and special attention to rapidly growing urban slums. In turn, these themes are drawn not only from this analysis but also are aligned with the Government's overarching Vision 2021 as well as the post-2015 global development agenda.

In all, these priority areas are intended to capture key development issues as well as broad and important immediate, structural and root causes – socio-cultural and behavioural, economic, institutional and those related to governance, and environmental – that form the basis of deeper themes of vulnerability. At the same time, it is also important to note that it is not that the structure, systems or legal provisions of Bangladesh are not changing; they are, sometimes even quite dramatically. What is at issue, however, is the very embeddedness of the analysed structural causes in everyday life, which still constricts social, economic, cultural and governance opportunities for significant numbers of children, adolescents and women in the country.

To address these broad areas, it will again be necessary to highlight the importance of context-responsive strategies that are tailored specifically to local realities as well as to disparities among and within Bangladesh's regions, socioeconomic groups, and others. In so doing, however, this can help to ensure that the well-being of all children, adolescents and women in Bangladesh, particularly those from disadvantaged and vulnerable groups, is enhanced to the maximum.



## Chapter 1

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# Introduction

Sustainable development, in Bangladesh as well as elsewhere, starts with safe, healthy, well-nourished and well-educated children and adolescents: Indeed, development during childhood<sup>2</sup> and adolescence<sup>3</sup> represents the basis for all human development. This means every child has the right to develop to her or his full potential. At the same time, any society has a corresponding obligation to ensure that no single moment of this unique period is lost.

As UNICEF Executive Director Anthony Lake has stated, “Investment in children is a fundamental means to eradicate poverty, boost shared prosperity, and enhance inter-generational equity. It is also essential for strengthening [children’s] ability to reach their potential as productive, engaged, and capable citizens, contributing fully to their families and societies.”<sup>4</sup>

Perhaps the most important years for a child’s survival, growth and development are from even before conception through the transition to school, with the fastest period of growth occurring during the first 3 to 4 years of life, when the child’s brain is rapidly adapting to the environment. During this period, the developing brain is most sensitive to risks of malnutrition, toxins, stress, or lack of nurturing and brain stimulation.

However, poverty, malnutrition, micronutrient deficiencies, and learning environments that do not provide enough responsive stimulation all provide formidable challenges. Up to 200 million young children, including in Bangladesh – more than 1 in 3 children globally who are

<sup>2</sup> The Convention on the Rights of the Child defines childhood, from birth to age 18 years, as a “separate space” from adulthood and recognises that what is appropriate for an adult may not be suitable for a child. It further recognises that children are the holders of their own rights and are therefore not passive recipients of charity, but rather, empowered actors in their own development. Overall, development during childhood refers to the ordered emergence of interdependent skills of sensory-motor, cognitive-language, and social-emotional functioning. This emergence depends on, and is interlinked with, the child’s good nutrition and health. The World Fit for Children document, adopted by the United Nations General Assembly in May 2002, states: “... Children should be physically healthy, mentally alert, emotionally secure, socially competent, and ready to learn.”

<sup>3</sup> Adolescence is defined as the second decade of life, ages 10-19 years.

<sup>4</sup> UNICEF, Sustainable Development Starts With Safe, Healthy and Well-Educated Children. New York, May 2013.

younger than age 5 – are developing more slowly, or failing to develop, critical thinking and learning skills.<sup>5</sup> After their last immunisation, many young children around the world may not even be reached by social services until they enter school, resulting in missed opportunities.

Later, adolescence is an equally key transitional period, separate from both childhood and adulthood; again, in Bangladesh, it requires special attention and protection (see also Section 2.4.4 and Chapter 7). Apart from the physical transitions children experience as they mature, the brain again undergoes quite substantial developments in early adolescence, which affect emotional skills as well as physical and mental abilities. As adolescent girls and boys grow, they take on additional responsibilities; adolescence is likewise a time in which values and skills are developed that have great impact on well-being, with the potential to break longstanding cycles of poverty, discrimination and violence. Even so, young adolescents in particular (ages 10-14) are often invisible in discourse and data, falling between policies and programmes focused on “children” and “youth.”<sup>6</sup>

Yet no aspect of childhood occurs independently. For the most disadvantaged and vulnerable children and adolescents, any deficit thus has a multiplying effect: children raised in poverty, for example, generally complete far less education than those from middle-income families, due in part to their lowered ability to learn in school. At the same time, many challenges exist to putting the concept of a holistic or integrated approach to children’s rights into practice, including in Bangladesh. Decision makers and families alike often do not understand the “cost” of non-achievement of children’s rights for society at large.

A number of conditions have been identified under which such a holistic approach is more likely to be effective,<sup>7</sup> including:

- National and local governments and civil society have knowledge, experience and capacity in child-friendly programming
- Service delivery systems are in place and are functioning effectively
- Relevant policy development is under way, or there are child- and gender-sensitive policies in place
- Decentralisation of resources and responsibilities results in strong local authority and decision making
- The focus is on particularly vulnerable/disadvantaged or marginalised populations
- Political support comes from a level higher than a particular Ministry
- Overall interest exists in supporting child health/survival, nutrition, education, protection, and water, sanitation and hygiene (WASH) services
- Government officials and international partners understand and can articulate clearly the role of fulfilment of children’s and women’s rights in poverty reduction
- The family and community are seen as active partners, and there exists recognition that a strengthened family or community can have a number of positive effects on children
- The Government uses the Convention on the Rights of the Child (CRC) and other rights instruments in making decisions about programming and policies for children
- The Government ensures that the activities and operations of business enterprises do not adversely affect children’s rights<sup>8</sup>

Bangladesh offers many of these enabling conditions, while more needs to be done with regard to others. The challenge now will be for the country to adopt best practices and

5 UNICEF, *State of the World’s Children 2006*. New York, 2006.

6 Youth are generally defined by the United Nations as ages 15-24.

7 UNICEF, *Programming Experiences in Early Child Development*. New York, November 2006.

8 See further: Committee on the Rights of the Child, General Comment No. 16 (2013), on State obligations regarding the impact of the business sector on children’s rights. UN Doc CRC/C/GC/16, 17 April 2013.



programme models to ensure that all children, especially those most vulnerable and disadvantaged, can thrive. For impact and efficacy, sectors need to increasingly work together where there is potential for real synergy. Combined with holistic programming for children and women, this can ensure the most positive and equitable development results.

## 1.1 OBJECTIVES AND CONCEPTUAL FRAMEWORK OF THE SITUATION ANALYSIS

The UNICEF Bangladesh Country Office (BCO) is undertaking to prepare its new Country Programme of Cooperation 2017-2020 with a view to inform and sharpen further key interventions on behalf of all girls and boys in Bangladesh, especially the most vulnerable and disadvantaged. This Situation Analysis 2015 is intended to be a key part of the new Country Programme process, analysing the situation of children and women with a rights-based, equity-focused and gender-sensitive approach. In particular, it builds on the Mid Term Review (MTR) of the current Country Programme 2012-2016, held in mid-2014, which involved an extensive review of secondary data both from surveys and administrative sources. In turn, the MTR identified levels of coverage of key interventions for priority sectors and further helped to identify bottlenecks and barriers for increased effective coverage.

The Situation Analysis thus provides a comprehensive analysis that develops an updated baseline of information for the realisation of the rights of children and women in Bangladesh, with the goal of having this analysis prepared again in four to five years' time. It synthesises new statistics, national policies, laws and trends, and new research since the previous UNICEF Situation Analysis in 2009, with special attention to the latest Multiple Indicator Cluster Survey (MICS 2012-2013) and Demographic and Health Survey (DHS 2014).

The Situation Analysis particularly seeks to strengthen the knowledge of UNICEF and partners on how Bangladesh – with its ambitions to attain Middle Income Country (MIC) status by the end of the next UNICEF Country Programme cycle in 2021 – can translate rapid economic growth into improved and equitable outcomes for children and women. It examines to what extent all children in Bangladesh, including the most vulnerable, are able to enjoy their rights as established by the CRC, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Convention on the Rights of Persons with Disabilities (CRPD) and other major international standards, agreements and Conventions.

Not only does the Situation Analysis use the CRC and CEDAW as essential references, but it also is guided by basic rights principles of universality, equality, non-discrimination, accountability and participation. It particularly takes into consideration the UNICEF Regional Knowledge and Leadership Agenda; this agenda focuses on reducing equity gaps across a wide range of issues in the areas of health, nutrition, education, child protection, WASH and prevention of HIV/AIDS.

Critically, findings of the Situation Analysis are expected to contribute to accelerated progress toward achievement of the Sustainable Development Goals (SDGs) for all children in Bangladesh over the period 2017-2021. As such, the Situation Analysis not only informs the new UNICEF Country Programme, but also provides evidence on persistent inequities and makes the most disadvantaged and vulnerable young children more visible for the purposes of policy decision making, legislation, budgeting and national research.

In all, the Situation Analysis attempts to begin to answer the question: where and how can UNICEF have the most impact on development progress for children, adolescents and women in Bangladesh? It thus forms a basis for adjusting UNICEF programme interventions and strategies to ensure that programmes and policies remain relevant to the lives of girls and boys as well as women, and especially the most vulnerable and disadvantaged among these groups. In turn, this will ensure that programmes and policies are likely to achieve the desired impact.

## 1.2 METHODOLOGY AND STRUCTURE OF THE SITUATION ANALYSIS

To carry out a comprehensive Situation Analysis, more than 250 primary and secondary data sources were used to better understand the state of children's and women's rights in the country, including the immediate, underlying and structural causes preventing the realisation of these rights. Efforts have been made to rely on official Government data and analysis to the extent possible. The Situation Analysis has further supplemented this review and analysis by engaging key partners and UNICEF staff in May 2015 to elicit their perspective on specific issues facing children and women (see also Annex 1 for full list of persons interviewed). These views are used particularly to contextualise secondary data, and to contribute to the analysis of role patterns and common capacity gaps among duty bearers at family/household, community, sub-national and national levels, as well as among international partners and the private sector (see also Annexes 2, 3, 4, 5, 6 and 7).

Nonetheless, some limitations to development of the Situation Analysis must be noted: First, not all data sources were consistent, up to date or sufficiently disaggregated yet, reflecting a continuing need for strengthened data collection with regard to children (see also Sections 2.2.2 and 2.4.1). Second, a number of the capacity gaps noted among duty bearers in sectoral capacity gap and role pattern analysis merit further study. Third, it was generally not possible for children themselves to contribute substantively to the Situation Analysis, although their views will continue to be proactively sought throughout the new UNICEF Country Programme cycle.

Chapter 1 has introduced the purpose of the Situation Analysis and the methodology for preparing this document. Chapter 2 comprises a brief synopsis of Bangladesh's development context, including a national overview of child and family needs, relevant trends, and status of children by region, rural/urban status, gender, wealth quintile, and other dimensions as available. Demographic profiles and trends, along with brief overviews of the country's economic and human development, are highlighted. A special section examines the role of social and cultural norms in influencing the lives of children and women, given its prominence in Bangladesh.

Critically, particular focus is given to six key crosscutting and interlinked development themes that are emerging as priorities for the realisation of children's and women's rights in Bangladesh during 2017-2021, and that form the "spine" of this Situation Analysis. These are:

- Strengthening systems and institutions
- Embedding effective planning and monitoring at the local level
- Mainstreaming gender and empowering women
- Empowering adolescents
- Ending child marriage
- Improving social services and opportunities for children and women in urban slums

In keeping with the first two of these six key themes, Chapter 3 presents the overall policy and governance context of children's lives, which underlies so many of the development opportunities and challenges in the years ahead. This leads to sectoral analyses of the status of children and their families, including causality analyses linked to overall structural causes and recommendations based upon the analysis as a whole. Chapter 4 focuses on the right to food and adequate nutrition health, while Chapter 5 highlights the right to health and survival for children, including issues of health, water, sanitation and hygiene, and HIV and AIDS. In Chapter 6, the right to education takes centre stage with an examination of education in Bangladesh from pre-primary through primary, secondary and Second Chance Education/Non Formal Education. Chapter 7 focuses on the right to be respected and protected, examining the many forms of protection issues for children and women in the country. Lastly, Chapter 8 offers a short conclusion and analysis of the way forward.



## Chapter 2

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# Development Situation of Bangladesh

As the sections below illustrate, Bangladesh has made remarkable development progress in a comparatively short period of time. Progress has been particularly impressive in terms of reducing headcount poverty and under-5 mortality rates (U5MR); using Government figures, it appears that the country has met both the relevant Millennium Development Goal (MDG) targets. Other areas of positive progress include primary school enrolment, gender parity in primary and secondary education, significantly reducing open defecation, and improving immunisation coverage.

Yet the question of whether Bangladesh is achieving progress with equity remains key. Overall, Bangladesh is classified as a country of “high inequity,” with a Gini coefficient of 0.46. Wide disparities at sub-national levels also are evident in the effective coverage of basic social services at disaggregated levels, as is highlighted throughout the Situation Analysis, by rural/urban location, by geographic region, by gender, and by wealth, among other factors. For example, in one recent study the rates of female child workers (not attending school) range from 0.1 per cent in one *upazila* (sub-district) to 27 per cent in another – a factor of 270 times’ difference within the same country.<sup>9</sup>

With few exceptions, the whole western and southern parts of the country are above average in performance on development indicators, while the northern and eastern parts often fall in the more deprived regions, particularly on social indicators.<sup>10</sup> Nearly 1 in 3 of the country’s *upazilas* (29 per cent), for example, are classified as “most deprived,” as are nearly 1 in 4 districts.<sup>11</sup> The best-performing districts are located around Khulna and Barisal Divisions, compared to Sylhet Division, which visibly lags behind;<sup>12</sup> development progress

9 Bangladesh Bureau of Statistics, Bangladesh Institute of Development Studies and UNICEF Bangladesh. *Child Equity Atlas: Pockets of Social Deprivation in Bangladesh*. Dhaka, October 2013 (hereafter Child Equity Atlas).

10 Ibid.

11 Ibid. A total of 90 “high deprivation” *upazilas* were identified; combined with the 50 “highest deprivation” *upazilas*, this comprises a total of 140 out of 483 *upazilas*. Among districts, 15 out of 64 (23 per cent) are considered “most deprived.”

12 Ibid. Sylhet’s Sunamganj District records all 11 of its *upazilas* as being among the “most deprived.”



also has been least in the most deprived areas (see also Section 2.5.3). In recognition of this, the United Nations Development Assistance Framework (UNDAF) 2012-2016 for Bangladesh identifies the reduction of socioeconomic inequalities as the main driver of positive development change for the country.<sup>13</sup>

For children, development with equity represents a major element of the CRC and other international human rights instruments. But as noted above, where children are born or live within Bangladesh, among other factors, underscores the notion of “different worlds” in terms of access to certain services (see Box 1 below). However, with the post-2015 development era unfolding, it is becoming ever clearer that reaching the poorest, most disadvantaged and most vulnerable children, along with their families and communities, will be pivotal to realisation of the new SDGs and, more broadly, to achieving a socially fair, politically stable and economically strong societies. This imperative underpins all aspects of the following analysis.

### Box 1: Two Different Worlds: Children in the Least and Most Deprived Upazilas

As with many countries, social deprivation in different geographic regions of Bangladesh varies significantly. This gulf is evident when the most deprived upazila in just one Division (Chittagong), Alikadam upazila in Bandarban District, is compared to the least deprived, Boalkhali upazila of Chittagong District. Progress in some indicators in Alikadam is half as good as in Boalkhali – or far less – a reality faced by children and their families due to circumstances of birth or place of abode.

Comparison between the most and the least deprived upazilas of the same Division

Indicators (%)	Alikadam Upazila	Boalkhali Upazila
Children under 18	48	39
Teenage marriage	32	15
Youth literacy	43	83
Female adult literacy	25	61
Out-of-school children	39	16
Net Attendance Rate (NAR), secondary level	29	59
Real child worker	21	2.2
No sanitary toilet	76	17
No electricity connection	84	12
Number of deprivations	7	0

Source; Child Equity Atlas, October 2013

<sup>13</sup> United Nations in Bangladesh and Government of Bangladesh. *United Nations Development Assistance Framework (UNDAF) for Bangladesh 2012-2016*. Dhaka, 2012 (hereafter UNDAF).

## 2.1 DEMOGRAPHIC PROFILE AND TRENDS

The greatest asset for Bangladesh going forward is its people, especially its population of children. Already the country comprises more than 150 million people,<sup>14</sup> of whom about three-quarters still live in rural areas. Bangladesh thus is the seventh most-populous country globally. Life expectancy has increased, with females achieving larger gains than males in recent years; in 2011, female life expectancy reached 70.3 years, compared to 67.9 years for males, a gap of 2.4 years that is similar to that found in developed countries.<sup>15</sup> This represents an impressive improvement over the figures of 47 and 49 respectively in 1970,<sup>16</sup> recorded just before Bangladesh gained independence in 1971.

Almost 62 million of Bangladesh's people – nearly 40 per cent – are younger than age 18 years, with some 16.3 million (10.5 per cent) younger than age 5.<sup>17</sup> The proportion of children is much higher in the eastern parts of the country – broadly, in Chittagong and Sylhet Divisions – than in the western and central areas;<sup>18</sup> this is largely congruent with the increased levels of deprivation illustrated in the introduction to Section 2 above, as well as in Section 2.5.3. Unlike other countries in South Asia, Bangladesh's predominantly rural society has a high degree of linguistic, religious and ethnic homogeneity.<sup>19</sup> Small ethnic minorities (tribal groups) and a large Hindu minority also are found.<sup>20</sup>

Bangladesh is particularly notable for its very high population density: At 976 persons per square kilometer in 2011<sup>21</sup> and 1,015 in 2014,<sup>22</sup> this was up significantly from an already-dense total of 839 in 2001.<sup>23</sup> As such, Bangladesh is the most densely settled country in the world apart from city-states such as Singapore or Hong Kong.<sup>24</sup> In parts of Dhaka District, the capital, the population density is an extremely high 8,229 persons per square kilometer, compared to 87 people per sq.km in Bandarban District.<sup>25</sup> Density also is particularly high in districts where the soil can best support intensive agriculture.<sup>26</sup> However, these acute population pressures, among many other factors, also have led to accelerating migration to urban areas (see also Section 2.4.6), as well as movement to less densely populated rural and marginal lands, including disaster-prone and climate-stressed regions (see also Section 2.5.2).

Crucially, Bangladesh, although still a country with many poor people, has managed in part to break the cycle of high mortality, high fertility and continued impoverishment and to achieve a key demographic transition. In particular, a demographic breakthrough has occurred<sup>27</sup> in reduced fertility, which has helped to propel substantially improved socioeconomic conditions overall (see also Section 2.2.1). The total fertility rate (TFR) of 2.3 births per woman in 2014 is the same as in 2011,<sup>28</sup> but represents a major decrease from barely a decade earlier, given that the TFR had stalled in the range of 3.3-3.4 for the second half of

14 The Demographic and Health Survey (DHS) 2014 found an estimated population of 156,511,000. The latest Population and Housing Census, in 2011, enumerated 144,043,697 people at all disaggregated levels, including 72,109,796 males and 71,933,901 females.

15 Planning Commission of Bangladesh and UNFPA Bangladesh. *The Impact of the Demographic Transition on Socioeconomic Development in Bangladesh: Future Prospects and Implications for Public Policy*. Dhaka, May 2015 (hereafter DIS).

16 Ibid.

17 National Institute of Population Research and Training (NIPORT) et al. *Bangladesh Demographic and Health Survey 2014*. Dhaka, April 2015 (hereafter DHS 2014).

18 Child Equity Atlas, op.cit.

19 World Bank. *Whispers to Voices: Gender and Social Transformation in Bangladesh*. Dhaka and Washington, D.C., March 2008 (hereafter Whispers to Voices).

20 Ibid.

21 Population and Housing Census 2011.

22 DIS, op.cit.

23 Population and Housing Census 2011.

24 DIS, op.cit.

25 Child Equity Atlas, op.cit..

26 DIS, op.cit.

27 Ibid.

28 DHS 2014, op.cit.

the 1990s and up to 2000. Moreover, it is a huge decline from the average of about 7 births per woman that predominated as recently as the early 1970s.<sup>29</sup>

Although the peak childbearing age has remained in the age group 20-24, the largest absolute change in fertility also occurred in this age group, declining from 192 births per 1,000 women in the DHS 2004 to 143 births per 1,000 women in the DHS 2014. Fertility rates vary widely according to geographic location, from 2.9 in Sylhet to 1.9 in both Khulna and Rangpur. In addition, women with no education have a TFR of 2.9, compared with 1.9 for those with completed secondary education or higher. Women in the top wealth quintile also have a TFR of 1.9, compared to 3.1 for women in the lowest quintile.<sup>30</sup> Between rural and urban areas, disparities are narrower, at 2.4 vs. 2.0 respectively.<sup>31</sup>

Even so, the annual increase in population reached nearly 2 million persons per year between the national population censuses of 2001 and 2011,<sup>32</sup> representing the continued considerable impact of population momentum on national development. Further, this population growth rate is expected to persist for some time to come, with expected negative impacts on rates of landlessness and agricultural productivity, among others, making the need to achieve even lower fertility rates acute.

National population projections for the year 2061 range from 201.1 million to 265.2 million people;<sup>33</sup> regardless of whether a “low” or “high” scenario is used, it seems evident that Bangladesh will reach the 200 million mark. While the elderly population is expected to be the age group increasing most rapidly, the youth population<sup>34</sup> is expected to expand in two “wave-like” patterns, with the first occurring from now until about 2026.<sup>35</sup> Potentially as soon as 2041, the population density in the whole of Bangladesh could reach more than 1,520 persons per sq. km., presenting an even more formidable development challenge.<sup>36</sup>

Taking full advantage of the current “demographic dividend”<sup>37</sup> thus is urgent for Bangladesh, given that such a dividend is believed to be ending between 2021 and 2031.<sup>38</sup> It will be necessary to pursue appropriate policies and development strategies, particularly those affecting children and women; for example, human resource development will imply greater investment in education, and particularly in technical and vocational training to build employment skills.

In all, Bangladesh has been virtually unique in lowering fertility to near-replacement levels while close to half the population was living in poverty for much of that period (see also Section 2.2.2).<sup>39</sup> Yet the challenges ahead remain daunting.

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29 DIS, op.cit.

30 Ibid.

31 DHS 2014, op.cit.

32 Population and Housing Census 2011.

33 DIS, op.cit.

34 Defined as the age group 15-29 years.

35 DIS, op.cit.

36 Ibid.

37 The accelerated economic growth that may result from a change in the age structure of the population.

38 DIS, op.cit.

39 Ibid.

## 2.2 RECENT SOCIOECONOMIC DEVELOPMENT TRENDS AND CONTEXT OF THE POST-2015 DEVELOPMENT AGENDA

### 2.2.1 Bangladesh's Economic Development: A Brief Summary

Between the 1980s and the 2000s, Bangladesh's Gross Domestic Product (GDP) increased by a factor of four, with annual economic growth rates reaching more than 6 per cent in both 2012-2013 and 2006-2007. In real terms, per-capita GDP increased from US\$206 in 1980 to US\$1,044 in 2014.<sup>40</sup> Indeed, over the years, the country's GDP growth has proven resilient to global shocks, natural disasters and political turmoil.<sup>41</sup> Bangladesh's Gross National Income (GNI) places it among the 25 largest developing countries in the world,<sup>42</sup> and the Government's Vision 2021 details the aspiration for national graduation to middle-income status by 2021. Despite slower projected growth in fiscal 2015,<sup>43</sup> observers frequently attribute Bangladesh's recent positive economic trends to:<sup>44</sup>

- The process of structural economic reforms beginning in the 1980s, which improved the efficiency of banking, telecommunications, aviation, the media and jute production through private sector development
- Emergence of a large-scale, export-oriented garment industry, facilitated by Bangladesh's ability to supply inexpensive factory labour,<sup>45</sup> a development viewed by some as a comparative advantage, and by the liberalisation of the textile trade
- Development of microcredit through the country's numerous non-Government organisations (NGOs; see also Chapter 3), stimulating rural entrepreneurship, especially among women
- The advent of large-scale international contract labour migration, which resulted in large remittance flows that provide a significant boost to domestic consumption
- Development and expansion of new industries, including shipbuilding, telecommunications, pharmaceuticals, ceramics, and Information and Communications Technologies (ICTs)
- Considerable foreign bilateral and multilateral assistance and Foreign Direct Investment (FDI) in export processing zones

Bangladesh has become the second-largest readymade garment (RMG) manufacturer in the world, after China; the industry generated nearly 80 per cent of total national export earnings in 2011, with a value of US\$16 billion in 2009-2010. In contrast, agriculture's share of GDP stood at about 18 per cent. Employment in the industry's approximately 3,500 factories is estimated to support more than 25 million people either directly or indirectly, particularly women and children.<sup>46</sup> In 2014, the Government and the Bangladesh Garment Manufacturers and Exporters Association announced ambitious targets to expand the sector from \$24 billion in 2012 to \$50 billion by 2021. The direct, indirect and cumulative impacts of the RMG sector on children's rights in Bangladesh are significant,<sup>47</sup> and an

40 Bangladesh Bureau of Statistics. *National Accounts Statistics (Provisional Estimates of GDP 2012-2013 and Final Estimates of GDP 2011-12)*. Dhaka: 2013.

41 World Bank. *Bangladesh Development Update (Annex 1)*. Dhaka, April 2015 (hereafter Bangladesh Development Update).

42 World Bank, *Towards Accelerated, Inclusive and Sustainable Growth – Opportunities and Challenges*. Dhaka and Washington, D.C., September 2012.

43 World Bank, Bangladesh Development Update, op.cit.

44 DIS, op.cit.

45 The monthly minimum wage for unskilled garment workers is less than US\$70 in Bangladesh. In Cambodia, Pakistan and Viet Nam, the comparative rates range from US\$85 to US\$128, much less than the lowest relevant minimum wage in China (US\$156). ILO Regional Office for Asia and the Pacific, Regional Economic and Social Analysis Unit (RESA), "Global Wage Report 2014/15: Asia and the Pacific Supplement." December 2014, available at: [http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-bangkok/documents/publication/wcms\\_325219.pdf](http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-bangkok/documents/publication/wcms_325219.pdf)

46 UNICEF Bangladesh. *Urban Programming in Bangladesh: Draft Guidance Note*. Dhaka, 2015 (hereafter Urban Programming). The Bangladesh Garment Manufacturers and Exporters Association presently claims a membership of around 4,200 RMG factories. The International Labour Organization (ILO), meanwhile, estimates that there are about 3,500 export-oriented RMG factories in Bangladesh.

47 UNICEF and BSR. *Impacts of the Garment Sector on Children's Rights in Bangladesh*. (Forthcoming, 2015).

urgent need exists to ensure that planning for growth also considers the impact of the industry on children's and women's rights alike.

Critically, Bangladesh has made significant progress in poverty reduction through broad-based development on a number of fronts, although the number of persons considered to be poor in the country varies widely with the definition of poverty (see also introduction to Chapter 2 and Section 2.2.2). At the same time, clear evidence exists of increasing rural landlessness and the decreasing size of landholdings among those with land.<sup>48</sup> Importantly, continued political polarisation likewise has been identified as a major source of uncertainty for Bangladesh's otherwise favourable economic outlook, with the potential for a heavy economic toll.<sup>49</sup>

Despite the decline in poverty overall, some aspects of income inequality have worsened over the past two decades, as reflected in the Gini coefficient (see also introduction to Chapter 2). The share of the poorest quintile in national income declined from 6.5 per cent in 1991-1992 to 5.2 in 2010, and a similar decline is evident in both rural and urban areas.<sup>50</sup> These data suggest that the poor are getting poorer relative to other income groups, with profound implications for the situation of children and women.

The growth rate of the working-age population since 2000 has exceeded the overall population growth rate because of the relatively high proportion of young people. Labour force absorption in Bangladesh has been inadequate in recent decades, leading to high rates of underemployment or unemployment; male underemployment rates in particular have doubled. In addition, employment remains overwhelmingly in the informal sector, at 87.5 per cent in 2010. Self-employed workers, the dominant group, declined somewhat, from 47 per cent in 2000 to 41 per cent in 2010. However, with continued population growth and the static supply of land noted above, a significant proportion of the rural labour force (around 23 per cent) remains poorly paid day labourers,<sup>51</sup> meaning that many families struggle to make ends meet.

Although much of the rise in overall labour force participation has been due to the greater participation of women, further increasing female participation in the labour force still represents a particularly urgent need (see also Section 2.4.3). Unless employment opportunities for a growing working-age population, including women, can be improved, the economic gains of the current demographic dividend are likely not to be realised. Overall, it has been estimated that raising the low female labour force participation rate to the same level as male participation – currently 82 per cent – within 10 years would boost the potential GDP annual growth rate by about 1.8 percentage points.<sup>52</sup>

Key challenges with regard to opportunities for formal-sector employment will be to ensure job-rich economic growth and the availability of decent work, and to find productive niches in the industrial sector outside of the successful RMG and construction industries, in which Bangladesh's comparative advantage, as noted above, is predicated on inexpensive labour and very low wages.<sup>53</sup> Job-friendly growth had appeared to be gaining momentum until the resurgence of political turmoil in January 2015, when supply chains across the country were severely disrupted, dampening growth prospects and fuelling fears of heightened inflation.<sup>54</sup>

48 Mahbub, A.Q.M. "Population Redistribution and Migration in Bangladesh: Prospects and Challenges of Sustainable Development" (PowerPoint presentation to the Planning Commission of Bangladesh). Dhaka, June 2014.

49 World Bank, Bangladesh Development Update, op.cit.

50 DIS, op.cit.

51 Ibid.

52 Ibid.

53 ILO Regional Office for Asia and the Pacific, op.cit.

54 World Bank, Bangladesh Development Update, op.cit.



Meanwhile, in 2010 between 10 and 16 per cent of Bangladesh's labour force was working abroad, reflecting an alternative and more lucrative form of labour absorption to local employment. These workers provide a flow of remittances that have had significant economic impact, particularly in the reduction of poverty. Evidence shows that remittances have substantially augmented household incomes, consumption and savings, and allowed households to attain better nutrition, education, health care, and housing.<sup>55</sup> At the same time, Bangladeshi migrants themselves face a range of challenges, including high fees charged by recruitment agencies; low wages, discrimination, exploitation and abuse by employers; and insufficient protection services.<sup>56</sup>

An idea of the importance of reported remittances to the Bangladesh economy as a whole, and to families in particular, can be obtained by the fact that in fiscal 2013 recorded remittances, at up to US\$14.5 billion, were equivalent to 60 per cent of earnings from garment exports and 53 per cent of total exports.<sup>57</sup> They also were equivalent to 11 per cent of GDP that year.<sup>58</sup>

Estimates suggest that a large proportion of migrant remittances to Bangladesh are channelled through the *hundi* system of transferring money and goods, which works by means of trusted individuals with strong family or community ties receiving money from migrants abroad to be delivered to relatives at home through a network of agents. If these informal transfers are taken into account, the magnitude of remittance flows on the national economy – and on families – would be even more significant.

## 2.2.2 Bangladesh's Human Development: A Brief Summary

Investment in human development and improvements in social protection have complemented economic reforms in Bangladesh over the years, and the very large network of NGOs as service providers has helped carry the development agenda forward (see also Chapter 3). Even so, the fast rate of economic development risks outpacing the country's human development and social change. For Bangladesh to harness the benefits of becoming a middle-income country by 2021, growth needs to continue, but in an inclusive, equitable and sustainable manner.

Bangladesh's performance in the global Human Development Index (HDI) is similar to its results with regard to poverty reduction (see also introduction to Chapter 2), showing a 46 percent improvement between 1990 and 2013.<sup>59</sup> Recent trends based on progress toward the MDGs and similar indicators show that Bangladesh compares favourably with neighbouring countries in South Asia. Yet despite this improvement, Bangladesh remains near the bottom of the "medium human development" category, and it was ranked 142<sup>nd</sup> out of 187 countries in 2014, tied with Sao Tome and Principe. In addition, Bangladesh recorded a 29.1 per cent loss in human development due to inequalities in health, education and income, notably more than the 22.9 per cent found worldwide.<sup>60</sup>

As highlighted in the introduction to Chapter 2, Bangladesh has met or nearly met several targets of the MDGs, including reducing under-5 mortality by two-thirds and reducing poverty by half. Achieving gender parity in primary and secondary education, containing HIV infections, ensuring more under-5 children are sleeping under insecticide-treated bed nets, and detection of and raising the cure rate for tuberculosis represent further

55 DIS, op.cit.

56 ILO. "Labour Migration," accessed at: <http://www.ilo.org/dhaka/areasofwork/labour-migration/lang-en/index.htm>.

57 Ibid.

58 Rahim, S.A. and Alam, M.A. "Foreign Remittance Income in Bangladesh: Opportunities and Challenges," in *Asian Business Review*, Vol. 2, No. 2. Dhaka, 2013.

59 UNDP. *Human Development Report 2013*. New York, 2014 (hereafter HDR).

60 Ibid. Inequality-adjusted HDI data.

MDG successes for the country. In addition, Bangladesh has made progress in the areas of reducing the prevalence of underweight children, increasing primary school enrolment, lowering the Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR) and improving immunisation coverage.<sup>61</sup>

On the other hand, areas in need of greater attention, among others, include reducing overall child undernutrition; increasing primary school completion and adult literacy rates; generating employment and creating decent wage work for women in particular; increasing appropriate levels of antenatal care (ANC) and the presence of skilled health professionals at delivery; expanding correct and comprehensive knowledge on HIV/AIDS; increasing forest coverage; and broadening ICT coverage. This is further illustrated in detail in the sections below, as well as in the sectoral analyses in Chapters 4, 5, 6 and 7.

Estimated Government figures suggest that the MDG target of halving the population living below the poverty line, from 56.7 per cent in 1990 to 29.0 per cent, has been achieved by 2012.<sup>62</sup> Nonetheless, determining the poverty rate is highly complex, and highly dependent on the definition of poverty: For example, according to the national definition of poverty (living on less than US\$1.09 per day), the proportion of poor people fell to 31.5 per cent in 2010, the latest year for which comparative data are available. About 18 per cent of the people remained extremely poor. However, moving from the national poverty line of US\$1.09 per day to the international standard for extreme poverty of US\$1.25 a day raises Bangladesh's poverty ratio to 43.3 per cent, nearly double the 24.5 per cent for South Asia as a whole.<sup>63</sup> Using a US\$2-per-day standard, 76.5 per cent of Bangladesh's population was still poor in 2010, a much higher figure and illustrative of the continuing acute vulnerability of many families in the country. All forms of poverty tend to be lower in urban areas as a whole, with a faster rate of decline than in rural areas.<sup>64</sup>

Poverty rates also vary by geographical area, and reflect the east-west divide noted in the introduction to Chapter 2 in terms of overall development. At the Division level, Barisal and Rangpur had the highest poverty rate in 2010, and Chittagong and Sylhet had the lowest; these Divisions also have the highest rates of extreme poverty. Poverty declines sharply as educational status rises: for example, the incidence of poverty is about six times higher among those with no education than those with completed secondary education and higher education.<sup>65</sup>

Recent revisions by the Asian Development Bank in 2014 to the measure of poverty in Asia, including consideration of food insecurity and vulnerability to shocks arising from drought, flood, earthquakes, storms and economic crises, indicate that as of 2010 Bangladesh had the highest poverty rate of any country in the Asia-Pacific region.<sup>66</sup> Critically, the United Nations Development Programme's (UNDP) Multidimensional Poverty Index (MPI), suggests that 60 per cent of women, men and children live in households experiencing "multiple deprivations," including in health, education and living conditions.<sup>67</sup>

61 United Nations. *Millennium Development Goals Report 2014: Bangladesh*. New York, 2014 (hereafter Global MDGR).

62 Planning Commission. *Millennium Development Goals Bangladesh Country Report 2013*. Dhaka, 2013 (hereafter National MDGR).

63 World Bank. "World Bank Data Bank," accessed at <http://data.worldbank.org>.

64 DIS, op.cit.

65 Ibid.

66 Asian Development Bank. "Key Indicators for Asia and the Pacific," accessed at [http://www.adb.org/sites/default/files/publications/43030/ki2014\\_0.pdf](http://www.adb.org/sites/default/files/publications/43030/ki2014_0.pdf).

67 UNDP, op.cit.



## 2.3 THE ROLE OF SOCIO-CULTURAL NORMS AND VALUES WITH REGARD TO CHILDREN AND WOMEN IN BANGLADESH

Beliefs about what others do, and what others think a person should do, often guide a person's actions in her or his social setting. Social norms emerge for almost every behaviour, and even young children quickly learn the social "rules of the game," following norms and punishing violators. Thus, such norms can evoke strong emotions with regard to the collective welfare of different groups, and breaking a social norm can create stigma for the person doing so.

Newly published research confirms that three principles stand out as providing the direction for new approaches to understanding overall human decision making, including in Bangladesh.<sup>68</sup> First, people make most judgments and most choices automatically, not deliberately – in other words, "thinking automatically." Second, how people act and think often depends on what others around them do and think – "thinking socially." Third, individuals in a given society share a common perspective on making sense of the world around them and understanding themselves, or "thinking with mental models," including stereotypes. In short, behaviours of individuals can be explained by the preferences they have, the options they have to choose from, and the beliefs they have – whether customary, moral or social norms – about those options.<sup>69</sup>

All this is particularly relevant with regard to views of children and women. For example, in Bangladesh as elsewhere, the various social and legal norms around gender strongly influence whether women can be educated or employed in decent work, whether they can participate in civic activities, and under what conditions they bring "honour" or "shame" to themselves and their families (see also Section 2.4.3). Yet social norms can change: An effective example in Bangladesh is that of open defecation, a social norm that directly affects public health and has consequences for socioeconomic outcomes. A shift to a social norms-based strategy to tackle the issue – engaging the full community using two-way communication or dialog approaches, demand-driven and participatory, and using non-monetary rewards such as pride and celebration – has yielded significantly more rapid and lasting abandonment of open defecation by millions of Bangladeshis (see also Section 5.2).

Although domestic legislation and policy in Bangladesh – particularly the new Children Act 013 – favour children (see also Chapter 3), the status of children also has been found to remain deeply rooted in social beliefs, norms, attitudes and practices.<sup>70</sup> Not every person younger than age 18 is considered a child, which deeply affects the realisation of children's rights; critically, social perceptions and expectations of childhood continue to vary according to age, gender, social class, wealth, disability and other factors. More broadly, a relationship exists between the level of implementation of the CRC and the cultural context, such that researchers believe that strengthening the Convention's implementation will require substantial changes in socio-cultural values regarding children and childhood.<sup>71</sup>

In all, the Bangla language does not have an all-encompassing word for "child" that indicates a person who is younger than age 18. Instead, a key concept is that of the development of a state of "understanding," but what should be understood, when and how varies widely for children in different circumstances; understanding is not recognised as an automatic consequence of physical growth or age. Children who are "non-understanding" are called *shishu*, and considered innocent and dependent. At the same time, at least six other words

68 World Bank. *Mind, Society and Behaviour: World Development Report 2015*. Washington, D.C., 2015 (hereafter World Development Report).

69 UNICEF. *A Social Norms Perspective on Child Marriage: The General Framework*. New York, May 2014.

70 Papavero, Rose-Anne. "Perceptions of Children in Bangladesh, Socioeconomic Status and Harmful Social Norms." Paper presented at the University of Pennsylvania in Philadelphia, USA, July 2013..

71 Ibid.

exist in Bangla that are used to designate a child with regard to her/his belonging to a particular stage of development and her/his gender. Critically, the child may be described as “old enough” to undertake something or “too young,”<sup>72</sup> thus, a 12-year-old girl who is married or a 9-year-old child labourer is not considered *shishu* any longer. Adolescents in their teens are never called *shishu*, even though they are still children according to the CRC definition.

“Understanding” is likewise linked to gender roles;<sup>73</sup> for example, an “understanding” girl is born to be given in marriage and is expected to be quiet/submissive and to participate in housework. Child marriage is not only linked with poverty, but also with security concerns and moral norms (see also Chapter 2.4.5). The risk of sexual abuse is considered a matter of family “honour,” and should it occur, the girl will be treated as “impure.” An “understanding” boy is expected to become a father, to work outside the household and earn an income, and to be responsible for the women and children in his family; he is likelier to take up or be forced into child labour. Overall, therefore, expectations for both girls and boys in Bangladesh regarding their rights remain to be developed, so that social perceptions of childhood and adolescence (see also Section 2.4.4) are further modelled on international standards.

## 2.4 KEY CROSSCUTTING DEVELOPMENT THEMES EMERGING AS PRIORITIES FOR CHILDREN AND WOMEN IN BANGLADESH IN 2017-2021

In the context for children and women outlined above, six key crosscutting and inter-related development themes have emerged as central to achieve equity and underlying progress in all relevant sectors of development in Bangladesh, for both the short- and long-term. Indeed, they are so crucial that they merit considerable upfront examination to enrich the appropriate context highlighted within further sectoral analyses in the following Chapters. These priority themes are:

- Strengthening systems and institutions
- Embedding effective planning and monitoring at the local level
- Mainstreaming gender and empowering women
- Empowering adolescents
- Ending child marriage
- Improving social services and opportunities for children and women in urban slums

Although some of these themes have been longstanding development issues, each has new resonance in Bangladesh at this time. Moreover, all are particularly critical to achievement of the SDGs and to the inclusive realisation of children’s and women’s rights, and will be analysed in additional detail below with regard to specific sectors.

### 2.4.1 Strengthening Systems and Institutions

Development issues are becoming ever more complex in the post-2015 era. Thus, it will be even more important than ever before to ensure that systems and institutions are responsive to the needs of children and women, and that they effectively deliver essential services while promoting equitable human development and inclusive growth. Countless development efforts around the world have failed because countries lack institutions with the ability to sustain their socioeconomic policies.<sup>74</sup> Improved governance across many

72 Ibid.

73 Ibid.

74 TACSO. “Institutional Development and Organisational Strengthening: Concepts and Framework,” accessed at [http://www.tacso.org/Capacity\\_Development/online\\_courses/cso\\_management\\_course/csomt\\_10.pdf](http://www.tacso.org/Capacity_Development/online_courses/cso_management_course/csomt_10.pdf), and Brookings Institution, “Strengthening Institutional Capacity in Poor Countries.” Washington, D.C., April 2002.

dimensions – particularly modelling effective service delivery systems and taking them to scale – will therefore be fundamental to achieving progress on all sustainable development objectives.

In addition, inclusive political processes will need to ensure that citizens can hold public officials to account for their actions. One of the major findings of various national and thematic consultations on the post-2015 development agenda was the need for strong participatory monitoring mechanisms by non-State actors (communities, civil society networks et al.) to hold governments accountable.<sup>75</sup> Women, youth/adolescents and children are crucial partners in all these processes.

Given that the core of sustainable development is meeting the needs of the present – social, economic and environmental – without compromising the ability of future generations to meet their own needs, a particular imperative exists to develop institutions that promote inter-generational equity and plan for the long term. However, as the United Nations Secretary-General's High Level Panel on Global Sustainability has highlighted,<sup>76</sup> globally “policies, politics and institutions disproportionately reward the short term.”

Moreover, planning institutions and processes in many countries, including Bangladesh, often still work along sectoral lines, while sustainable development requires finding synergies and coherence between what have been largely separate development goals. Importantly, however, capacity for sustainable development is not just about efficient administration; it also requires recognition of the separate needs and rights of children, women and men.

There are, however, no “magic bullets” for strengthening systems or institutions. Often, it is easier to circumvent weak institutions than to “fix” them. Sources of systemic/institutional malfunction, in Bangladesh as elsewhere, can arise from various issues, including:<sup>77</sup>

- Resources. This may encompass chronic congestion; an insufficiently educated workforce; a weak tax base; lack of thorough, competent legal and regulatory standards; or insufficient funding for resolving key issues/objectives because of a concentration of funding on personnel costs.
- Politically driven. Corruption, politicisation and capture by special interests, including the private sector, are common characteristics.
- Organisational. Institutions may be volatile, such as when priorities fluctuate due to political turnover. They also may suffer from ambiguous or overly ambitious goals, or too much/too little of a “hands-on” approach by Government.

All of these result in core issues of legitimacy, effectiveness, efficiency, suitability, sustainability and flexibility of systems.<sup>78</sup> Because of the critical importance of system/institution strengthening with regard to all development aspirations for children and women in Bangladesh, Chapter 3 analyses their overall relevant policy and governance context.

Crucially, the explosive growth in the use of ICTs – notably, mobile phones and social media – represents a key development that is rapidly opening up new forms of engagement among citizens, governments and the private sector, as well as new forms of monitoring and evaluation. These developments of new technologies further put a high premium on the capacity of the public sector to innovate and collaborate with people and businesses, as well as develop results-based partnerships around CSR – skills that many government institutions frequently lack. Similarly, the data revolution is less than a decade old, and extremely rapid. Without high-quality data providing the right information on the rights

75 UNDP. *Governance for Sustainable Development: Integrating Governance into the Post-2015 Development Framework*. New York, March 2014.

76 United Nations Secretary-General's High-Level Panel on Global Sustainability. *Resilient People, Resilient Planet: A Future Worth Choosing*. New York, 2012.

77 Brookings Institution, op.cit.

78 TACSO, op.cit.

issues at the right time, designing, monitoring and evaluating effective policies becomes almost impossible.

Bangladesh has quite rich data sources in many areas, such as for population and development planning (census, MICS, DHS, labour force surveys, maternal and child health surveys), while other data are more limited (see also Section 3.3). The data revolution also therefore becomes key to supporting a transformative response to sustainable development, such that improving data will effectively serve as a post-2015 development agenda in its own right.

The United Nations System as a whole, and particularly UNICEF, will have a strong role to play to identify the critical data that will need to be mobilised at country level within the new SDG framework on behalf of children and women. These data – including “big data”<sup>79</sup> – will need to support a deeper analysis of inequalities and vulnerabilities at sub-national levels, as well as to help capture the interconnectedness of the three pillars of sustainable development.

Properly analysed, these new data can provide snapshots of the well-being of populations both more frequently and from a wide range of angles, narrowing both time and knowledge gaps that constrain traditional data sources such as surveys. Real-time awareness of the status of a child, for example, and real-time feedback on the effectiveness of policy actions, should in turn lead to a more agile and adaptive approach by institutions – and ultimately, to greater resilience and better outcomes for children and women.

Already, Bangladesh is a leader in applying UNICEF’s Monitoring Results for Equity Systems (MoRES) approach to development, resulting in the reduction of identified development bottlenecks and improved coverage of interventions in 20 of the most socioeconomically deprived (UNDAF) districts in the country.<sup>80</sup> This included an increased proportion of pregnant women in urban slums and deprived areas consuming an adequate dose of iron/folic acid tablets, an increase in HIV-positive pregnant women who are on antiretroviral therapy at their fourth ANC visit, and improved coverage of safe water. To achieve this, community outreach and engagement provided key information and skills on life-saving household-level behaviours.

Union-level engagement has been particularly robust, strengthening the evidence for effective coverage. Evidence collected at local level also has informed national-level strategies and plans, including the National HIV Risk Reduction Strategy, counselling guidelines and peer education linked to services for adolescents, as well as the incorporation of birth registration within 45 days into a national-level standard for monitoring and civil registration strategy.

Equally important, the use of MoRES has challenged the culture of planning by assumption and drawn attention to data gaps and systemic weaknesses.<sup>81</sup> Now, a need exists to continue to mainstream the approach into current monitoring systems of Government and stakeholders, especially at local level, in order to be able to upscale this level of monitoring at the appropriate frequency and to inform policy and systemic reforms (see also Section 2.4.2).

#### 2.4.2 Embedding Effective Planning and Monitoring at the Local Level

Closely related to system/institution strengthening is the strengthening of local-level planning (LLP), which is particularly key in Bangladesh given the traditionally highly centralised governance structure. LLP is not about weakening central authority; it is to make the local

79 Big data are characterised by such high volume, velocity and variety as to require specific technology and analytical methods for their transformation into value. Big data “size” is a constantly moving target, but can encompass up to many petabytes (a petabyte is 1 million gigabytes/GB).

80 UNICEF. *Pursuing Equity in Practice: A Compendium of Country Case Studies on the Application of the Monitoring Results for Equity System (MoRES)*. New York, August 2014.

81 Ibid.

government more responsive to the needs of the local populations. However, it depends upon the strength of local Government institutions, not only in planning but also in key managerial skills related to financing and human resources. Importantly, local-level planning is a key component of the critical investments needed to strengthen the overall planning process in Bangladesh, which also encompasses evidence-based planning, "bottom-up" planning and integrated planning; for example, "bottom-up" planning already has been supported by UNICEF in 60 *upazilas* in the country. Strengthening overall planning also is linked to the need for establishment of Divisional- and district-level planning and monitoring units, as well as capacity development of relevant stakeholders.

Overall, the implementation of LLP can help to address development bottlenecks; strengthen the supply of services and improve their quality; raise economic efficiency of resource use through the enhancement of service providers' accountability; allow greater political representation of diverse groups in decision making; and relieve top managers in central Ministries of routine tasks.<sup>82</sup> Accountability is particularly crucial in any country, since without a strong system of local accountability, such as through civil society "watchdogs," the risk for corruption and political capture may be acute.

LLP has undergone many transformations over the years in Bangladesh. For example, it is being supported effectively in the health sector, among others (see also Section 5.1), where it was first piloted in 39 *upazilas*, under five districts, in 2000-2001. These early efforts did not have much influence on policy, strategy, or resource allocation.<sup>83</sup> With time and experience, however, the Government now is using LLP in the sector in 206 *upazilas*; in addition, UNICEF-supported LLP has been initiated in all *upazilas* of 10 districts<sup>84</sup> with the objective of achieving the MDGs in maternal, neonatal and child health (MNCH) services.

In seven low-performing districts, communities are engaging with micro-planning by using Participatory Rapid Appraisal (PRA) tools. They generate social mappings and action planning by involving community members in situation assessments and the identification of solutions to challenges. Communities then use the mapping tools to monitor the well-being of each household over time and to link trends in household wellbeing to changes introduced by a project.

Critically, LLP should not be seen in an overly simplistic manner: It involves a process of re-definition of structures, governance procedures and practices, so that there is a system of co-responsibility among institutions of governance at the central, regional and local levels. LLP also is intended to increase the overall quality and effectiveness of the system of governance, while increasing the authority and capacities of sub-national levels.<sup>85</sup> Common issues in many countries, including Bangladesh, involve weak policymaking capacity at local levels, as well as retaining professional and qualified local government staff. In all, however, lack of sustainability of development results may be caused in part by not fully incorporating local institutions and organisations into development processes, as well as improving their functioning.

### 2.4.3 Mainstreaming Gender and Empowering Women

Women in Bangladesh have made important strides in development in recent decades, even as they face significant continuing challenges. For example, the Government's investment in rural infrastructure, particularly durable roads, since the late 1970s has had a considerable

82 Nikolov, Dimce (for UNDESA). *Decentralization and Decentralized Governance for Enhancing Delivery of Services in Transition Countries*. New York, 2006.

83 Ministry of Health and Family Welfare. *Mid Term Review (MTR) of the Health, Population and Nutrition Sector Development Programme 2011-2016 (HPNSDP)*. Dhaka, October 2014 (hereafter HPNSDP MTR).

84 Five more districts will start implementing the model during 2015.

85 Nikolov, op.cit.



impact on many women's physical mobility and access to health care, education, markets and information. Female adult literacy has more than doubled between 1991 and 2011.<sup>86</sup> Campaigns for clean drinking water, immunisation and the use of oral rehydration for babies have not only reduced diarrhoea and other childhood diseases (see also Chapter 5.1), but also mothers' drudgery. In addition, the country's total sanitation campaign (see also Chapter 5.2), which has led to the widespread use of toilets, meant that many girls could now attend school more comfortably.

Particularly in rural areas, women's economic participation has been advanced by their increasing access to microcredit schemes, which has enabled them to learn to become self-employed and to save money. The expansion of the RMG sector, along with women's increased involvement in agriculture, has helped to raise the female labour force participation rate from 24 per cent to 36 per cent between 2002 and 2010<sup>87</sup> (see also Section 2.2.1). Overall, the CEDAW Committee, in its latest Concluding Observations on Bangladesh in 2011,<sup>88</sup> commended the Government for its adoption of a wide range of policies, programmes and plans of action to promote gender equality and eliminate discrimination against women, although enforcement of a number of these policies requires significant further strengthening.<sup>89</sup>

Nevertheless, gender inequality remains a serious impediment to women's advancement. On the new global Gender-related Development Index (GDI) 2014, which measures indicators of women's health, education and economic resources, Bangladesh ranks 107<sup>th</sup>; this is significantly lower than the global average ranking of about 45. Bangladesh also ranks 115<sup>th</sup> out of 151 countries in the 2014 global Gender Inequality Index (GII), tied with Uganda and Swaziland, both low-human-development countries.<sup>90</sup> In particular, property rights for women remains a major issue in Bangladesh, closely tied to issues of dowry, violence against women, and child marriage.

Meanwhile, the CEDAW Committee expressed its concern that only limited information and data are available on the most disadvantaged groups of women and girls, including ethnic minority women, women with disabilities, migrant women, refugee women, older women, and girls living on the streets.<sup>91</sup> For example, indigenous women in the Chittagong Hill Tracts face often face a type of "double jeopardy" as a result of their ethnic origins; they continue to suffer numerous rights violations, whether sexual or deprivation of access to property and/or services.

The Committee's Concluding Observations further raised concerns in a number of other areas. On the legal front, the Committee cited the lack of a constitutional guarantee for equal rights for women in private life, as well as the persistence of a significant number of discriminatory laws and provisions, including laws relating to property, marriage, divorce, nationality, guardianship and custodial rights. The Committee also expressed concern at "the persistence of patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men ... [which] perpetuate discrimination against women and girls and are reflected in their disadvantageous and unequal status in many areas, including in employment, decision making, marriage and family relations, and the persistence of violence against women."<sup>92</sup>

86 National MDGR, op.cit.

87 Bangladesh Bureau of Statistics. *Report of the Labour Force Survey 2010*. Dhaka, 2011.

88 Committee on the Elimination of All Forms of Discrimination Against Women. *Concluding Observations of the Committee on the Elimination of All Forms of Discrimination Against Women: Bangladesh*. New York, February 2011 (hereafter CEDAW Concluding Observations).

89 These include the Domestic Violence Act 2010; three laws from 2009: the National Human Rights Act, the Right to Information Act, and the Citizenship (Amendment) Act, which entitles a Bangladeshi woman to transmit citizenship to her children; the Policy for the Advancement of Women, aimed at eradicating gender disparities; and the Vision 2021 programme, which aspires to mainstream gender issues. The Committee also welcomed the establishment in 2009 of the National Council for Women and Child Development, headed by the Prime Minister, and the establishment of gender-responsive budgeting in 10 Ministries in 2009-2011.

90 HDR, op.cit.

91 CEDAW Concluding Observations, op.cit.

92 Ibid.

Overall, the vulnerability of women is critically dependent on the immediate social environment in which they live. For example, the Committee noted that many forms of violence against women (VAW) remain prevalent, including domestic violence, rape, acid throwing, dowry-related violence, *fatwa*-instigated violence, and sexual harassment in the workplace (see also Chapter 7).<sup>93</sup> Young girls on the way to school also may be subjected to sexual harassment and abuse, often known as “eve teasing.”

Trafficking in women and girls remains a widespread issue, and the provisions of the SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution, ratified by Bangladesh in 2002, have not been incorporated into domestic law.<sup>94</sup> Many women have been found to continue in abusive relationships because of their fear of loss of shelter and lack of economic options.<sup>95</sup> At the same time, ownership of property, including land, a house, or both, by women may provide them with a means of sustained social and economic security and protection against both physical and psychological violence at home.<sup>96</sup>

Safety and security in public spaces also remains a key issue for women in Bangladesh. Only 49 per cent of older women and 38 per cent of younger women feel safe going out alone, even within their village or neighbourhood.<sup>97</sup> At least some of this may be related to the extent to which men accept women’s visibility in public spaces, in a culture that has traditionally emphasised seclusion. For some women, even the perception of public insecurity can prevent them from taking up new opportunities and exploring new frontiers. Regional variations are wide. Women in Sylhet and Rajshahi appeared most intimidated, according to survey data; for example, women in Sylhet felt about 85 per cent less safe than their counterparts in Dhaka. A correlation also was found between adherences to social norms – for example, the wearing of make-up– and perceptions of safety.<sup>98</sup>

While there exists a gender balance in primary and secondary school enrolment rates, women are still not yet proportionately represented in technical/vocational education or in higher-level technical and managerial positions. Moreover, while the proportion of the female population completing junior secondary schooling or higher has risen significantly,<sup>99</sup> access to secondary education overall remains a major challenge for girls, and constraints to opportunities at this stage of life are a key contributing factor to child marriage; boys also are beginning to be disadvantaged in education (see also Chapter 6). Women, including adolescents and young women, also exhibit very low rates of exposure to mass media and use of ICTs, further severely limiting their meaningful contribution to a knowledge-based society.<sup>100</sup>

The CEDAW Committee was particularly concerned at the high level of dropout rates among girls, especially in rural areas;<sup>101</sup> this is linked to extremely high levels of child marriage (see also Section 2.4.5), which the Committee urged the Government to take all appropriate measures to end. In all, marriage represents a defining reality and a key determinant of numerous outcomes for women; in Bangladesh, almost everyone gets married. While divorce is fairly rare, abandonment of women has been reported as quite common.<sup>102</sup>

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93 Ibid.

94 Ibid.

95 International Center for Research on Women. *Property Ownership and Inheritance Rights of Women for Social Protection: The South Asia Experience*. Washington, D.C., 2006.

96 Ibid.

97 Whispers to Voices, op.cit.

98 Ibid.

99 DIS, op.cit.

100 Bangladesh Bureau of Statistics and UNICEF Bangladesh. *Multiple Indicator Cluster Survey 2012-2013/Progothir Pathy – Final Report*. Dhaka, December 2014 (hereafter MICS 2012-2013).

101 CEDAW Concluding Observations, op.cit.

102 World Bank, Whispers to Voices, op.cit.



At the same time, although women lead both of Bangladesh's dominant political parties and there are quotas for women in local government, women also continue to be under-represented in public and professional life and in decision making in the judiciary, diplomatic service, civil service and administration, and elected positions in Parliament and local bodies (see also Chapter 3).<sup>103</sup> Elected women members in reserved seats of a Union *Parishad*, the lowest tier of local government, are accountable to three wards each, while non-reserved members, both male and female, are elected from single wards. Critically, women in reserved seats also do not have clear-cut job descriptions or resources, functioning primarily through negotiations with other Union *Parishad* members.<sup>104</sup>

Women's decision-making voice in the family and the community also remains comparatively less than men's, and restricted to the domestic sphere, with a focus on aspects of household functioning and on children. One recent study showed that only half of all women were regularly consulted in matters such as discipline of children, or decisions regarding a sick child's treatment or children's schooling.<sup>105</sup> The difference in decision-making power between younger and older women was found to be small, suggesting little change over time. In addition, as Bangladesh's population ages in the coming decades,<sup>106</sup> there also exists a need to ensure that the family's contribution to elder care does not fall overwhelmingly on women.

In nutrition, a key factor that contributes to high child undernutrition rates is low birth weight (LBW), which affects more than 1 in 4 babies and is caused by a mother's poor physical condition (see also Chapter 4). Although care-seeking during pregnancy and childbirth have improved, many women still lack adequate access to reproductive health services, including for safe delivery (see also Section 5.1), with national figures that are high when compared to neighbouring countries.<sup>107</sup> An additional issue of concern is the high level of cooking and heating with solid fuels, which leads to significant levels of indoor smoke, thus damaging women's and children's health. The MICS 2012-2013 shows that solid fuels are widely used as a main source of energy for domestic cooking in Bangladesh (88.2 per cent), particularly in rural areas (96 per cent, vs. 58.3 per cent in urban areas).

Meanwhile, despite girls' gains in education, in some cases there are signs in Bangladesh of educational hypogamy – women “marrying down” in terms of educational attainment – that have been noted, which subverts the South Asian “ideal” that women should marry men more educated than themselves.<sup>108</sup>

The policy response to women's employment has been largely through anti-poverty programmes such as microcredit (see also Section 2.2, Bangladesh's Economic Development sub-section), small livelihoods programmes, safety nets, social protection initiatives, and others. Much more attention is needed to macro policy linkages, however,<sup>109</sup> including with tertiary education, technical training, provisioning of early childhood care and development (ECCD) programmes, gender-sensitive extension services and marketing information, and laws and policies that combat discrimination and promote women's empowerment in the private sector, among others.

This under-representation of women in decision-making roles also crosscuts with the private sector, where women often work at the lowest level of the employment hierarchy in low-pay, low-status jobs with tenuous employment security.<sup>110</sup> Indeed, the majority of women

103 Ibid.

104 Interviews with women UP members in Islampur (Jamalpur District), Bangladesh, May 2015, and World Bank, *Whispers to Voices*, op.cit.

105 Ibid.

106 DIS, op.cit.

107 *Whispers to Voices*, op.cit.

108 Ibid.

109 Bangladesh Development Update, op.cit.

110 ILO, “Equality and Discrimination,” accessed at: <http://www.ilo.org/dhaka/areasofwork/equality-and-discrimination/lang--en/index.htm>.

workers are engaged in the informal economy, where the application of social protection and legislation is weak.<sup>111</sup> The labour market remains highly segmented along gender lines, with women concentrated in domestic services and home-based work, for which many do not report income. The national Labour Act also does not cover workers in the informal sector. Less than 4 per cent of women of prime working age work for a cash wage in Bangladesh, and despite legal prohibitions, women often are paid less than men.<sup>112</sup> One study found that women's earnings were generally 21 per cent lower than men's, of which the "pure" gender wage gap was 15.9 per cent.<sup>113</sup>

While men's aggregate labour force participation rate at ages 10 and above has fallen slightly, from 84.0 per cent in 2002 to 82.5 per cent in 2010, for females it rose sharply over the same period, as noted in Section 2.2.1.<sup>114</sup> The increase, however, is partly attributable to a more complete enumeration of unpaid family workers engaged in activities such as livestock and poultry raising. Thus, the rise in female employment has been heavily concentrated in the category "unpaid family helpers;" in 2010, 56.3 per cent of working women were unpaid family helpers, compared with only 7.1 per cent of working males. Consequently, rural women accounted for 43 per cent of the total increase in the economically active population.<sup>115</sup> In all, however, women's participation in the formal labour market is still very low, even by South Asian regional standards.<sup>116</sup>

Younger women's employment has seen the largest increase, due primarily to the expanding garment industry and to women's employment as teachers and health care workers. This may offer opportunities to raise the value of women's labour overall and, accordingly, their wages and social status. Policies and practices on the part of some business enterprises appear to constitute a continuing barrier to women's empowerment in the garment sector; for example, some RMG industry employers have been reported to prefer to recruit young unmarried women, since they are often perceived as less likely to join trade unions. Even so, while women comprised about 90 per cent of garment workers up to the end of the 1990s, when the industry focused on woven garments, this had fallen to 62 per cent by 2009 with a rise in the share of knitted garments, a sector in which men provide more than half the workforce.

In all, the garment industry provides direct employment for some 4.2 million workers, 80 per cent of whom are women;<sup>117</sup> in other words, some 3.4 million women are employed in the sector. Recent discussions have cited the need to spread the location of factories further to enable more women from outside of major cities to find employment in the RMG sector.

A recurring issue of concern on the RMG industry in Bangladesh is that many factory buildings appear not to meet international occupational health and safety standards, including with regard to fire as well as building and electrical safety, and provide limited staff amenities. A series of high-profile industrial accidents and disasters in the sector has resulted in calls for major reforms in the sector, particularly following the deaths of at least 1,100 factory workers in the Rana Plaza building collapse in April 2013. Further, a study by the Workers' Rights Consortium in July 2013 found that prevailing wages in Bangladesh provide just 14 per cent of a living wage, and that workers in the garment industry earned an average of just \$0.22 per hour, further indicating the acute challenges of many women's

111 ILO Regional Office for Asia and the Pacific, op.cit.

112 Whispers to Voices, op.cit. In the casual agricultural labour market, women earn about 60 to 65 per cent of men's wages.

113 DIS, op.cit.

114 Ibid.

115 Ibid.

116 Whispers to Voices, op.cit. Women's employment in South Asia is found to be lower than in any other part of the world except perhaps the Middle East. Bangladesh is at the lower end of the South Asian spectrum, second only to Pakistan.

117 ILO, "Improving Working Conditions in the Ready Made Garment Industry: Progress and Achievements," accessed at [http://www.ilo.org/dhaka/Whatwedo/Projects/WCMS\\_240343/lang-en/index.htm](http://www.ilo.org/dhaka/Whatwedo/Projects/WCMS_240343/lang-en/index.htm). In comparison, the World Bank (2013) estimates 3 million women working in the sector, while the 2013 edition of the *Statistical Pocketbook of Bangladesh* indicates overall RMG employment of 4 million in 2012, with no gender-disaggregated figures. The source of the latter was not official labour force surveys, but rather, the Bangladesh Garment Manufacturers and Exporters Association.

working conditions. Many stakeholders consider this to fall short of a fair living wage that would enable a female worker to provide an adequate standard of living for her dependent children.<sup>118</sup>

Lastly, legal and social impediments to freely pursuing a profession also are strongly associated with the persistence of large gender gaps in labour force participation, while as noted above, traditional customs, norms and practices, prevalent in rural areas, often restrict women's rights to inheritance and property. Although more recent data appear not to be available, a 2006 study found that fewer than 10 per cent of all women and less than 3 per cent of younger women had their names on marital property papers such as rental agreements or title to land or a homestead.<sup>119</sup>

#### 2.4.4 Empowering Adolescents

Children born in the milestone year of 2000 are now well into adolescence, defined by the United Nations as those between ages 10 and 19. More than 1.2 billion adolescents are found worldwide<sup>120</sup> – with more than half of these in Asia, including Bangladesh – but their vulnerabilities and needs often remain unaddressed. Every year, up to 1.4 million adolescents die from road traffic injuries, complications of childbirth, suicide, violence, AIDS and other causes.<sup>121</sup> In general, the youngest mothers are the most likely to experience complications and die of pregnancy-related causes (see also Section 2.4.5). Some 71 million children of lower secondary school age around the world are not in school, and 127 million youth aged 15-24 are illiterate, especially in South Asia (see also Chapter 6).<sup>122</sup> Behaviours often established in adolescence, such as using tobacco, alcohol or drugs, having unprotected sex, and avoiding physical activity, account for two-thirds of premature deaths and one-third of the total disease burden in adults (see also Section 5.1).<sup>123</sup>

The Office of the High Commissioner for Human Rights (OHCHR) has further identified several wide-ranging challenges that are most relevant to address the rights of adolescents, including in Bangladesh.<sup>124</sup> These include: (1) A growing gulf between the experience of adolescents and that of their parents or other caregivers; (2) Stigmatisation/negative perceptions of adolescents; (3) Invisibility of adolescents in policymaking, with a lack of a holistic vision for their development; (4) Lack of understanding of adolescent development; (5) Balancing continuing entitlement to protection with emerging capacities for participation; and (6) Adolescents bearing adult responsibilities. Adolescents of working age also face different risks in the workplace than adults, implying the need for tailored policy and practice responses on the part of governments and business enterprises alike.<sup>125</sup>

As neither young children nor adults, adolescents in Bangladesh often may lack the services that respond to their distinctive needs. Important gaps in the knowledge base exist, in Bangladesh as elsewhere, with more needing to be known and understood about the underlying social and economic determinants of vulnerability and deprivation in adolescence. In particular, little is known about adolescents aged 10-14, constraining evidence to inform

118 Publicly available estimates of what would reasonably constitute a fair and living monthly wage in Bangladesh range from about US\$107 to US\$148; see, for example, the estimates reviewed in CSR Centre and Danish Institute for Human Rights, "Human Rights and Business Country Guide: Bangladesh," accessed at <http://hrbcountryguide.org/countries/bangladesh/>. The monthly minimum wage for unskilled garment workers is less than US\$70 in Bangladesh. ILO Regional Office for Asia and the Pacific, Regional Economic and Social Analysis Unit, "Global Wage Report 2014-15: Asia and the Pacific Supplement." December 2014, accessed at: [http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-bangkok/documents/publication/wcms\\_325219.pdf](http://www.ilo.org/wcmsp5/groups/public/---asia/---ro-bangkok/---sro-bangkok/documents/publication/wcms_325219.pdf).

119 World Bank 2006 data.

120 UNICEF. *Progress for Children: A Report Card on Adolescents*. New York, April 2012 (hereafter Adolescent Report Card).

121 Ibid.

122 Ibid.

123 Ibid.

124 Office of the High Commissioner for Human Rights. "Outline Scoping Document for the General Comment on Rights of Adolescents," accessed at <http://www.ohchr.org/EN/HRBodies/CRC/Pages/CallRightsofAdolescents.aspx> (hereafter OHCHR).

125 UNICEF, United Nations Global Compact, and Save the Children, "Children's Rights and Business Principles." 2012, accessed [http://www.unicef.org/csr/css/PRINCIPLES\\_23\\_02\\_12\\_FINAL\\_FOR\\_PRINTER.pdf](http://www.unicef.org/csr/css/PRINCIPLES_23_02_12_FINAL_FOR_PRINTER.pdf).

policies and guide programme investments. Interventions for children traditionally focus on the youngest ages; adolescents thus may “age out” of paediatric health care, for example, and are often unreached by programmes for adults.

Traditional beliefs and social norms again continue to represent a strong factor in the socialization and social expectations of both girls and boys;<sup>126</sup> as already noted in Section 2.3, adolescent girls in the country are more likely to have to halt their education if they are subject to child marriage and its attendant early sexual activity (see also Section 2.4.5 and Chapter 7). Overall, a major issue affecting adolescents in Bangladesh has been found to be related to reproductive health and sexuality; in a conservative social environment with strong religious influences, the space remains comparatively limited for adolescents to have easy access to information on sexual health and sexuality, discuss taboos openly, and explore some of the related barriers and social dichotomies. At the same time, adolescent boys are now less likely to obtain a secondary education and more likely than girls to engage in child labour, much of it hazardous (see also Chapters 6 and 7). Yet through secondary education, adolescents expand their skills and ability to think critically, which can translate into increased opportunities in the future; education also shapes the attitudes, values and aspirations that affect adolescents’ ability to function as members of their families, communities and societies.

Moreover, adolescents need to be engaged in decisions that contribute to developing policies and delivering services that affect them. In Bangladesh, adolescent clubs are a popular activity, including theatre groups, life skills trainings, child rights discussions, disaster management, sports, singing and dancing, and reading books (see also Chapter 7).<sup>127</sup> Yet whether it is related to choosing partners, affiliating with religious or social groups, or making career choices, pressure to conform has been found to be significant. Thus, while young people are being exposed to new ideas and thinking – for example, through social media – other perspectives view websites, mobile services and other media as potential negative influences on adolescents and youth.

Notably, more than 1 in 3 adolescent girls are underweight in Bangladesh;<sup>128</sup> in adolescent mothers, undernutrition is related to slow foetal growth and low birth weight (see also Chapter 4 and Section 5.1). A large proportion of adolescent girls aged 15-19 also have experienced sexual violence. Domestic violence is common among adolescent girls who are in relationships, as well as among most-at-risk adolescents and especially vulnerable adolescents (see also Chapter 7). For example, in Bangladesh 47 per cent of married adolescent girls reported that they had experienced emotional, physical and/or sexual violence, globally behind only Bolivia (48 per cent), Zimbabwe (51 per cent), Uganda (67 per cent) and the Democratic Republic of Congo (70 per cent).<sup>129</sup> In particular, adolescents with disabilities are at increased risk of physical, sexual or psychological abuse.<sup>130</sup>

Each year, an estimated 20 per cent of adolescents worldwide also experience a mental health problem, most commonly major depression or other disturbances of mood.<sup>131</sup> As already noted, suicide is a leading cause of death among adolescents globally; it may be associated with mental health issues or with difficulties within the family. Mental health issues in adolescence, if unaddressed, can carry over and negatively affect individuals over the long term (see also Chapter 7).<sup>132</sup> Yet in Bangladesh, as in most developing countries, few mental health services or resources are available for adolescents and young people.

126 Papavero, op.cit.

127 UNICEF Bangladesh. *Piloting L3M for Child Marriage: Experience in Monitoring Results in Equity Systems (MoRES) in Bangladesh*. Dhaka, February 2014 (hereafter Child Marriage Report).

128 Adolescent Report Card, op.cit.

129 Ibid.

130 Ibid.

131 Adolescent Report Card, op.cit.

132 UNICEF Bangladesh. *Suicide: Ideation and Attempt Amongst Bangladeshi Adolescents*. Dhaka, 2014 (hereafter Suicide Report).

Mental health professionals are often in short supply, and non-specialist health workers may not be able to provide quality mental health services to young people. The stigma associated with mental disorders represents a further challenge to addressing adolescents' mental health needs.<sup>133</sup>

All this indicates that it is more critical than ever to nurture Bangladeshi adolescents' potential, providing them with quality learning and better preparation for the world of work; fostering healthy behaviours that reduce non-communicable diseases, obesity, HIV and other health risks; and protecting them from becoming victims of violence. OHCHR has identified four general principles of human rights contained in the CRC as influencing and informing all measures undertaken to guarantee the realisation of all other rights for adolescents under the Convention. These are:<sup>134</sup>

- Article 2: Non-discrimination
- Article 3: Best interests
- Article 6: Right to life and optimum development
- Article 12: Participation

As an indication of the increasing attention being given to adolescents globally, OHCHR further recommends to all Governments that (1) cross-sectoral child rights strategies explicitly address the rights of adolescents, including transparent budgetary analysis that renders adolescents visible; (2) the collection of comprehensive and disaggregated data on adolescents; (3) capacity development for all professionals working with and/or for adolescents on the principles and provisions of the CRC, in particular, the obligation to recognise adolescents' capacities; and (4) awareness raising of and education for adolescents on their rights.<sup>135</sup> These recommendations will have particular resonance for Bangladesh in the coming years, given that, for example, disaggregated data on adolescents in the country require significant strengthening.

Clearly, understanding adolescents in all their diversity – particularly their intense physical, psychological, emotional and economic/employment changes – is fundamental to improving their lives, and to building on the investment already made in their early years. In Bangladesh, as in other countries, adolescents' relative invisibility and unique challenges will need to be complemented by an emphasis on the need to respect and nurture their evolving capacities to ensure the realisation of their rights. In so doing, however, positive opportunities for development among this critical age group can be maximised.

#### 2.4.5 Ending Child Marriage

As the introductory analyses of gender equality and of adolescence indicate, social norms and economic realities alike mean that child marriage is widely accepted and common in Bangladesh (see also Chapter 7). Extensive global evidence shows that child marriage disproportionately affects young girls, who are much more likely to be married as children than young boys. Based on current rates of child marriages around the world between 2011 and 2020, some 39,000 girls younger than age 18 would be marrying every day, with nearly 1 in 3 of these girls marrying before they are 15.<sup>136</sup> At the same time, some 50,000 girls around the world aged 15-19 die from maternal causes annually.<sup>137</sup> Moreover, the practice of child marriage disrupts a girl's educational and economic opportunities, raises her chances

133 Adolescent Report Card, op.cit.

134 OHCHR, op.cit.

135 Ibid.

136 Council on Foreign Relations. *Child Brides, Global Consequences: How to End Child Marriage*. New York, July 2014, and WHO, "Child Marriages: 39,000 Every Day," 7 March 2013, accessed at [http://www.who.int/mediacentre/news/releases/2013/child\\_marriage\\_20130307/en](http://www.who.int/mediacentre/news/releases/2013/child_marriage_20130307/en).

137 Adolescent Report Card, op.cit.



of exposure to violence and abuse, threatens her health and the health of her children, and ultimately hampers progress toward nearly every international development goal. Young girls may be cut off from their families, and child marriage with wide age differences between spouses (see also Chapter 7) tends to keep women in a subservient role.<sup>138</sup>

Although the issue of child marriage is longstanding, ending this practice now has more urgency, given that it is a specific target for the SDG to empower women and girls and achieve gender equality. Only then can the main principles of the post-2015 development framework – human rights, poverty eradication, gender and other forms of equity, and social justice – be fulfilled.

While child marriage in Bangladesh has decreased overall in recent decades, the country ranks amongst the highest proportion of child marriage globally, alongside Niger and Chad,<sup>139</sup> and also in prevalence of early childbearing.<sup>140</sup> Bangladesh, India and Nigeria alone account for 1 in every 3 of the world's adolescent births. Nearly two-thirds of girls in the country (62.8 per cent) are married before they reach their 18<sup>th</sup> birthday, and nearly 1 in 4 (24.4 per cent) become mothers before they are 18.<sup>141</sup> Overall, adolescent childbearing rates have been largely unchanged since 2011.<sup>142</sup>

Despite the adoption in Bangladesh of the 1929 Child Marriage Restraint Act and the 1984 Ordinance on minimum age of marriage, which specifies a minimum legal marriage age of 18 for girls and 21 for boys, these laws and their implementation are outdated.

Currently, 1 in 3 women aged 15-19 years are married. The proportion is lower in urban (28.1 per cent) than rural areas (36.1 per cent), and wide regional variations are evident.<sup>143</sup> Rates are generally higher in the western part of the country and lower in the east, offering a possible context to better understand and respond to the social norms that underlie this practice, its variability and socioeconomic impact. A widespread practice is the falsification of birth certificates, or families may go to neighbouring villages to marry their daughters, where the *kazi* (registrar), for example, is more lenient and more willing to register an illegal marriage.<sup>144</sup>

Progress, although slow, is occurring: The median age of marriage has risen from around 14 years for women who are currently in their late 40s to 16.6 years for women in their early 20s;<sup>145</sup> mother's age at first birth also has been increasing. Only 4 per cent of women aged 15-19 in 2011 reported having had their first birth before reaching age 15, compared to 11 per cent of women in their 40s. About 52 per cent of younger women (15-25 years) had some say in the choice of their groom, compared to 20 per cent of older women (45-60 years).<sup>146</sup> Yet typically, the large age gap between spouses – often 10 years or more<sup>147</sup> – has a negative effect on women's life chances, resulting in a high probability that they will live for years as widows, creating economic instability, and negatively affecting their social status.

Ending child marriage also will be necessary to help get fertility rates to below-replacement level, lower population growth and reap the overall "demographic dividend."<sup>148</sup> Particular attention will need to be given to reducing the level of unmet need for contraception and increasing the uptake of available services (see also Section 5.1). Greater maturity at the

138 Ibid., and Ford Foundation, *Ending Child Marriage in a Generation: What Research Is Needed?* New York, January 2014.

139 Child Marriage Report, op.cit.

140 Adolescent Report Card, op.cit.

141 MICS 2012-2013, op.cit.

142 DHS 2014, op.cit.

143 MICS 2012-2013, op.cit.

144 Child Marriage Report, op.cit.

145 DIS, op.cit. In this respect, marriage patterns in Bangladesh are not unlike those in India or Nepal.

146 Ibid.

147 Adolescent Report Card. Survey data from Bangladesh indicate that up to 1 in 3 girls aged 15-19 are married or in union with a man at least 10 years their senior. The actual percentage may be even higher; in some surveys, large proportions of girls said they did not know their husband's/partner's age.

148 DIS, op.cit.

time of marriage will likely lead to lower fertility by opening other potential roles for the woman and reducing the likelihood of unwanted pregnancies. Moreover, later childbearing will reduce rates of population growth by extending the mean length of time to replace a generation.<sup>149</sup> Benefits of delayed marriage also extend to the next generation, because those who marry later, and have more authority, are likely to invest in their children in ways that establish a virtuous cycle of improved health and education.<sup>150</sup> In Bangladesh, delaying marriage by one year increased the likelihood of literacy by almost six percentage points and kept a girl in school for longer.<sup>151</sup>

A 2014 situation analysis of child marriage in Bangladesh, focused on Khulna and Sylhet, showed that poverty often is a root cause of child marriage, but poverty likewise is reinforced by the practice.<sup>152</sup> Poverty was the most frequently mentioned reason for child marriage; poor families cannot afford to pay food and schooling fees for all of their family members and therefore opt to marry their daughters when an opportunity arises.<sup>153</sup>

Critically, the situation analysis on child marriage also highlighted<sup>154</sup> the central importance of traditional beliefs and social norms as a key bottleneck (see also Section 2.3). This relates to protecting the family's "honour" by assuring the virginity of adolescent girls at marriage. For example, one mother in a focus group discussion for the situation analysis of child marriage highlighted that if the girl "talks with boys, her parents become afraid of some scandal."<sup>155</sup> Many families thus consider girls ready for marriage at the onset of menstruation.<sup>156</sup> The range of actors involved in determining when a girl is ready for marriage and when she should be married generally includes the girl's parents or guardians, elder brothers, grandparents, aunts and uncles.

In addition, the onset of natural disasters – to which Bangladesh is extremely vulnerable – limits economic opportunities and weakens social institutions (see also Section 2.5.2). In such circumstances, as well as in times of high food insecurity or drought, child marriage becomes a more palatable option for parents and families looking to "protect" their girls and to reduce their own household vulnerabilities.<sup>157</sup> The Government of Bangladesh found it was common for those adolescent girls who had lost an academic year of school due to a cyclone to then be forced into marriages.<sup>158</sup>

Figure 1 below summarises<sup>159</sup> the main drivers of child marriage in Bangladesh, deriving from root causes of poverty, social norms and vulnerability to disaster. As the above analysis in this section and other sections indicates, the underlying drivers of child marriage include: (1) Lack of knowledge and awareness among communities of the definition of childhood and child development, which is often complicated by a lack of acceptance of the legal age of adulthood and recognition of the status and rights of the child and the implications for caregivers (see also Sections 2.4.3 and 2.4.4); (2) Shortcomings in the legal and policy framework for child protection, including a need for strengthened implementation overall and non-enforcement of policies surrounding child marriage and birth registration (see also

149 Ibid.

150 Ford Foundation, op.cit.

151 Council on Foreign Relations, op.cit.

152 UNFPA. *Marrying Too Young: End Child Marriage*. New York, 2012. Across South Asia, women aged 20-24 in the poorest 20 per cent of the population are four times more likely to be married before age 18 than those in the richest 20 per cent.

153 One religious leader in Khulna proposed how some fathers estimate the burden of a girl child in the family: "Because of poverty, a father arranges his daughter's marriage before 18; a father calculates in this way that for food and clothing a girl needs 12 *mund* (40kg = 1 *mund*) of rice in one year, i.e., 1 *mund* for 1 month. This means 1,000 Taka per month; the father wants to save that money."

154 Child Marriage Report.

155 Ibid.

156 Ibid.

157 As one young girl in Bangladesh told interviewers: "After cyclones, families think their condition is worse and send their daughters to get married." Plan International, "Weathering the Storm: Adolescent Girls and Climate Change, June 2011, accessed at <http://plan-international.org/about-plan/resources/publications/emergencies/weather-the-storm-adolescent-girls-and-climate-change>

158 Government of Bangladesh, Department of Environment, Climate Change Cell. *Climate Change, Gender and Vulnerable Groups in Bangladesh*. Dhaka, 2011.

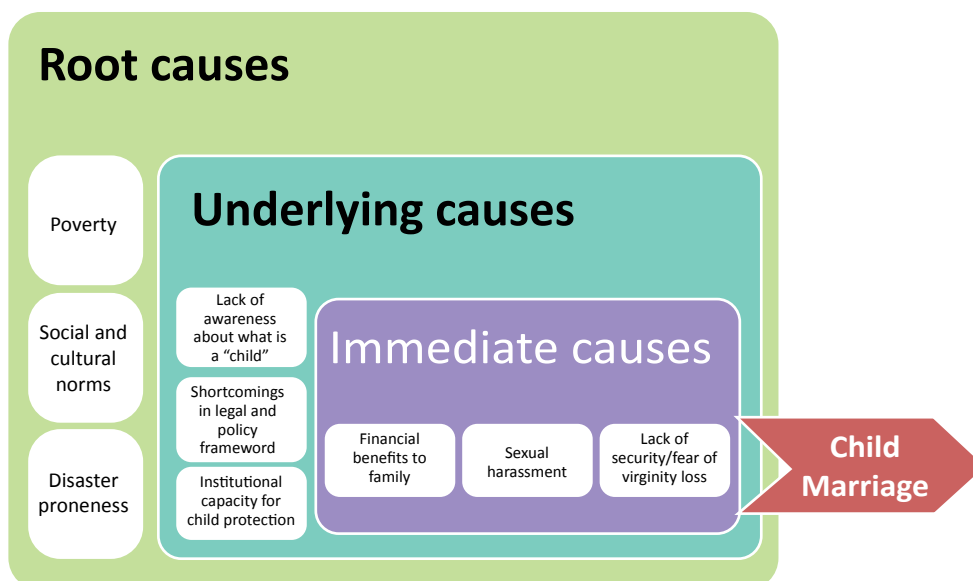
159 Child Marriage Report, op.cit.



Chapter 7); and (3) The lack of institutional capacity for child protection, with key actors such as police officers and marriage registrars lacking capacity, and potentially also willingness, to enforce the laws.<sup>160</sup>

In turn, several immediate causes include: (1) Child marriage of daughters is often financially beneficial for their families; boys are seen as worth investing in, while girls may be seen as a financial burden. Boys are viewed as the future heads of households and the principal source of household income. In contrast, girls typically leave their parent’s home to live with their husband’s families, and may therefore be perceived as making little financial contribution to the household. Also, the sooner the girls get married, the fewer school fees and food costs their families would incur. (2) Although dowry for marriage is illegal, the practice remains widespread. The older a girl is when she is married, the larger the dowry payment her family will need to make to the groom’s family, a hardship for poor families. (3) Child marriage is also thought to mitigate the risk of girls’ losing their virginity before marriage, and to halt the frequency of teasing and sexual harassment, both of which can diminish family “honour,” bring shame to the girl, and diminish the likelihood of the girl marrying later.

**Fig. 1: Root, Underlying and Immediate Causes of Child Marriage**



Source: *Child Marriage Report*.

Religion has been found to be an additional major contributing factor to child marriage. For example, an imam interviewed in Khulna during the research for the situation analysis on child marriage explained that when a girl “is only 12 or 13 of age, in Islamic religious point of view she is in marital age.” In addition to these religious beliefs, there are also superstitions that “grown-up girls should no keep in house.”<sup>161</sup>

To overcome these bottlenecks, numerous actions, on numerous fronts, are required. Among the most important, expansion of adolescent stipends and conditional cash transfer (CCT) programmes may be necessary (see also Chapter 6). Intensified communication efforts also are warranted with regard to raising awareness about and acceptance of the legal definition of a child. Critically, the enforcement of child marriage policies – in terms of the minimum marriage age and having valid birth registration for marriage – requires significant strengthening (see also Chapter 7).<sup>162</sup>

<sup>160</sup> Ibid.

<sup>161</sup> Ibid.

<sup>162</sup> Ibid.

## 2.4.6 Improving Social Services and Opportunities for Children and Women in Urban Slums

Urbanisation is an important form of structural transformation of an economy and society, and is closely associated with the demographic transition.<sup>163</sup> At independence in 1971, only about 9 per cent of the population of Bangladesh (6.2 million) lived in urban areas.<sup>164</sup> By 2011, the census reported that the urban population had reached 41.9 million that year and comprised 28 per cent of the population. The urban population is distributed in 11 city corporations and 277 municipal towns.

Urbanisation is linked to economic advancement and brings with it new opportunities as well as challenges for sustainable and inclusive development. What is unique to Bangladesh is the speed and scale of urbanisation – with an annual growth rate of 3.6 per cent, the urban population is expected to reach 50 million in 2015, a third of whom will comprise the urban poor (GoB, 2011). According to projections by the United Nations Expert group, by 2025 the urban population in Bangladesh will be around 77 million, while according to the McKenzie global report, Dhaka will have the third-largest child population in the world.

However, the 2011 census reported that the urban population had reached 41.9 million that year and comprised 28 per cent of the population.<sup>165</sup> While this remains well below the global average of 54 per cent,<sup>166</sup> Bangladesh is still urbanising at a rate of about 2.9 per cent per year, which is double the national population growth rate;<sup>167</sup> According to the World Bank, Bangladesh is now the third- most-urbanised country in South Asia, after Pakistan and India, with enormous resulting pressure on existing infrastructure and basic civic facilities.

Economic “push” and “pull” factors have been identified as the most significant reasons for rural-urban migration.<sup>168</sup> Yet at present, 28.4 per cent of the total urban population is poor and 14.6 per cent lives in extreme poverty. A total of 12 million people live in the slums of Bangladesh, of which 1 in 3 are in the slums of Dhaka alone.

Dhaka is ranked by the United Nations’ population division as the 11<sup>th</sup>-largest urban centre in the world, a mega-city with a 2011 population of 17 million in an area of more than 1,500 sq. km.,<sup>169</sup> and home to one-third of Bangladesh’s people. Dhaka’s population more than tripled between 1991 and 2011, and is expected to increase to 27 million by 2030<sup>170</sup>. Population projections suggest that all future population growth in Bangladesh will be in urban areas<sup>171</sup>, so that the absorption of tens of millions of additional people in Bangladesh’s already crowded cities – with an expected increase of 50 per cent in the next 13 years – will present a huge development challenge, including for delivery of quality services for children and women.

At the same time, a global livability survey in 2014 by the UK-based Economic Intelligence Unit ranked Dhaka as one of the least livable urban centres among the 140 cities surveyed, based on increasingly dense population, uncontrolled and haphazard growth of the city, destruction of natural drainage and wetlands, and severe air and water pollution. This is particularly true in Dhaka’s 5,000 slums, where more than 1 in 3 Dhaka residents – some

163 DIS, op.cit.

164 Ibid.

165 The 2011 census identified 506 urban centres in the country, of which 43 are cities (100,000 to 4,999,999 population), 310 are *paurashava* towns or municipalities (5,000 to 99,999 population) and the rest are classified as “other urban areas,” which usually have no full-fledged municipality.

166 According to UNDESA figures in 2014.

167 DIS, op.cit. Over the period 2001-2011, calculated on the basis of 2001 urban boundaries. Boundary changes in 2011 make it difficult to calculate the present urban growth rate.

168 UNICEF, “Understanding Urban Inequalities in Bangladesh: A Prerequisite for Achieving Vision 2021.” November 2010, accessed at [http://www.unicef.org/bangladesh/Urban\\_paper\\_lowres.pdf](http://www.unicef.org/bangladesh/Urban_paper_lowres.pdf).

169 World Urbanization Prospects: <http://esa.un.org/unpd/wup/Highlights/WUP2014-Highlights.pdf>

170 Ibid.

171 DIS, op cit.

4 million people – live; slum populations have been increasing at an even higher rate than urban areas in general, by a factor of about 2.

It is estimated that 3.5 per cent of the population migrates every year, mostly from rural to urban areas. Economic “push” and “pull” factors have been identified as the most significant reasons for rural-urban migration. In particular, the growth of the garment industry has been a significant driver in the expansion of urban slums which lack basic entitlements of formal housing, nutrition, health, education, water, sanitation and protective services for children and families.

In particular, the growth of the garment industry has been a significant driver in the expansion of urban slums; many residents of these areas are recent migrants who have come to work in the garment industry.<sup>172</sup> As cited above, along with favourable international agreements and supportive policies by the Government, the main drivers behind the growth of the garment sector were price and capacity. However, this rapid growth has not necessarily included the provision of essential services for the millions of workers who supply these factories with labour, so that slum areas located close to or surrounding garment factories house a large percentage of garment workers.

Three-fourths of slum households live in one room, and the median living area is less than 40 per cent of that of non-slum areas. Moreover, sometimes the urban poor pay as much as, and sometimes more, per square foot than people in better-quality housing. Utilities are more expensive, and the urban poor also frequently pay more for water that is not as clean and electricity that is less reliable.

Land values in parts of Dhaka exceed those in Manhattan, making evictions a constant threat for those living in informal settlements. Practices by the private sector exacerbate insecurity of tenure for residents of urban slums; for example, according to USAID research, business figures in Bangladesh may be involved in so-called “land grabbing,” encroaching on public land, creation of false documents, and obtaining of court decrees that falsely confirm their ownership.

In the context of urbanisation, therefore, both basic infrastructure and public services have failed to keep pace with rapid population growth. Children are affected by inadequate access to services in terms of health care, education, child protection, water supply, sanitation and waste management. In addition, children in urban areas are vulnerable to the impacts of climate change, environmental hazards and natural disasters. Where basic services exist, quality often may be substandard and, as noted above, costs can be prohibitive. For example, private health care services and private education services are prominent in urban areas, with concomitant challenges in terms of affordability, quality, and accountability.

Data from the MICS 2012-2013 indicate that living conditions in urban slum areas are much worse than those in rural Bangladesh across a range of key indicators, including stunting among children, proportion of deliveries attended by skilled birth attendants, secondary school net enrolment ratio, and access to improved sanitation facilities (see Table 1 below).

172 UNICEF, “Factsheet: Developing Integrated Social Services for Slum Dwellers.” Accessed at <http://www.unicef.org/bangladesh/FactsheetDH.pdf>.

**Table 1. Indicator values for urban, rural and poorest urban population based on MICS 2012-2013 (%)**

Indicator	Urban	Rural	Urban poorest (Q1)*	Difference between urban poorest and rural population (percentage points)
Stunting among children < 5	36.3	43.4	55.5	+12
Underweight among children < 5	27.0	33.2	46.0	+13
Deliveries attended by skilled birth attendant	59.1	39.3	27.9	- 11
Pregnant women with 4+ ANC visits	43.3	19.7	17.0	-3
Birth registration among children < 5	42.9	35.5	37.6	+2
Primary school net attendance ratio	77.2	72.3	67.3	-5
Children entering at Grade 1 and reaching Grade 5	96.1	96.5	92.1	-4
Out-of-school children (primary level)	22.7	27.7	32.7	+5
Secondary school net attendance ratio	52.2	44.7	27.4	-17
Out-of-school children (secondary level )	21.0	21.1	37.2	+16
Primary school gender parity	1.05	1.07	1.00	-0.07
Secondary school gender parity	1.27	1.31	1.50	+0.19
Women 20-49 married before age 18	54.4	65.3	67.5	+2
Access to improved drinking water sources	99.1	97.6	95.8	-2
Access to improved sanitation facilities	58.6	55.2	32.7	-23
Open defecation	1.4	4.6	10.5	+6

\* Note: The wealth quintile class used is based on quintile class at the national level

What this ultimately means is that indicators of children's socioeconomic status are frequently worse in urban slums than in rural areas, challenging the so-called "trickle-down" effect of economic growth. Environmental factors have contributed to the rise of respiratory and communicable diseases in urban slums. At the same time, non-communicable diseases (NCDs) also are escalating in urban areas, reflecting the increasingly difficult living environment and poor diets.

In particular, industrial pollution from the private sector is a key cause of critical challenges for the health of children as well as their parents in Bangladesh, particularly in urban areas. For example, wet processing of textiles is a major polluter of surface and groundwater in the Dhaka region. The World Bank has estimated recently that reducing industrial air pollution could avoid up to 230 million cases of respiratory diseases annually in Bangladesh, with two of the country's biggest air polluters being the brickfields industry and the transport sector.

The two Ministries directly related to urban administration are the Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives

(MoLGRD&C) and the Ministry of Housing and Public Works (MoHPW). The LGD controls agencies responsible for construction and for providing services; *pourashavas* (municipalities) and City Corporations generally extend only selected services, including sanitation, road construction, street lighting and water supply, except in Dhaka and Chittagong. Other important services such as electricity, telephone, judiciary and police are provided by respective departments of the central Government.

In addition, the Ministry of Education, Ministry of Health and Family Welfare, Ministry of Women and Child Affairs, and other Ministries have their own decentralised structures to provide services both in urban and rural areas. A need for strengthened ownership by local governments poses coordination and integration gaps between levels of government in planning and implementation. In turn, these will need to be addressed by institutionalising a coordination mechanism to improve social services and opportunities for children and women in urban slums.

Although health and education are the responsibility of the public sector, in poor urban areas both these important services remain dominated by NGOs, as noted above. The strong reliance on NGO service provision has raised concerns regarding the vulnerability of the urban health care system to external political or financial shocks. Private-sector companies are providing other services, albeit often illegally and with associated costs.

Significant disparities have been found in the availability of interventions related to preventive health care, nutritional well-being, child protection, and sanitation and hygiene. For example, only 9 per cent of households in slums use improved sanitation facilities (see also Section 5.2). All this has major implications for the population living there, including children, in terms of their vulnerability to multiple deprivations and access to the services and opportunities they need to realise their rights and potential (see also sectoral analyses in Chapters 4, 5, 6 and 7).

The Government has developed a new policy on urban development and poverty reduction, which was nearing formal adoption in late 2015. This policy sets out directions and objectives including: (1) Facilitating economic development, employment generation, reduction of inequality, and poverty eradication in urban areas through appropriate regulatory frameworks and infrastructure provisions; (2) Ensuring social justice and inclusion by measures designed to increase the security of the urban poor through their access to varied livelihood opportunities, secure tenure and basic affordable services; (3) Taking account of the needs of women, men, children, youth, the elderly and people with disabilities in developing urban policy responses and implementation; and (4) Devolving much of the authority, power and responsibility for urban development and poverty reduction to local urban authorities and building their capacity so they can fulfil their mandate properly. For health, a National Urban Health Strategy has been in place since November 2014. It addresses issues of financing, infrastructure and skilled human resources for providing services, especially for the poor. The Local Government Division is working on operationalisation of this strategy.

In 2008, Government of Bangladesh also initiated the Urban Partnerships for Poverty Reduction (UPPR) programme with support from DFID and UNDP, with the goal of lifting 3 million urban poor and extreme poor people out of poverty by 2015 in 23 cities and towns across the country. Currently, the Government is developing the National Urban Poverty Reduction Programme (NUPRP) 2015-2022. The key elements of NUPRP are (a) development of city development plans and strategies for local economic development; (b) municipal capacity building to strengthen municipal planning, local revenue generation and financial management; (c) mobilisation of the urban poor, incorporating savings and credit schemes; (d) piloting secure tenure and housing finance; and (e) improvements to the local environment through infrastructure improvements.

Lastly, it was traditionally believed that investing in urban slums would only attract more rural migrants. Yet to address growing inequity in Bangladesh, it will be necessary to equip a rapidly growing population in slums with the knowledge and skills that enable them to more effectively contribute to the acceleration of poverty reduction instead of becoming an increasing burden to national development.

Building a participatory approach to urban planning and management, improving the evidence base, expanding child-sensitive budgeting, and strengthening coordination for more responsive management and accountability of both public and private-sector actors (see also Chapter 3) can particularly go a long way toward ensuring the development of a more equitable development environment, starting with children. In addition to building on initiatives with regard to sectoral urban policies and strategies, strengthening overall local government on behalf quality services in urban slums will be particularly critical (see also Section 2.4.2 and Chapter 3).

## 2.5 OTHER KEY DEVELOPMENT CONSIDERATIONS AFFECTING CHILDREN AND WOMEN IN BANGLADESH

Three more key development factors also bear a detailed mention as affecting children and women in Bangladesh: disability, vulnerability to disaster, and living in hard-to-reach areas. All three exacerbate inequities and provide important crosscutting development areas requiring special attention in the coming years.

### 2.5.1 Disability

Development progress has been slow overall for children with disabilities in Bangladesh (see also Chapter 7), but changes are occurring as a result of policy modifications and social mobilisation. For at least some children with disabilities, this includes increased access to school (see also Chapter 6) and to opportunities for skills development and employment; in turn, their status in the family and the community is improving.<sup>173</sup> Progressive policies have been established. Building codes require ramps in all newly built schools; all new public buildings are required to be accessible to persons with disabilities; a 2002 Executive Order from the Prime Minister called for actions to reduce barriers in public transportation; and efforts are under way to provide assistive devices free of charge. Moreover, children with disabilities are increasingly speaking up for their rights and finding support from advocates, ranging from the highest levels of Government to committee professionals, dedicated parents and a vibrant mass of civil society actors.<sup>174</sup>

Despite this progress, however, discrimination within the family, the community and the workplace remains at the core of most violations of the rights of children and young workers with disabilities in Bangladesh. The paradigm shift – from viewing children as having disabilities to viewing their abilities, and from a welfare approach to a rights-based approach – is yet to be realised in the country.<sup>175</sup> Social norms and cultural beliefs around disability are deeply rooted: For example, the belief that disability is a “curse” and a punishment for “sinful” behaviour remains strong at all levels of society and affects access to adequate care, health, services, education and participation. Laws and policies continue to discriminate, are slow to be implemented and are often not adequately funded.<sup>176</sup>

Depending on data source and age cohort, children with some form of disability constitute

<sup>173</sup> UNICEF Bangladesh. *Situation Analysis on Children With Disabilities in Bangladesh 2013-2014*. Dhaka. June 2014 (hereafter Disability Situation Analysis).

<sup>174</sup> Ibid.

<sup>175</sup> Ibid.

<sup>176</sup> Ibid.



between 1.4 per cent and 18 per cent of the population, ranging from 805,000 to 10 million.<sup>177</sup> Yet whatever figure is used, existing social protection services for children with disabilities fall short in coverage and content. For example, the stipend for students with disabilities plus the grants for schools for children with disabilities currently reach only 47,000 of the estimated 2 million eligible children (see also Chapter 6). Most initiatives for children with disabilities are specialised and separate, rather than addressed in mainstream programmes and services; however, even specialised sports and cultural activities for children with disabilities benefit a only some of these children overall.

Furthermore, data from a variety of sectoral programmes at national level remain to be further disaggregated by disability, thereby contributing to the “invisibility” of children with disabilities. A need for more coordination between the Government and civil society partners also continues to hinder progress. Representation by disabled persons organisations (DPOs) often is not sufficient in decision making, policy development and design of programmes to ensure the disability perspective, while competition among service providers reportedly sometimes weakens efforts to influence the Government.<sup>178</sup> The Committee on the Rights of the Child has noted difficulties in translating policies into concrete actions and is concerned that children with disabilities, in particular girls, experience discrimination and prejudicial treatment throughout their development. Further, the Committee was concerned that services for early detection of disabilities are inadequate.<sup>179</sup>

The realisation of rights for all children with disabilities thus remains highly uneven: For comparatively few, there are highly developed inclusive and specialised intervention models meeting international standards, along with state-of-the-art training programmes. The majority, however, face limited capacities and inadequate basic services.<sup>180</sup>

Several key crosscutting issues have been found to hinder progress toward the realisation of the rights of children with disabilities in Bangladesh: Lack of physical access continues to be a major barrier, especially to the rights to education, health and participation. Capacity and expertise to mainstream inclusive services also are critical; most mainstream service providers require further training to effectively implement current policies for inclusive health, education and protection services. In turn, this also may result in a lack of adequate resources; limited budget allocations likewise affect implementation of policy toward full realisation of rights, and programmes that support equal access to services for children with disabilities continue to depend heavily on external funding and individual corporate donations.<sup>181</sup>

However, an encouraging sign is a steady increase since 2010 in expenditures for programmes operated by the Ministry of Social Welfare (MoSW) in support of children with disabilities. In the 2012-2013 Annual Development Budget, for example, the Government allocated 2.5 per cent of GDP and 15 per cent of the total budget for social protection programmes, including programmes for children with disabilities.<sup>182</sup>

Chapters 4, 5, 6 and 7 offer further details of specific key development challenges with regard to children with disabilities. Overall, this calls for socially inclusive services across sectors, with key priorities including (1) disability-friendly changes to school infrastructure and instruction as well as teacher skills; (2) scaling up of social protection interventions, including cash transfers for children with disabilities; (3) provision of disabled-friendly,

177 Population and Housing Census 2011, and MICS 2006, which referred to children aged 2-9 years; cited in UNICEF Bangladesh, *Children in Bangladesh and the 7th Five Year Development Plan 2016-2020*. Dhaka, 2014 (hereafter Children and 7FYP).

178 Disability Situation Analysis, op.cit.

179 Committee on the Rights of the Child. *Concluding Observations of the Committee on the Rights of the Child: Bangladesh*. New York, June 2009 (hereafter CRC Concluding Observations).

180 Disability Situation Analysis, op.cit.

181 Ibid.

182 Government of Bangladesh, *Fifth Periodic State Party Report on the Convention on the Rights of the Child*. Dhaka, 2012 (hereafter CRC State Party Report).

gender-sensitive WASH facilities; (4) enhanced parenting skills to favour early identification and referral of children with disability; and (5) community awareness raising and sensitisation to prevent discrimination and stigmatisation and improve community social responsibility.

### 2.5.2 Vulnerability to Disaster

According to the World Risk index 2012, Bangladesh ranks as the world's fifth-highest disaster risk country. Bangladesh thus is one of the world's most disaster-prone countries, with nearly all of its area and nearly all of its people at risk of multiple hazards; children and women have particular need for strengthened resilience. While cyclones and floods pose the greatest risk to Bangladesh at national level, the northeastern and southeastern regions are vulnerable to earthquake as well.<sup>183</sup> In 2011, about 92.5 million people (64 per cent of the total population) were exposed to flood hazards to some degree. More than two-thirds of these people were subject to low or moderate river flooding or low flash flooding, which are the processes by which historically soil fertility has been maintained. However, about 10 per cent of these – some 9.3 million people – were exposed to severe flash and river flooding. Another 7.2 per cent were exposed to severe tidal surges, which produce inundation, a form of flooding that can have long-lasting effects.<sup>184</sup>

Recurrent hazards erode development gains and perpetuate vulnerability. Moreover, the impact of hazards is evident in reduced food intake and reduced levels of sanitation and hygiene, as well as limited health expenditures. Global evidence shows that disasters affect children and women more than men. During disasters, child marriage and child labour becomes an option for parents to reduce their own household vulnerabilities. Withdrawal of children, especially boys, from school for child labour is also more common during disasters.<sup>185</sup> Disaster likewise disrupts learning as classrooms are destroyed and being used as shelters. Child trafficking, drowning, malnutrition and infectious disease as a result of disaster further threaten lives and well-being of children.

People with disabilities face acutely heightened vulnerability in light of this proneness to national disaster,<sup>186</sup> with targeted measures needed to reduce their risk and ensure that emergency response reaches them in time. Refugee children with disabilities, living in camps for Rohingya refugees from Myanmar, often face double discrimination in accessing mainstream services due to negative attitudes of teachers and health service providers, as well as facing difficulty accessing water, sanitation and hygiene facilities.<sup>187</sup>

International observers predict that Bangladesh will be adversely affected by climate change in the form of the melting of Himalayan glaciers, global warming, rising sea levels, reduced land under cultivation and greater water scarcity. Bangladesh's vulnerability to disasters will be aggravated by climate change in two ways: first, through the likely increase in weather and climate hazards, and second, through increases in the vulnerability of communities to natural hazards, particularly through ecosystem degradation, reductions in water and food availability and changes to livelihood. Those who lose their livelihood due to climate change have to migrate to new habitats that usually lack safe drinking water, sanitation, health and education services, or roads, severely reducing children's and women's resilience towards hazards.

Although hazards cannot be prevented, their effects can be mitigated and socio-economic vulnerability to disasters can be reduced. In recent decades, the Government has invested

183 Bangladesh Disaster Risk Managements Profile, 2006

184 Ibid.

185 Government of Bangladesh. *Bangladesh Household Income and Expenditure Survey 2010*. Dhaka, 2011.

186 Disability Situation Analysis, op.cit.

187 Ibid.

more than US\$10 billion to make the country less vulnerable to natural disasters.<sup>188</sup> It also has developed state-of-the-art warning systems for floods, cyclones and storm surges, and is expanding community-based disaster preparedness. Climate-resilient varieties of rice and other crops also have been developed. In addition, the Government's Vision 2021 document clearly states the need for the integration of Disaster Risk Reduction (DRR) and Climate Change Adaptation (CCA) in all development plans and projects.<sup>189</sup> The Government also jointly developed a draft framework on DRR in Education in Emergencies, with the Education Cluster. The challenge Bangladesh now faces, however, is to scale up these investments to create a suitable environment for socioeconomic development and to secure the well-being of the people, including women and children.

Although the population of Bangladesh has increased exponentially since independence, the land under cultivation has declined by 6.6 per cent.<sup>190</sup> Essentially, no "land frontier" remains in Bangladesh that would allow the supply of land to be augmented. It has been estimated that 26,000 people per year are losing their land because of the effects of flooding and erosion.<sup>191</sup> Climate-related risks in particular can have negative consequences for agricultural output and livelihoods in general.

### 2.5.3 Hard-to-Reach Areas

Bangladesh is progressing homogeneously in some of its development outcomes, but it also is home to more challenging disparities than previously believed. Geographic remoteness or isolation has been identified as a major driver of social stagnation, despite increased efforts to reach and open up these hard-to-reach areas.<sup>192</sup> For example, the 50 most deprived/least performing *upazilas* are generally in the remotest parts of the country, many of which have the lowest population density. Vast inequalities may occur even within the same district: Noakhali District, for example, is home to both the best- and worst-performing *upazilas* in its Division, Chatkhilis and Hatiya respectively.<sup>193</sup>

As indicated in Section 1.2, the intensity of deprivation generally reduces from the east to the west of the country. High-deprivation areas are mainly in the Divisions of Chittagong and Sylhet, particularly in the hilly areas of Chittagong (see Box 2).<sup>194</sup> The highest-deprivation areas are mostly concentrated in the region between Dhaka and Sylhet Divisions and in the far south in Chittagong; in addition to these least accessible areas, deprivation is also highest in the most densely populated areas (urban slums) (see also Section 2.4.6).

Tea garden populations, especially children and women, also are extremely poor and vulnerable, and need to be considered from a corporate social responsibility (CSR) perspective. For example, the situation in the tea gardens is considerably worse in some areas of development than for Bangladesh as a whole, including in terms of poverty, infant and under-5 mortality, child malnutrition, and education.<sup>195</sup> In many cases, the development

188 Government of Bangladesh. *Bangladesh Climate Change Strategy and Action Plan 2009*. Dhaka, 2009.

189 Government of Bangladesh. *Bangladesh national progress report on the implementation of the Hygo Framework for Action (2013-2015)*, 2015

190 Estimated from data published in the Bangladesh Bureau of Statistics' *Statistical Pocketbook 2012*.

191 DIS, op.cit.

192 Child Equity Atlas, op.cit.

193 Ibid.

194 Ibid.

195 UNICEF Bangladesh. *Assessment of the Situation of Children and Women in the Tea Gardens of Bangladesh*. Dhaka, 2011. Tea garden workers were originally brought to Bangladesh from different parts of India by the British colonisers; the tea garden population spreads over five major tea-growing districts (Chittagong, Habiganuj, Moulvi Bazar, Panchagarh and Sylhet). Some 30 different ethnic backgrounds have been identified among the tea workers, who tend to speak their own languages and communicate relatively little with those from different ethnic identities. Infant mortality rates in the tea gardens are almost twice as high as the national average (83 per 1,000 live births), while 74 per cent of households fall below the absolute poverty line, more than double the national average. Overall prevalence of underweight, stunting and wasting in under-5 children is alarmingly high, at 61.4 per cent, 56.4 per cent and 29.3 per cent respectively, further indicating the challenges to achieve equity for these children. Daily food intake is only 761.5 grams, lower than the minimum 934 grams required for balanced nutrition. Reflecting poor complementary feeding practices, only 29.6 per cent of children aged 0-11 months are adequately fed in terms of both breastfeeding and complementary foods. Only 5 per cent of children aged 36-59

indicators are far worse than even those in other hard-to-reach areas. Therefore, to reduce inequity and achieve Vision 2021 with justice, the most deprived areas will need to be given due priority to ensure effective coverage of basic services.

### Box 2: The Special Case of the Chittagong Hill Tracts\*

The Chittagong Hill Tracts (CHT) are located in the southeast of Bangladesh and consist of three districts (Bandarban, Khagrachari and Rangamati). The region is home to 11 ethnic groups in addition to the Bengali population, and has a total population of 1.6 million (1 per cent of the national population). Each ethnic group retains a distinct language, culture, tradition and justice system. Furthermore, CHT is geographically distinct from most parts of plains Bangladesh, characterised by very steep, rugged, mountainous terrain and dense jungle in areas.

The region was marked by 25 years of conflict, which formally ended with the signing of a Peace Accord in 1997. Special local government institutions such as Regional Councils, Hill District Councils and traditional institutions (circle chief, mouja headman) are in place, with special and customary laws prevailing. Despite significant progress in Bangladesh as a whole, however, poverty remains prevalent in CHT. More than 60 per cent of households live in absolute poverty, twice the national rate, and one-fourth of the population is extremely poor.\*\* The poverty status of women in CHT is of even greater concern, as almost all women there (94 per cent) live below the absolute poverty line and about 85 per cent fall below the threshold of the extreme poor. About 18 per cent of people in CHT are aged 15-24; however, many of these youth have missed out on development initiatives, leading to high levels of unemployment and social discontent.

Human development indicators in CHT are consistently below national averages. All three districts fall in the 20 underperforming/deprived districts identified by the United Nations Development Assistance Framework 2011-2015. Even among these 20 districts, the CHT sites are at the bottom for most indicators. For example, the prevalence of stunting and chronic undernutrition in CHT is significantly higher, at 48 per cent, than the national average; according to the MICS 2012-2013, undernutrition ranges up to 53 percent in Khagrachari District. Reduced dietary diversity, a strong predictor of stunting, also shows poor minimal acceptable diets among children aged 6-23 months. Key drivers of disparities in CHT context include inadequate infant and young child feeding and care practices, including hygiene and improved WASH facilities. Early initiation of breastfeeding and diversity of complementary foods for young children also are much lower. Details of disparities in other human development indicators in CHT are given in Chapters 4, 5, 6 and 7.

Major bottlenecks affecting effective coverage of basic services include the availability of facilities, which is far below the norms set for the country, compounded by large-scale vacancies and chronic absenteeism as obstacles to service delivery. Although Hill District Councils are intended to assume many of the responsibilities for service delivery, many of the transferred responsibilities have not been adequately financed. Hence, a network of “para centres” – venues for early learning, micronutrient supplementation and nutrition counselling, and health service delivery – are using members of the local community, usually women, to deliver basic services.

\*Source: UNICEF Bangladesh, “Concept Note on UNICEF Support to CHT.” Dhaka, 2015.

\*\* Human Development Resource Centre, Household Survey in Bandarban, Khagrachari and Rangamati, 2013.

months are attending preschool, while the overall net primary school attendance rate (ages 6-10 years) is only 62 per cent, compared to nearly universal primary education overall in the country. Only 24 per cent of children had completed their full course or primary schooling in a given year and at the correct age for graduation. Only 32 per cent of women aged 15-24 in the tea gardens are literate; in some tea gardens, women’s literacy stood at just 12 per cent.





## Chapter 3

# The Policy and Governance Context for Children's Lives

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Throughout nearly 45 years of independence, Bangladesh has been determined to achieve social justice in its development.<sup>196</sup> The Constitution is built upon the principles of fundamental human rights and freedom, equality and justice, and non-discrimination; in turn, these values underlie the intertwined objectives of the Sixth Five Year Development Plan 2011-2015.

Accordingly, Bangladesh's Vision 2021 seeks to achieve higher per-capita income in a development scenario where citizens are expected to enjoy an improved standard of living, better education, increased social justice, a more equitable socioeconomic environment, and sustainability of development through protection from climate change and natural disasters. The associated political environment is to be based on democratic principles, with an emphasis on human rights, freedom of expression, rule of law, equality irrespective of race, religion and creed, and equality of opportunities.<sup>197</sup> However, political institutions are still evolving, and political violence and strikes are common; community mobilisation also occurs for political reasons.<sup>198</sup>

Bangladesh has made notable progress in democratic governance, successfully managing the democratic transition from a caretaker Government to an elected Government in 2008 with one of the highest levels of participation in the country's history.<sup>199</sup> In particular, electoral management and institutions of accountability have been strengthened. The judiciary has been separated from the executive branch of Government, and laws establishing a National Human Rights Commission, Right to Information Commission and Anti-Corruption Commission have been passed. In addition, the United Nations Convention Against Corruption was ratified in 2007, a National Identity Card was introduced in 2009 to support

196 Child Equity Atlas, op.cit.

197 Centre for Policy Dialogue, *Bangladesh Vision 2021*. Dhaka, 2007.

198 Political Economy, op.cit.

199 UNDAF 2012-2016, op.cit.

public service delivery, efforts are being made to establish a pro-poor media environment, and a highly proactive civil society (see also Section 3.4) continues to support poverty alleviation. Nonetheless, overall the structure of Government requires astute responses to power, autonomy, relationships and associated sensitivities.<sup>200</sup>

With regard to its commitment to children, Bangladesh has implemented various development programmes through different social sector Ministries, such as the Ministry of Health and Family Welfare (MoHFW), Ministry of Primary and Mass Education (MoPME) and MoSW. It also has recently adopted a considerable number of laws/Acts for protecting the rights of children (see also Section 3.2), including the Children Act 2013, the Birth and Death Registration Act 2013, the Disabled People's Rights and Protection Act 2013, and National Human Rights Act 2009. These have been complemented by a number of national policies, including the Early Childhood Care and Development Policy 2013, National Children Policy 2011, National Health Policy 2011, National Education Policy 2010, Child Labour Elimination Policy 2010, and National Population Policy 2012. Amendments to the Labour Act made in 2013 include several provisions to improve workplace safety,<sup>201</sup> and require the establishment of health centres in workplaces of more than 5,000 employees.<sup>202</sup>

Despite these achievements, gains that have been made are fragile and numerous challenges remain, particularly in a highly polarised political environment.<sup>203</sup> In particular, good governance and strong institutions that protect human rights are inter-linked, as the Government acknowledges.<sup>204</sup> Yet capacities for effective governance require significant strengthening to make institutions more responsive, capable and accountable, and to benefit the most vulnerable people, including children and women.

Central and local governments alike are undergoing organisational and legislative change driven by the need to significantly improve service delivery; however, these are long-term processes. The Government has highlighted the need to reform the civil service, including merit-based recruitment and promotion; strengthened capacity development; promotion of an effective work environment and incentives; establishment and enforcement of clear codes of conduct; and seeking of feedback on performance from citizens. The Government also has pledged to progressively decentralise much of the responsibility for delivering basic services to local governments, with the aim of instituting strong elected local governments that are vested with adequate financial autonomy and accountability for results. (Overall roles and capacities of duty bearers with regard to issues affecting children and women, including local Government bodies, local service providers, and national Government, are analysed and detailed in Chapters 4, 5, 6 and 7.)

Under the Sixth Plan, emphasis is being given to improving service delivery in the areas of education, health, population, nutrition and water supply, with consideration of strengthened public-private sector partnerships for selected economic services.<sup>205</sup> The Government also is focusing on the review of national laws and their effective implementation by strengthening law enforcement agencies and the judiciary, a particularly important sector given its role in upholding the rule of law, resolving disputes and providing checks and balances; however, the judiciary continues to suffer from large backlogs of more than 1.8 million unresolved complaints.<sup>206</sup> Consequently, the poor and disadvantaged, especially women and children/adolescents, may not be able to always access fair and equitable justice.

200 UNICEF. *Formative Evaluation of UNICEF's Monitoring Results for Equity System (MoRES), Case Study: Bangladesh*. New York, August 2014 (hereafter MoRES Evaluation).

201 United Nations News Centre, "Revised Bangladesh Labour Law 'Falls Short' of International Standards – UN Agency." 22 July 2013, accessed at <http://www.un.org/apps/news/story.asp?NewsID=45470#.VbBy5rXxlU>.

202 Ibid.

203 UNDAF, op.cit.

204 Sixth Plan, op.cit.

205 Ibid.

206 Ibid.



Critically, child-focused budgeting is expected to be initiated by the Government beginning in fiscal 2015-2016, a development that is aimed at strengthening systemic and institutional responses on behalf of children. Taking this initiative forward implies that each intervention should be costed, budgeted and funded to cover the full population of children whose rights are encoded in each specific social service. In addition, the budgetary outlay will need to be linked to a means of measuring the value for money that public investment procures through robust and sound delivery strategies and accountability of public or private institutions. Affordability analysis of each of the interventions will be crucial, encompassing equity and social justice considerations of not only financial and human resources, but also of facilities.

Other improvements in planning and budgetary processes are focused on strengthening annual performance reviews, enhancing capacities of line Ministries to undertake effective planning and budgeting, and streamlining project approval. Efforts also are being undertaken to implement a medium-term budgetary framework in all line Ministries and to institute and implement an effective, results-based monitoring and evaluation (M&E) framework for public programmes.<sup>207</sup>

Overall, however, Bangladesh has not yet effectively utilised the basic infrastructure it has in place for good governance; it continues to rank low not only on global measures of human development (see also Section 2.2), but also on budget transparency and corruption control.<sup>208</sup> Further, Bangladesh still scored lowest (2.9 out of 6) for public sector management and institutions in the World Bank's Country Policy and Institutional Assessment 2013. One recent small-scale survey<sup>209</sup> on the impact of corruption on the quality of governance of Bangladesh found that 40 per cent of respondents felt it hindered the development process; 28.33 per cent said it limits public access to State services; 20 per cent said it degraded social norms and values; and 11.67 per cent believed it abused the Government exchequer.

Evolution and implementation of new policy often is slow.<sup>210</sup> In particular, as noted above, confrontational "winner-take-all" political dynamics continue to hamper efforts to strengthen democratic governance, develop mechanisms to protect human rights and achieve international development goals.<sup>211</sup>

Despite the new focus on local-level planning, issues of decentralisation and local governance continue to be prominent. Local government bodies still face challenges in functioning independently of the centre (see also Section 2.4.2), and of political interests; lack of a specific decentralisation policy, as well as a separate budget code for local expenditures, represent major concerns. Many local government bodies also are still dominated by powerful local residents.<sup>212</sup> Urban governance (see also Section 2.4.6) faces particular challenges that require an enhanced focus, especially with regard to strengthening and institutionalising community structures and poverty reduction tools.

At the same time, positive changes are occurring: For example, local capacity building and community empowerment interventions have resulted in the establishment of inter-sectoral coordination committees at district, *upazila* and union levels in 20 low-performing UNDAF districts for better convergence. Similarly, local-level evidence bases have been developed with community information and bottleneck analysis at union, *upazila* and district levels. Some pilot districts are beginning to develop integrated plans for children, including

207 Sixth Plan, op.cit.

208 Bangladesh is ranked 145<sup>th</sup> out of 175 countries by Transparency International on the Global Corruption Perception Index 2014. It has a corruption perception index of 25 out of 100 (zero being highly corrupt and 100 being very clean); and a ranking of 48 out of 100 for 2010 under the "open budget index" measuring transparency of budget reporting.

209 Miazi, Md. Abu Nayem and Md. Nahidul Islam. "Prospect of Good Governance in Bangladesh: A Review," accessed at [http://www.primeuniversity.edu.bd/070513/journals/contents\\_pdf/06\\_Prime\\_University.pdf](http://www.primeuniversity.edu.bd/070513/journals/contents_pdf/06_Prime_University.pdf)

210 Political Economy, op.cit.

211 Ibid.

212 Miazi and Islam, op.cit.

with regard to emergency preparedness, and to allocate funds for children from the local government budget.<sup>213</sup>

In all, effective governance during the upcoming Seventh Five Year Plan 2017-2021 presents a unique opportunity to take Bangladesh to the next level, where no child is left behind, particularly the most disadvantaged and vulnerable. Specifically, it offers opportunities<sup>214</sup> to prioritise investment into rights-oriented interventions, including addressing all forms of violence and harmful practices against children and women.

Ending child marriage and child labour, promoting child-sensitive social protection and early childhood development, giving adolescents opportunities to acquire productive skills for gainful employment in decent work, ensuring the rights of children with disabilities, reaching out to protect the rights of families and children in urban slums and environmentally challenged areas, and creating an enabling policy environment for business enterprises to respect the rights of children and their parents<sup>215</sup> – all these, and more, must receive additional attention if Bangladesh is to increase its voice in the global development arena. Combined with a variety of other key development factors – enhanced child care and parenting support; social protection and strengthened data on excluded children; a society that accepts children's potential; institutions and systems that give them voice and protect their rights, along with sufficient public investments that reach them; and mechanisms that keep public and private sector actors accountable – then Government decisions can become more rights-based and equity-driven on behalf of children, adolescents and women.

### 3.1 INTERNATIONAL COMMITMENTS ON CHILD RIGHTS AND GENDER EQUALITY

Through the endorsement and promulgation of numerous instruments, Bangladesh has demonstrated its commitment to promote a sound legislative and policy environment for the realisation of the rights of every child. Bangladesh became a State Party to the CRC in 1990<sup>216</sup> and ratified CEDAW in 1984 and CPRD in 2007. Further, Bangladesh endorsed the Sustainable Development Goals in September 2015, the Millennium Declaration in 2000 and the World Fit for Children document, an outcome of the 2002 United Nations General Assembly Special Session on Children, while also endorsing the Beijing Platform for Action in 1995 to attain the objectives of safeguarding gender equality, legal rights and empowerment of women. It also is among governments that have adopted the Dakar Framework for Action for Attaining Education for All, which calls for expansion and improvement of comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children, and the Declaration of Commitment on HIV/AIDS, from the United Nations General Assembly Special Session on HIV/AIDS in 2001.

Regionally, Bangladesh is a party to the SAARC Regional Arrangements for the Promotion of Child Welfare in South Asia and SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution, both 2002; the SAARC Social Charter 2005; the Colombo Statement of Children of South Asia 2009; and, most recently, the Colombo Declaration 2011, which promotes child-sensitive social protection.

The Committee on the Rights of the Child, in its most recent Concluding Observations of 2009, welcomed the strong political will to address children's issues in Bangladesh; new Concluding Observations were awaited following Bangladesh's most recent review

213 The Government has initiated district budgeting in three low-performing UNDAF districts.

214 Children and 7<sup>th</sup> FYP, op.cit.

215 See further: Committee on the Rights of the Child, note 8, para. 5.

216 Bangladesh still holds reservations to CRC Article 14 (with regard to freedom of thought conscience and religion) and Article 21 (with regard to adoption, including inter-country adoption); the Government has not made a final decision about withdrawal of these reservations, and considers that the Constitution has recognised the right to freedom of thought, conscience and religion to every citizen of the country.

in late September 2015. Nevertheless, the Committee expressed concern that effective coordination and monitoring have not been fully developed, in particular due to the relatively low empowerment of the Ministry of Women and Children Affairs (MoWCA) as the coordinating body vis-à-vis other Ministries, sectors and levels of administration involved in implementation of the rights of the child. In addition, the Committee noted with concern the risk of overlapping and duplication between the National Council for Women and Child Development, MoWCA and the anticipated Department for Children under MoWCA, which only now is being established.

In particular, the Committee was concerned that the principle of non-discrimination contained in Article 2 of the CRC is not fully respected in practice. It noted that girls continue to face discrimination and disparities (see also Section 2.4.3), as do vulnerable groups of children, including children with disabilities, children in slums and rural areas, refugee children, and children of ethnic and religious minorities.

The Committee additionally regretted that investment in children, especially regarding health, education and social protection, continues to be too low to ensure the full exercise of all rights by all children. It recommended that the Government share of available resources for implementation of the rights of the child be increased. Weak monitoring and accountability mechanisms for budgetary expenditure at different levels of the administration also was a significant concern of the Committee, as was evidence that corruption continues to divert resources that could enhance the implementation of the rights of the child. The Committee particularly highlighted that a significant percentage of the national budget comes from donor and external sources, which may not be sustainable. The Committee also recommended that Bangladesh take urgent measures to monitor and address exploitative forms of child labour and consider ratifying ILO Convention No. 138 (1973) on the Minimum Age for Admission to Employment.<sup>217</sup> Lastly, it was of the view that the right to be heard needed further development, and was concerned at the few opportunities that the family in particular provides for voicing a child's own opinion and for participation in family, school and community decision making (see also Chapter 7).

Many of these concerns continued to be reflected in the Universal Periodic Review (UPR) 2013 of Bangladesh, where numerous recommendations related to strengthening efforts to empower women and children, particularly with regard to addressing violence against women and children, trafficking in women and children, and inclusiveness for children with disabilities.<sup>218</sup>

### 3.2 NATIONAL LEGISLATION AND CHILD RIGHTS POLICIES

The Constitution encompasses several key Articles with regard to child rights, including: Article 17 (universal system of education); Article 18(1) (raising the level of nutrition and improving public health); Article 27 (all citizens are equal before the law and entitled to equal protection of the law); Article 28(1) (non-discrimination); Article 28(2) (equal rights for women in public life); Article 28(3) (access to public facilities for all); Article 28(4) (allowing special provisions for women and children); Article 29(1) (equality of opportunity); and Article 29(2) (no discrimination in public employment).

Bangladesh also has a number of longstanding national policies and laws/Acts related to children; for example, the Compulsory Primary Education Act was enacted in 1990. Since 2009, the date of the last UNICEF Situation Analysis, a number of critical laws, policies and

<sup>217</sup> Committee on the Rights of the Child, op.cit.

<sup>218</sup> United Nations General Assembly, Human Rights Council. *Report of the Working Group on the Universal Periodic Review: Bangladesh*. New York, July 2013.

strategies have been enacted that are of particular importance for children and women. Table 2 below details the most important of these.

In particular, the Children Act 2013 represents a breakthrough for child rights and child protection, especially for children in contact with the law (see also Chapter 7). The Act, which abolishes the Child Act 1974, explicitly defines a child as anyone younger than age 18 and brings Bangladesh into congruence with the definition of a child in the CRC. At the same time, however, the Act still adheres to Bangladesh's longstanding and very low age of criminal responsibility, at only 9 years.<sup>219</sup> It also commits to the appointment of probation officers and the formation of a National Child Welfare Board, as well as relevant bodies at district and *upazila* levels. Child Help Desks also are to be formed in police stations across the country. Other reforms mandate at least one Children's Court in a district or metropolitan area, and the trial of a child in that court, regardless of the crime of which s/he is accused. Arrest procedures for children and sentencing for abuse of children also are covered.

Table 2: Key National Legislation with Regard to Children and Women

Date	Act	Details
2009	National Human Rights Act	Mandates the provision of adequate human and financial resources for promoting and monitoring human rights, including child rights, and for redressing complaints of rights violations
2010	National Education Policy	Focuses on development of an education system suitable for the delivery of high-standard education for all children beginning with preschool age
2010	Child Labour Elimination Policy	Aims at making meaningful changes in the lives of children by withdrawing them from all forms of child labour, including hazardous work and worst forms of child labour
2010	Domestic Violence (Prevention and Protection) Act	Establishes equal rights for women and children as prescribed in the Constitution for ensuring protection of women and children from family violence
2011	National Children Policy	Recognises the age of children at below 18 years to help realise child rights in light of the national Constitution and international Conventions
2011	National Health Policy	Recognises that despite successful implementation of current activities to reduce child mortality, differences exist by geographic regions and thereby impede positive results from Government initiatives and efforts to reach the public, as well as obstruct the attainment of sustainable and stable development results overall. With regard to malnutrition, the policy acknowledges that malnutrition, along with diseases caused by malnutrition, associated gender discrimination and food insecurity, have added a new dimension to tackling the challenges related to malnutrition issues, which in turn demands more attention for further planning.

<sup>219</sup> Ali, Hon. Justice M. Imman. *Justice for Children in Bangladesh: The Children Act 2013 – A Brief Commentary*. Dhaka, 2013.

Date	Act	Details
2011	National Women Development Policy	Elimination of all forms of discrimination against women, recognising the fact that men and women are equal in all areas of human rights and fundamental freedoms
2011	National Skills Development Policy	Provides a clear statement of the reform agenda and strategy for skills development with quality, as well as delivery mechanisms to meet requirements of the labour market. Includes employability of people with disabilities, along with strengthened coordination and monitoring among and by involved Government and non-Government agencies.
2012	Bangladesh Population Policy	Two important objectives are to reduce child and maternal mortality and to take necessary steps to improve child and maternal health by ensuring safe motherhood while also achieving gender equity in child and maternal health
2012	The Prevention and Suppression of Human Trafficking Act	Enacted to prevent and subdue human trafficking, including that of children, and to ensure protection and rights of the victims of human trafficking, as well as to ensure safe migration. The spirit of the Act is to prevent and subdue human trafficking-related inter-country organised crimes in conformity with international standards
2012	Pornography Control Act 2012	The Pornography Control Act 2012 prevents depreciation of the social and moral values, with special focus on women and children. The definition of pornography includes production and dissemination of video documentary, audio-visual materials, graphics, books, periodicals, sculpture, cartoons, leaflets and imaginary statues using uncivil dialogue and picture, acting, body movement, naked dance, etc., which may create sexual appeal. The Act strongly prohibits production, preservation, marketing, supply, buying and selling and dissemination of all forms of pornographic items.
2012	Prime Minister's Education Assistance Trust Fund Act	Aimed at ensuring education for poor meritorious students from Class 6 to graduate or equivalent class



Date	Act	Details
2013	Bangladesh Water Act 2013	Enacted for integrated development, management, extraction, distribution, usage, protection and conservation of water resources in Bangladesh, which provide the right framework for better management of water resources in the country. Also provides the formation of the high-level National Water Resources Council with the Prime Minister as the head, signifying the importance the Government is giving to the management of this precious resource. The Act also provides provisions for punishment and financial penalty for non-compliance, including negligence to abide by Government policy, ordinance, non-cooperation with Government officials, refusal to present necessary documents, providing false information, affiliation with perpetrators, and protection measures for water resources management.
2013	The Children Act 2013	The new Act is harmonised with the United Nations Convention on the Rights of the Child (CRC) and references the CRC in the preamble. It replaces the Child Act 1974. The Act recognises an individual aged 18 or younger as a child, providing a universal and internationally recognised definition for a child. It introduces Child Help Desks in police stations and emphasises the necessity of dealing with children in conflict with the law through diversion, family conferencing and dispute resolution procedures. It also establishes Children's Courts in districts and metropolitan areas, and ensures Child Welfare Boards at national, district and <i>upazila</i> levels to oversee the due rights of children in need of care and protection. Provisions also include protection of child victims and witnesses.
2013	Breast Milk Substitutes, Baby Foods, Commercially Manufactured Supplementary Baby Foods and Its Equipment (Regulation of Marketing) Act	The Act calls for complete restriction on advertisement of breastmilk substitutes, baby foods, children's food supplements and related equipment. Breastmilk substitutes refer to any food which is represented as a partial or total substitute to breast milk for the infant up to 6 months of age. Display, distribution, exhibition, publishing or advertisement in any form to the public (especially to those involved in the health, nutrition and education sectors), is prohibited. Likewise, offering any kind of promotional package like free products, discount, gifts, etc. for the purpose of selling or marketing; organising or supporting any event, programme or competition to promote any breastmilk substitutes, baby foods or supplementary baby foods; and using health care centres or drugstores as sales or promotional points are violations of the Act.



Date	Act	Details
2013	Birth and Death Registration (Amendment) Act	The Act has introduced a provision for birth and death registration of expatriate Bangladeshis, as well as incorporates a 17-digit Personal Identification Number (PIN) of the respective persons. It also provides one-year jail term or a fine of Taka 5,000, or both, for providing false information in connection with birth and death registration. The Government will appoint a Registrar General and adequate manpower to intensively supervise and conduct birth and death registration activities. According to the new law, the record of birth and death registration will be preserved in a digital system.
2013	Disabled People's Rights and Protection Act	The Act has been enacted and harmonised with the United Nations Convention on the Rights of the Persons with Disabilities (CRPD) to protect the dignity of the persons with disabilities and ensure their educational, physical and mental improvement as well as participation in social and State activities, removing all discrimination.
2013	The Safe Food Act	Enacted to stop widespread food adulteration through commissioning of separate courts for the disposal of food-related crimes. It provides departmental disciplinary actions against public servants failing to discharge duties stipulated in the law.
2013	The Neuro-Developmental Disabled Protection Trust Act	Enacted to provide assistance to autistics, including their nurture, security and rehabilitation. It also provides for placement of autistic children under the care of a guardian, who can be a person or organisation.
2013	Fortification in Edible Oil with Vitamin A Act	Enacted to compulsorily fortify edible oil with Vitamin A and prohibit the import of unfortified edible oil. It imposes fines of maximum Taka 1,00,000 for violation of the law. Those repeatedly violating the law could be fined Taka 2,00,000 or given five years' imprisonment
In process	<i>National Plan of Action to End Child Marriage</i>	In process of drafting, under the leadership of MoWCA.
	The Police Act	The proposed Act will both modernise the Bangladesh police force and introduce service delivery, community policing, and protection of human rights- and evidence- based crime investigations. However, the status since April 2013 is unclear.
	Government Employee Act (Public Service Act)	This Act seeks to change the way that civil servants are promoted and to significantly alter the way the civil service is structured, works and operates. However, the Act has been stalled since 2010.

Date	Act	Details
	New Child Marriage Suppression/Restraint Act (intended to replace the one from 1929)	The Act will harmonise the age of marriage of boys and girls to 18 (at the moment girls 18 and boys 21) and will increase severity of punishment for parents, brokers and legal guardians for facilitating child marriage, while introducing penalties for civil servants and <i>kazi</i> registrars who sanction child marriages.
	<i>New draft Anti-Discrimination Act</i>	The proposed Act is to tackle discrimination based not only on sex, sexual orientation, disability, religion, race and ethnicity, but also place of birth, profession, pregnancy status, maternity and mental health
	Revision of the National Human Rights Commission Act	Proposed to ensure the independence of the National Human Rights Commission
	Amendment of CHT Land Dispute Resolution Commission Act, 2001	As per the provisions of the CHT Peace Accord. The law enacted in 2001 was not accepted by all signatories to the Peace Accord. Negotiations chaired by the Law Minister in 2012 resulted in agreement on amendments to 13 points. In 2013, the Cabinet approved amendments that did not fully reflect the 13 points and additional negotiations took place subsequently. The Amendment is yet to be approved by Parliament.
	<i>Education Act</i>	Drafted in 2013; still to be passed.
	<i>Communication Policy</i>	A National Communication Policy with a strong social and behaviour change communication component. Ongoing.
	<i>ECCD Policy</i>	.
	<i>Alternative Care Policy</i>	
	<i>Harmonisation of other key laws with the Children Act 2013</i>	
	<i>Child Protection Policy</i>	
	<i>Children's Department Strengthening of MoWCA</i>	
	<i>National Maternal Health Strategy</i>	
	<i>National Strategy for Urban and Rural Water Supply and Sanitation</i>	
	<i>National Nutrition Policy</i>	

Source: UNICEF Bangladesh

### 3.3 ISSUES OF DATA

National ownership and capacity in evidence generation, data analysis and quality assurance is increasing, as illustrated by the effort of the Bangladesh Bureau of Statistics (BBS) to manage the MICS 2012-2013 survey independently for the first time (see also Section 2.2.2). However, the Committee on the Rights of the Child, in its 2009 Concluding Observations, has expressed particular concern that reliable, disaggregated official data in important areas of the Convention were not available, including statistics on child births, health, child abuse, child labour, and children working and/or living in the streets. It noted the lack of coordination and collaboration among Government agencies in data collection and inadequate technical capabilities for data collection, analysis and reporting.<sup>220</sup> A limited range of partners at national level with the capacity to produce high-quality research and analysis, particularly on child-sensitive social protection issues (see also Chapter 7), remains a key challenge.<sup>221</sup>

It will be necessary to continue and expand capacity development partnerships to track, report and use knowledge of bottlenecks to promote effective coverage of social services.<sup>222</sup> In particular, the introduction of scalable innovations to generate and use close to real-time data to inform social sector annual planning/budget decision making can be useful. In addition, reforming of primary data collection within BBS with innovative tools would strengthen the data collection system overall, complemented by the strengthening of existing data collection mechanisms to collect information on selected social sector indicators. With the expected advent of child-focused budgeting, a specific Government unit dedicated to this can strengthen the link between evidence on equity and disparities, public finance and social budgeting for children.

### 3.4 OTHER KEY ACTORS ON BEHALF OF CHILDREN AND WOMEN

A striking feature of service delivery in Bangladesh is the historically strong role of community-based and non-Government organisations in development, often supported by funds from international development partners. Bangladesh has more NGOs per capita than any other developing nation, providing social services, microcredit and other services. As of July 2013, 2,252 NGOs were registered by the Government's NGO Affairs Bureau; more than 18,000 NGO-supported projects were reported in the country in 2011.<sup>223</sup> Other sources document the existence of more than 23,000 NGOs, of which more than 4,000 work in the health, population and nutrition sectors alone. The Bangladesh Rural Advancement Committee (BRAC), for example, reaches around 110 million people through 64,000 village health workers.<sup>224</sup> These NGOs fill gaps left by a need for strengthened public services, and many enjoy good relationships with both major political parties.

From a corporate social responsibility (CSR) perspective, the private sector also offers significant promise for fuller engagement on behalf of children and women. As noted in Section 2.2.1, Bangladesh is the second-largest garments exporter in the world. Given its economic influence, the RMG sector has perhaps greater potential than any other sector in the country to reduce poverty and contribute to the well-being of children and women through involvement in CSR. In turn, the impact of the sector on children's rights can be considerable: from income and services afforded to parents, predominantly mothers, to support children and families, to the provision of decent work and youth employment, to child labour in the informal economies that have grown with and around the garments sector.

220 CRC Concluding Observations, op.cit.

221 UNICEF Bangladesh. *Mid Term Review Government of Bangladesh-UNICEF Country Programme 2012-2016*. Dhaka, June 2014 (hereafter UNICEF MTR).

222 Ibid.

223 Political Economy, op.cit.

224 Ibid.

It will be important to build on experience already gained in working with respected international companies<sup>225</sup> to engage businesses and other key stakeholders in relation to living conditions in the urban slums in particular, the growth of which has been significantly driven by the expansion of the garment industry; to ensure that the activities and operations of business enterprises do not adversely impact on children's rights; to create an enabling environment for business enterprises to respect the rights of children, young workers, parents and caregivers, inside as well as beyond the factory gates;<sup>226</sup> and to encourage the building of better factories, as well as better outreach of services, in communities where children's and women's rights can be further respected and supported.

Lastly, Bangladesh is supported by an active group of development partners. At the Government level, the country has established a Joint Cooperation Strategy to Enhance Development Effectiveness 2010-2015 with 18 development partners.<sup>227</sup> The World Bank provides the largest share of development assistance, with a commitment portfolio of US\$6.5 billion in August 2014.<sup>228</sup> Development partners also have actively supported the strong NGO movement in the country, as well as providing support for internationally recognised research institutions such as the International Centre for Diarrhoeal Disease Research, Bangladesh (iccdr,b).

At the same time, development partners need to increasingly understand the political economy of decision making and resource allocation to maximise impact. While Official Development Assistance (ODA) can be helpful and catalytic in supporting reforms, the key to improved outcomes will be how countries prioritise and use their own resources. The "country-driven development" vision of the Paris Declaration and Accra Agenda for Action further point unmistakably to the importance of national planning and budgeting.<sup>229</sup>

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225 Including Marks & Spencer, H&M and UNIQLO.

226 Committee on the Rights of the Child, *op.cit.*

227 Asian Development Bank, Australia, Canada, Denmark, European Union, Germany, International Development Bank, Japan, Republic of Korea, Netherlands, Norway, Spain, Sweden, Switzerland, United Kingdom, United Nations, United States, and World Bank.

228 World Bank data.

229 Political Economy, *op.cit.*





## Chapter 4

# The Right to Food and Adequate Nutrition

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### 4.1 INTRODUCTION

Nutrition issues have assumed new prominence in the post-2015 era, with the proposed SDG2 focused on ending hunger, achieving food security, improving nutrition, and promoting sustainable agriculture. Several other SDGs also refer to nutrition-sensitive interventions, indicating the critical importance of nutrition to the international development framework. Global evidence shows that adequate nutrition in the first 1,000 days between a woman's pregnancy and a child's second birthday has enormous benefits throughout the life cycle and across generations. Most of the cognitive and physical damage or underdevelopment that happens due to poor nutrition during this sensitive 1,000-day window of opportunity is irreversible.

Undernutrition leads to poor health, through reducing immunity and increasing susceptibility to disease; to lower educational attainment, through impaired physical and mental development; and to reduced productivity and earning potential. Evidence indicates that children who are well-nourished do better in school, go on to earn 20 per cent more in the labour market later in life and are 10 per cent more likely to own their own businesses;<sup>230</sup> thus, making nutrition a top national priority not only enhances social equity but also leads to increased economic growth.<sup>231</sup> Ensuring adequate nutrition has been declared a "best buy" for development by the 2012 Copenhagen Consensus findings of Nobel Laureates and internationally renowned economists and researchers. In all, it has been found that every US\$1 spent on improving nutrition can have a US\$30 return on investment.<sup>232</sup>

230 UNICEF Bangladesh et al. *Nutrition Background Paper to Inform the Preparation of the 7<sup>th</sup> Five Year Plan*. Dhaka, February 2015 (hereafter Nutrition Background Paper).

231 UNICEF Bangladesh et al. *Undernutrition in Bangladesh: A Common Narrative*. Dhaka, 2014 (hereafter Common Narrative).

232 Nutrition Background Paper, op.cit.

Bangladesh has significantly reduced undernutrition in the last two decades, driven partly by sustained income growth and partly by greater coverage of health and nutrition services. For example, its progress in reducing childhood stunting rates by nearly half between 1986 and 2013<sup>233</sup> stands as a global success story. Despite these achievements, the pace of the decline in undernutrition as a whole does not match the rapid improvements in other development indicators such as child and maternal mortality, education, poverty reduction and rice production; overall, undernutrition rates among children and women remain serious.<sup>234</sup> Undernutrition already costs Bangladesh more than 7,000 crore Taka (US\$1 billion) in lost productivity every year, and even more in health costs.<sup>235</sup>

Moreover, investment in nutrition is necessary to address disability and untimely death: 45 per cent of under-5 mortality is attributable to undernutrition, including foetal growth restriction, stunting, wasting, deficiencies of Vitamin A and zinc, and suboptimal breastfeeding practices. In Bangladesh, this translates to about 250 under-5 deaths every day. Nutritional deficiencies also are responsible for more than 50 per cent of the years lived with disability in children younger than age 4 years.<sup>236</sup>

Overall, Bangladesh still suffers from two key sets of nutrition issues: The first is a high burden of child and maternal undernutrition, while the second relates to a rapid increase in overweight and obesity and in nutrition-related NCDs,<sup>237</sup> including hypertension, diabetes, heart disease, cancer and osteoporosis. While the country is on track to meet the MDG target on underweight, it is currently off-track for at least four out of six World Health Assembly targets to reduce undernutrition by 2025,<sup>238</sup> to which the Government agreed in 2012. At the same time, food security has generally improved across a range of indicators, and behaviours linked to food insecurity, such as skipping meals and eating less preferred foods, fell dramatically between 2011 and 2013.<sup>239</sup>

Nutrition issues are exacerbated by several of the key crosscutting themes identified in Sections 2.3 and 2.4. For example, traditional practices and social norms may be strongly linked to nutritional status; poor psycho-social care for women has been found to impact on care and feeding practices, with these practices accentuated, and with a greater effect, during pregnancy.<sup>240</sup> In one recent study, it was consistently identified that women reduced food intake in the third trimester of their pregnancy in order to have a baby with a lower birth weight. A perception in the community existed that larger babies need to be born by caesarean section, a belief reinforced by traditional birth attendants.

Climate change also amplifies the threats for all underlying causes of undernutrition, including food security, water and sanitation, and child care practices. Notably, coverage of national programmes tends to be lower in hard-to-reach areas, including CHT and urban slum areas, which face significant bottlenecks in geographic accessibility.<sup>241</sup>

233 Ibid.

234 Common Narrative, op.cit.

235 Nutrition Background Paper, op.cit.

236 Ibid.

237 Ibid.

238 Ibid.

239 Helen Keller International and BRAC Institute of Global Health. *State of Food Security and Nutrition in Bangladesh 2013*. Dhaka, 2014 (hereafter Food Security 2013).

240 ACF-International and European Commission. *Nutrition Causal Analysis in Four Upazilas, Satkhira District*. Dhaka, March 2014.

241 Nutrition Background Paper, op.cit.



## 4.2 NUTRITION INSTITUTIONS, SYSTEMS AND GOVERNANCE

Nutrition is not a sectoral issue, but rather, a complex, multisectoral development challenge, with many underlying determinants (see also Sections 4.3 and 4.4), particularly maternal education, the status of women and girls, access to food and health care, nutrition knowledge, hygiene practices, and infant and young child feeding and care practices. This requires coordinated and comprehensive multisectoral interventions within the Government, with leadership emanating from the highest level. It also requires multi-stakeholder solutions, including partnerships with civil society, the private sector, academia and development partners.

Political commitment of the level required to promote and enable multisectoral approaches in Bangladesh has been generally acknowledged as inadequate,<sup>242</sup> although new momentum and commitment appears to be emerging. Many of the structures, systems and institutional arrangements to accelerate progress in addressing undernutrition are in place, but are often inadequately resourced or insufficiently authorised to fulfil their functions to optimal benefit;<sup>243</sup> strengthening of local-level funding and autonomy to districts offers an important opportunity in this regard. Critically, multi-stakeholder coordination has not yet been institutionalised, and increasing numbers of prominent national or local nutrition champions are required.

Bangladesh was one of the first countries to sign up to the Scaling Up Nutrition (SUN) initiative, an international initiative that aims to bring together a coalition of international and domestic partners, including the private sector, with an interest in nutrition to intensify efforts to address undernutrition. While Bangladesh has been cited for raising the profile of nutrition issues, an assessment of national efforts to achieve the SUN aim also has identified particular weaknesses in terms of public support, effective surveillance, and human resources and capacity, along with good coordination and adequate financing.<sup>244</sup>

Evidence suggests that significant gaps exist between knowledge, policies and action, manifesting as system-wide supply and, especially, demand bottlenecks such as sub-national capacity building and communication for development (C4D) interventions for community mobilisation/engagement, all of which have been acute. Therefore, it is critical that underlying conditions for effective performance of the nutrition system, including policies, legislation, resource allocation and capacity development, be both built up and transformed.<sup>245</sup> Review of project-based and non-project-based support by UNICEF in 20 low-performing UNDAF districts showed that effective coverage of nutrition services delivered through health facilities is not equally distributed and is generally low.

Systems building for nutrition thus must be further promoted on all fronts, including coordination, for leadership, accountability, harmonised approaches and maximised resources and area coverage; access to information, demand generation and community participation, to support evidence-based decision making, monitor results and equity, and ensure a common narrative among stakeholders; policy and budgets, to ensure clear, realistic goals and targets, set standards and guidelines, and ensure adequate allocation of resources; human resources capacity, to ensure interventions meet norms and standards and improve management of resources; and supply chain, to ensure materials, equipment and commodities are adequate for effective coverage and to improve efficiency.

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242 UNICEF MTR, op.cit.

243 Nutrition Background Paper, op.cit.

244 UNICEF Bangladesh and UNICEF EAPRO. *Nutrition Capacity Assessment in Bangladesh*. Dhaka, March 2013 (hereafter Nutrition Capacity Assessment).

245 UNICEF MTR, op.cit.

Critically, nutrition-specific interventions must be complemented by other nutrition-sensitive interventions. This may involve areas such as homestead gardening, nutrition education, and livelihoods diversification, with the objective to improve utilisation and consumption of nutritious foods, especially for women, adolescents and young children. In education, nutrition and physical exercise may be incorporated in the curriculum, while advocacy of education completion for girls and delay of first pregnancy also is key. Social protection likewise can be involved by helping to ensure that poorer households have adequate resources. Industries can be encouraged to adhere to high standards in advertising and marketing, particularly toward children.

NGOs and civil society, academic and research institutes, bilateral development agencies, multilateral development banks, private foundations and media all can also contribute to strengthening evidence-based interventions and programmes. At the same time, it will be critical to ensure that nutrition-sensitive interventions remain adequately focused.

Further progress on nutrition issues in Bangladesh will require significant changes in the level and scope of current investment for nutrition, as well as in the quality of nutrition governance and service delivery. Bangladesh spends only about 3 per cent of GDP on education and health from the national budget, compared to 5 to 6 per cent in East Asian countries.<sup>246</sup> This financing challenge was recognised in the Sixth Five Year Plan but remains unaddressed.<sup>247</sup> Allocations for the agricultural and food sectors also will need to be higher if these are to positively impact people's nutritional status.

In all, Bangladesh has a relatively strong policy mandate for food and nutrition; although the 1997 National Food and Nutrition Policy remains the current national nutrition policy, a new National Nutrition Policy has been finalised and is undergoing the approval process. Introduction of the National Nutrition Services (NNS) in 2011 shifted the nutrition agenda in the health sector significantly, with the mainstreaming of these services becoming the primary focus of nutrition activities. The comprehensive strategy of the NNS replaced the previous stand-alone nutrition programme to directly address undernutrition through mainstreaming of nutrition in existing health and population services as part of the Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011-2016 of MoHFW.

In line with global evidence and consensus that nutrition-specific and nutrition-sensitive interventions alike are needed to address direct and underlying causes of undernutrition, a set of 15 Direct Nutrition Interventions (DNIs) have been included in the HPNSDP.<sup>248</sup> However, the NNS has yet to translate the substantial funds allocated into effective action on the ground.<sup>249</sup> An analysis of the most critical challenges facing the NNS highlighted two in particular: (1) Poor management of the plan in the districts and sub-districts; at district and sub-district levels, no one from any sector has taken responsibility for ensuring that the plan is being rolled out, or for monitoring the results; and (2) Lack of relevant capacity, including interpersonal communication and community engagement skills for demand generation, among health and family planning workers.

Although the Government has conducted large-scale traditional training programmes, health workers do not have the skills that they need to deliver nutrition interventions to the community.<sup>250</sup> In addition, NNS capacity itself remains highly constrained; a wide mismatch exists between extensive activities planned (20 priority areas) and only 13 managers who have been entrusted to look after the countrywide programme. This dearth of trained managers makes supervision and monitoring, as well as coordination, difficult. Retention

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246 Nutrition Background Paper, op.cit.

247 Ibid.

248 Children and 7FYP, op.cit.

249 UNICEF Bangladesh and Children's Investment Fund Foundation. *Bangladesh: Accelerating Implementation of the National Nutrition Services*. Dhaka, October 2014 (hereafter NNS Accelerating).

250 Ibid.

of trained and skilled human resources and an inadequate staffing mix also have become issues.<sup>251</sup> Critically, the core intervention of infant and young child feeding requires significant strengthening in design and implementation, since its promotion is planned to hinge on a curative service platform, where only sick children are brought in.<sup>252</sup>

Under the NNS, a promising pilot in 38 districts has now deployed temporary dedicated nutrition resources, known as District Nutrition Support Officers (DNSO), one per district, to work with district and *upazila* management teams since 2014. The goal is to institutionalise provision of nutrition services into public health facilities and other relevant sectors at the sub-national level. Although the initiative is still new, results achieved so far indicate promise. Just four months after the first DNSOs were deployed, data showed improvements in nutrition inputs and outputs.<sup>253</sup>

Also in terms of local-level planning, data from pilots in two selected unions have highlighted clear bottlenecks resulting in very low levels of both adequate and effective coverage of iron-folic acid (IFA) supplementation. Because the bottlenecks were different in the two unions, the data could be used as a way to work with stakeholders at national level to highlight the fact that a more nuanced and detailed understanding of the issues involved in IFA supplementation is needed.<sup>254</sup>

The data also allowed detailed analysis of bottlenecks for effective coverage of IFA supplementation to be conducted jointly with communities, and corrective actions to be implemented. In turn, the proportion of pregnant women consuming an adequate dose of IFA tablets during pregnancy in the unions has since increased from 13 per cent to 21 per cent.<sup>255</sup>

In other sectors, the Country Investment Plan for agriculture, food security and nutrition, and associated areas of the National Food Policy, both present wide-ranging plans with important implications for food security. Overall, a mapping of nutrition stakeholders in 2012 identified more than 40 entities, including Government agencies, NGOs, research organisations, multilateral agencies, and donors.<sup>256</sup>

As also noted in Chapter 3, Article 18(1) of the Constitution declares that “the State shall regard the raising of the level of nutrition and improvement of public health as among its primary duties.” Several enabling laws and policies have been enacted or are nearing approval. In addition to the new National Nutrition Policy, a law mandating the fortification of edible oil with Vitamin A, complemented by intensive advocacy and support to monitoring and quality control systems, ensured that 16 national oil refineries are producing Vitamin A-fortified edible oil.<sup>257</sup> A revised law on marketing of Breast Milk Substitutes 2013 has been adopted, consistent with international standards. A National Micronutrient Deficiency Control Strategy has recently been approved by the Government, and is based on findings of the 2012 National Micronutrient Survey. Additional initiatives to indirectly affect nutrition outcomes through action on food insecurity, social protection and women’s empowerment are being implemented through Ministries represented on the National Steering Committee for Nutrition.

Other relevant laws include: Formalin Control Act 2014; Food Safety Act 2013; Maternity Protection Law 2011; Pure Food (Amendments) Act 2005; Prevention of Iodine Deficiency

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251 Ibid.

252 Ibid.

253 Ibid.

254 MoRES Evaluation, op.cit.

255 Ibid.

256 Nutrition Capacity Assessment, op.cit.

257 By the end of 2013 market coverage had reached 68 per cent, with more than 109 million people estimated to consume Vitamin A-fortified oil – double the figure of 2012.

Disorders Act 1989; and Food Safety Ordinance 1985. At the same time, wide and effective enforcement of laws relevant to nutrition and food, including with respect to the practices of companies in the agriculture and food and beverage sectors, remains a major challenge overall.<sup>258</sup>

Priority actions also have recently been agreed in the South Asia Regional Action Framework for Nutrition 2014, which builds on SAARC Development Goal 3 (“Ensure adequate nutrition and dietary improvement for the poor”). Bangladesh likewise has made further commitments to address malnutrition at the Nutrition for Growth Summit 2013 and the Second International Conference on Nutrition 2014 (ICN2). Under the Nutrition for Growth Compact, Bangladesh specifically committed to: (1) Reduce stunting from 41 per cent in 2011 to 38 per cent in 2016, and wasting from 16 per cent in 2011 to 12 per cent in 2016; (2) Review the National Nutrition Policy to ensure that both nutrition-specific and -sensitive interventions are given due attention; (3) Strengthen the national coordination mechanism for improving nutrition; (4) Review national safety net programmes to ensure that they are nutrition-sensitive and deliver improved nutrition outcomes; and (5) Mobilise domestic and international finance to support national efforts to improve nutrition.

From a CSR perspective, industry can be encouraged or required to adhere to international standards<sup>259</sup> on advertising and marketing of foods and beverages toward children and their parents.<sup>260</sup> The private sector also can ensure that workplace policies and practices respect international standards as well as national laws regarding maternal and child care practices. Pilot engagement with garment factories in urban areas, for example, is showing improvement in exclusive breastfeeding rates and practices among urban working mothers with children aged 0-6 months.<sup>261</sup>

Critically, a challenge arises in this because of avoidance of, or reluctance to, engage with the private sector due to potential conflicts of interest in nutrition programmes and how to manage this within relevant laws.<sup>262</sup> This issue needs further attention and understanding of ways to mitigate any negative impacts, to engage the widest spectrum possible of stakeholders in promoting nutrition.

### 4.3 KEY INDICATORS OF CHILDREN'S AND WOMEN'S NUTRITIONAL STATUS

Nutritional challenges begin straight from conception for children in Bangladesh, and encompass both quality of nutrition as well as feeding/dietary practices. According to the MICS 2012-2013, more than 1 in 4 infants (26 per cent) weigh less than 2,500 grams at birth and are considered to have low birth weight (LBW), which is an indicator of the newborn's chances for survival, growth, long-term health and psycho-social development (see also Chapter 5.1). As also noted in Section 2.4.3, LBW is strongly associated with mothers' own inadequate nutrition before and during pregnancy; adolescents who give birth when their own bodies have yet to finish growing run a particularly high risk of bearing low-birth-weight babies.<sup>263</sup>

258 Nutrition Background Paper, op.cit.

259 Relevant World Health Assembly (WHA) instruments on marketing and health include, among others, the Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children. National measures have been adopted in many countries to give legal effect to such international standards.

260 See further: “Children's Rights and Business Principles,” op.cit., particularly, Principles 6 & 7.

261 Nutrition Background Paper, op.cit. Innovative tools and approaches have come out of this interaction, such as factories providing time and a safe space for working mothers to breastfeed their infants in the workplace, integrating nutrition counselling in the health clinics of garment factories, and development of tools for safe breastmilk expression and storage.

262 Ibid.

263 MICS 2012-2013, op.cit.

Very little difference is noted between rural and urban areas (37.8 per cent vs. 37.6 per cent), while disparities between Divisions in Bangladesh range from a rate of 33.9 per cent in Rajshahi to 41.3 per cent in Sylhet and Chittagong.<sup>264</sup> Interestingly, LBW is very high in all wealth quintiles, such that more than 1 in 3 babies born even to the richest women is low birth weight; among the poorest, the rate is even higher, at 41.7 per cent. Similarly, even 32.8 per cent of mothers with complete secondary education or higher also had low-birth-weight infants, compared to 41.9 per cent of those with no education.<sup>265</sup> At the same time, a dearth of data exists on risk factors on how best to address LBW.<sup>266</sup>

Childhood stunting (low height for age) is strongly associated with cognitive functioning, poor attention span, physical growth and mortality,<sup>267</sup> and remains prevalent in Bangladesh. More than 4 in 10 children younger than age 5 years (42 per cent) are moderately or severely stunted, while almost 1 in 3 children are moderately or severely underweight (31.9 per cent). About 1 in 6 children are severely stunted (16.4 per cent), and almost 1 in 10 are severely underweight (8.8 per cent). Lastly, about 1 in 10 children (9.6 per cent) are moderately or severely wasted (too thin for their height).<sup>268</sup> The prevalence of wasting has been largely unchanged between 2010 and 2013.<sup>269</sup> Using these figures, the average annual rate for reducing stunting has been only 1.1 per cent, and 1.2 per cent for underweight.<sup>270</sup>

In absolute numbers, all this means that about 6 million children are stunted and 2.4 million children are wasted; another 600,000 children suffer from severe acute malnutrition, a condition that has a 12 times higher risk of death compared with healthy children.<sup>271</sup> Critically, it also must be noted that acute undernutrition peaks during the monsoon season, and thus can be seasonal, adding to the complexity of nutrition issues among children and women in the country.

Those children whose mothers have secondary or higher education or who are from the richest wealth quintile are the least likely to be underweight and stunted, compared to children of mothers from the poorest quintile or with no education; even so, stunting still affects children in nearly a quarter of the wealthiest households.<sup>272</sup>

Notable disparities also exist between rural and urban children. Undernutrition mapping shows that both stunting and underweight rates at Division level are highest in Sylhet, followed by Chittagong, compared to the lowest stunting and underweight rates in Barisal and Khulna;<sup>273</sup> this largely follows the east-west human development divide noted in the Introduction to Chapter 2. Between 2011 and 2012, stunting decreased between 2 and 7 percentage points in all Divisions except Sylhet (5 per cent increase) and Rangpur (1 per cent increase), while wasting decreased in all Divisions except Rajshahi (1 per cent increase). Evidence suggests that factors such as household food security, mother's education and nutritional status, and behaviours related to hygiene and infant and young child feeding may explain higher rates of stunting in Divisions that are lagging behind.

By district, disparities likewise are marked, with at least 1 in every 2 children stunted in about eight districts spread over different Divisions; 39 out of 64 districts have stunting rates above the international critical threshold level (40 per cent). Netrokona district in Dhaka Division has the highest percentage of stunted children, while Meherpur in Khulna Division

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264 Ibid.

265 Ibid.

266 Nutrition Background Paper, *op.cit.* Recent multi-country analysis has shown that since the 1990s, half of all LBW babies born in lower-middle-income countries are pre-term, a proportion greater than estimated in the past.

267 Ibid.

268 MICS 2012-2013, *op.cit.*

269 Food Security 2013, *op.cit.*

270 MICS 2012-2013, *op.cit.*

271 Nutrition Background Paper, *op.cit.*

272 MICS 2012-2013, *op.cit.*

273 Ibid.



has the lowest proportion. At *upazila* level, 300 out of 487 *upazilas* and unions/*thanas* (55 per cent) have a stunting rate above 40 per cent, again demonstrating heightened disparities at more local levels.<sup>274</sup>

Nonetheless, some improvement in child nutritional status over the past decade has occurred. According to the DHS 2014, the level of stunting among children has declined from 51 per cent in 2004 to 36 per cent in 2014, including a decline of 5 percentage points since 2011. The level of underweight has fallen from 43 per cent in 2004 to 33 per cent in 2014. Using these figures, Government targets for 2016 have been achieved. Improvements in wasting have been much slower, however, from 15 per cent in 2004 to only 14 per cent in 2014, indicating the need for continued attention.<sup>275</sup>

Breastfeeding for the first few years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe. International standards recommend that infants be breastfed within one hour of birth, breastfed exclusively for the first 6 months of life, and continue to be breastfed up to age 2 years and beyond. In Bangladesh, nearly all children (97.1 per cent), both girls and boys, are breastfed at some point.<sup>276</sup> However, fewer than 3 in 5 are breastfed within one hour of birth; wide regional disparities are seen, ranging from 47.3 per cent in Khulna Division to 73.5 per cent in Sylhet Division.

Similarly, marked differences are seen between mothers from the poorest and richest quintiles of the population (48.1 per cent vs. 62.5 per cent respectively), and by educational background (48.8 per cent of mothers with complete secondary education or higher; 67.2 per cent of mothers with no education). Urban-rural differences are much less pronounced, at 52.7 per cent and 58.6 per cent respectively. Rates improve significantly in all categories for breastfeeding within one day of birth.

In all, however, this indicates significant gaps in an important step in the management of lactation and establishment of a physical and emotional relationship between baby and mother. Moreover, according to the Government's Utilisation of Essential Service Delivery (UESD) Survey 2013,<sup>277</sup> babies delivered in a health facility have a dramatically lower likelihood of being breastfed within the first hour (29 per cent) compared to 53 per cent of infants delivered at home, which demonstrates a gap in health facilities in counselling on adequate infant and young child feeding and on baby-friendly approaches.

In addition, only 56.4 per cent of children younger than age 6 months are exclusively breastfed, a level lower than recommended.<sup>278</sup> The DHS 2014 reports a decline in exclusive breastfeeding since 2011, down to 55 per cent from 64 per cent, but still well above the 43 per cent recorded in 2007. With 71.9 per cent of children predominantly breastfed, it is evident that water-based liquids are displacing feeding of breastmilk to a great degree. Differences in exclusive breastfeeding between girls and boys are minimal, as are differences between different levels of mother's education and wealth background. However, rates vary significantly between Divisions, from 46.2 per cent in Dhaka to 69.4 per cent in Chittagong. Among children under age 3, the median duration of breastfeeding is 32.1 months for any breastfeeding, 3.1 months for exclusive breastfeeding, and 4.9 months for predominant breastfeeding.<sup>279</sup>

274 Bangladesh Bureau of Statistics, IFAD and WFP. *Undernutrition Maps of Bangladesh 2012: Key Findings*. Dhaka, 2013 (hereafter *Undernutrition Maps*).

275 DHS 2014, op.cit.

276 MICS 2012-2013, op.cit.

277 National Institute of Population Research and Training (NIPORT). *Utilisation of Essential Service Delivery (UESD) Survey 2013*. Dhaka, October 2014.

278 MICS 2012-2013, op.cit.

279 Ibid.



As a result of different feeding patterns, appropriate feeding of children aged 6-23 months across Bangladesh is low to very low. The MICS 2012-2013 reports that only 2 in 3 children aged 6-23 months (69.7 per cent) are being appropriately fed, with breastmilk and solid, semi-solid or soft food. At the same time, the DHS 2014, which includes additional factors such as meal frequency and diversity of food groups in this category, indicates that only 1 in 4 children (22.8 per cent) receive recommended appropriate infant and young child feeding practices. This is far below the Government target for 2016 of 52 per cent, indicating that adequately diversified complementary feeding for children requires urgent attention.

Rangpur shows the highest percentage of appropriately fed children (76.8 per cent) and Chittagong the lowest (58.3 per cent). Overall, less than half of infants aged 6-8 months (42.4 per cent) received solid, semi-solid or soft foods at least once during the day before the survey; wide differences are observed in rates between children in urban and rural areas, at 51.2 per cent and 40.2 per cent respectively.<sup>280</sup> In addition, about 12.1 per cent of children aged 0-23 months are bottle fed, ranging from 4.5 per cent in Sylhet to 17.4 per cent in Dhaka and positively correlated with mother's education and higher wealth quintile; the DHS 2014 indicates that an even higher 22 per cent of infants aged 6-9 months are fed with a bottle. Regardless of the figure used, this represents a concern because of possible contamination due to unsafe water and lack of hygiene in preparation (see also Section 5.1).

Micronutrient deficiencies in children remain widespread. For example, only 54.3 per cent of households were found to be consuming adequately iodised salt, ranging from 33.8 per cent in Rangpur to 64.6 per cent in Dhaka.<sup>281</sup> Iodine Deficiency Disorder (IDD), arising from consumption of un-iodised salt, is the world's leading cause of preventable mental retardation and impaired psycho-motor development in young children; in its severe form, iodine deficiency causes cretinism. It also increases the risks of stillbirth and miscarriage in pregnant women. IDD takes its greatest toll in impaired mental growth and development, contributing in turn to poor school performance, reduced intellectual ability and impaired work performance. Thus, ensuring adequate iodisation of salt for use by families in Bangladesh continues to represent a critical issue. From a CSR perspective, this implies engagement and oversight, as appropriate, of food manufacturing companies to promote and ensure responsible practices.

Severe deficiency of Vitamin A, an essential micronutrient for the immune system, can result in childhood blindness, increase the severity of infections such as measles and diarrhoeal diseases in children, and slow recovery from illness. The National Micronutrient Survey 2011-2012<sup>282</sup> found significant deficiencies in Vitamin A among both preschool- and school-age children, at 20.5 per cent and 20.9 per cent respectively. Anaemia in preschool children stood at 33.1 per cent (36.6 per cent rural, 22.8 per cent urban), with far lower prevalence in school-age children aged 6-14 years. Meanwhile, no disaggregated data exist to fully clarify the number of children with disabilities among children who are malnourished, or care and feeding practices for children with disabilities (see also Section 2.5.1).<sup>283</sup>

Urban undernutrition prevalence data also mask disparities between the urban non-poor and urban poor/slum dwellers. Nearly all forms of undernutrition are significantly higher in urban slum populations, surpassing national averages, and only 36.3 per cent of slum households are food-secure, compared to 53.5 per cent in urban areas overall.<sup>284</sup> Other high-risk factors include poor sanitation and overcrowded living conditions, precarious livelihoods, and reduced access to quality health care services. For example, only 24 per

280 Ibid.

281 Ibid.

282 Ministry of Health and Family Welfare Institute of Public Health Nutrition. *National Micronutrient Survey 2011-2012*. Dhaka, June 2014 (hereafter National Micronutrient Survey).

283 Disability Situation Analysis, op.cit.

284 National Micronutrient Survey, op.cit.

cent of infants in urban slums receive breastmilk within the first hour of birth, less than half of the national average;<sup>285</sup> likewise, only 1 in 4 children aged 6-23 months in slums are fed with appropriate infant and young child feeding practices, compared to 40 per cent for non-slums.<sup>286</sup>

The prevalence of Vitamin A deficiency also is more than one-third higher in urban slums.<sup>287</sup> Lastly, half of under-5 children in slums are stunted, compared to around one-third for non-slums; child underweight in slums, at 43 per cent, is considerably higher than non-slums (26 per cent).<sup>288</sup>

Among women, nutritional status has improved slightly, but undernutrition continues to represent a serious issue for both women and adolescent girls, compounded by access to education, socioeconomic group, age of marriage at first birth, and control over resources. In 2013, nearly 1 in 4 women aged 15-49 (24 per cent) was undernourished, with a Body Mass Index of less than 18.5; 17 per cent were overweight or obese (Body Mass Index of more than 25.0). Among adolescent girls aged 10-18 years, only 53 per cent have a normal Body Mass Index, with 30 per cent considered mildly undernourished, 10 per cent moderately undernourished and 2 per cent severely undernourished (see also Section 2.4.4).<sup>289</sup>

Moreover, 29 per cent of adolescent girls were short for their ages, with little difference between urban and rural areas. Adolescents younger than 18 years with under-5 children are shorter than women in that age group without children. Meanwhile, nearly one-quarter of women were chronically energy deficient, indicating a medium-severity public health issue.<sup>290</sup>

Over the past decade, mixed progress has been observed in reduction of anaemia among women, according to various data sources. Anaemia continues to remain highly prevalent, affecting on average half of all women. However, evidence also indicates a need to better understand the full relationship between anaemia and iron deficiency. Geographic disparities in micronutrient deficiencies exist among women, with those living in urban slums having greater deficiencies in Vitamin A, D and zinc;<sup>291</sup> the latter represents an important supplementation during diarrhoeal episodes.

In times of food scarcity, women and girls also are found to reduce food consumption at a much higher rate than men and boys. Married young girls and women also have less power over household resources than men, including decision on what food to buy and how it gets distributed to household members.<sup>292</sup> When only one person is required to reduce food consumption in a household, this individual was almost always an adult woman. When two people reduced consumption, male adults and female adolescents also sacrificed. Notably, when three or more members had to sacrifice, female children younger than age 10 sacrificed in a much greater proportion than their male counterparts.<sup>293</sup>

Further illustrating the marked disparities in nutritional status, as wealth quintile increases, there is a decrease in the proportion of underweight women (poorest, 29 per cent; wealthiest, 8 per cent) and an increase in the proportion of overweight women (poorest, 20 per cent; wealthiest, 61 per cent). Women's overweight is a growing problem, nationally, in 2013

285 Bangladesh Urban Health Survey 2006.

286 Urban Health Survey, op.cit.

287 National Micronutrient Survey, op.cit.

288 Urban Health Survey, op.cit.

289 Food Security 2013, op.cit.

290 Ibid.

291 UNICEF MTR, op.cit.

292 Nutrition Background Paper, op.cit.

293 Helen Keller International and BRAC Institute of Global Health. *State of Food Security and Nutrition in Bangladesh 2012*. Dhaka, 2013 (hereafter Food Security 2012).

even more adult women were overweight than chronically energy deficient.<sup>294</sup> Meanwhile, 2 in 5 pregnant women reported never taking IFA during their pregnancy; moreover, IFA supplementation rates were extremely low during the first trimester (13 per cent daily), although this is the period during which folic acid helps to prevent neural tube defects in the foetus.<sup>295</sup> Large gaps between availability and utilisation also are found, as well as utilisation and effective coverage; overall, these can be explained by factors that influence behaviour, such as knowledge gaps and taboos.<sup>296</sup>

Lastly, diarrhoea and intestinal worm infestations can cause the loss of nutrients from the body and decrease absorption of nutrients from food. Hygiene-related practices (see also Section 5.3) are the third-most significant contributor to undernutrition in Bangladesh, with multiple data sources showing that few caregivers wash their hands before eating, handling food and feeding their child.<sup>297</sup> Preventing infections by washing hands with soap at critical times thus can contribute to preventing undernutrition.

#### 4.4 ROOT AND UNDERLYING CAUSES OF KEY NUTRITION CHALLENGES

Based on the above analysis as well as a UNICEF capacity gap and role pattern analysis (see also Annex 2), a number of key/root causes for nutrition-related challenges in Bangladesh, at different levels of duty bearers, have been identified:

- Traditional lower priority given to nutrition in the political economy and public sector budgeting
- Fragmentation of national responses on nutrition, especially weaknesses in multisectoral coordination, despite strong national commitments and numerous policy frameworks
- Insufficient attention to community-based nutrition
- Challenges in detection/management of acute malnutrition
- Household food insecurity and poverty
- Generally low status of women and adolescents, which also contributes to child marriage, inequitable household access to food, and an inter-generational cycle of undernutrition
- Insufficient attention to WASH/education/social protection linkages

All this results in a variety of underlying challenges, again multisectoral and multi-level, including:

- Lack of strong institutional mechanisms and capacities, particularly at sub-national levels
- Insufficient quality programmes for breastfeeding/complementary feeding/Early Childhood Care and Development
- Sub-optimal infant and young child feeding and dietary practices
- Limited dietary diversity, particularly among the poorest families
- A growing challenge of overweight and nutrition-related NCDs
- Insufficient attention to maternal nutrition and the nutrition of adolescent girls, and data and programmes on low birth weight, an important determinant of later nutrition outcomes
- Poor care practices related to hygiene and sanitation

294 Ibid.

295 Ibid.

296 UNICEF MTR, op.cit.

297 Ibid. For example, in one 2013 survey, while soap was present in 98 per cent of households and used the day before the survey in 96 per cent of households, only 5 per cent of those managing the kitchen reported washing hands before preparing food and only 7 per cent before eating.

## 4.5 RECOMMENDATIONS TO IMPROVE CHILDREN'S AND WOMEN'S NUTRITIONAL STATUS

All children and women in Bangladesh should be able to enjoy optimum nutrition to lead healthy and productive lives. Overall, this can be achieved only by prioritising nutrition services and key target groups, scaling up nutrition-specific and nutrition-sensitive interventions, and strengthening the enabling environment for concerted, multisectoral action on nutrition. All nutrition-relevant sectors – health, education, WASH, child protection, agriculture, food, social protection et al. – will need to align around nutrition as a fundamental component of human and economic development. Recommendations include:

Policy/Strategy	Support establishment of an effective multisectoral leadership and coordination mechanism
Institutions/ Governance	<p>Support institutional strengthening to effectively address malnutrition, including sustaining and adequately resourcing coordination institutions</p> <p>Adopt a convergence and equity approach for multisectoral and multi-stakeholder responses</p> <p>Strengthen and scale up a full set of Direct Nutrition Interventions</p> <p>Scale up nutrition-sensitive interventions, particularly in areas of WASH, reproductive health/family planning, adolescents, social protection, education and agriculture, to further address some of the underlying and root causes of malnutrition</p> <p>Prioritise gendered approaches to support nutrition interventions in all sectors and at all levels</p>
Programme, Including Gender/Adolescents/ Child Marriage/Urban Slums	<p>Build a stronger focus and investment in infant and young child feeding as a core nutrition component</p> <p>Support strengthened household access to foods of appropriate quality/diversity, including through enhanced engagement with and oversight of food and beverage companies</p> <p>Increase attention to/resource allocation for nutrition in urban slums/hard-to-reach areas, to close acute equity gaps</p> <p>Support capacity development of human resources at national and sub-national levels, as well as sub-national-level technical assistance in planning and implementation</p> <p>Develop and resource interventions that address overweight and nutrition-related non-communicable diseases</p> <p>Intensify and expand multi-level C4D efforts at household and community levels to increase knowledge, information and demand for quality services, as well as for behaviour and social change (including norms, to adopt and maintain Infant and Young Child Feeding (IYCF) practices</p>
M&E/Data/Knowledge Management/ Innovation	<p>Support technical assistance at sub-national level in information management</p> <p>Advocate for the development of effective monitoring, evaluation and accountability of public as well as private-sector actors, as well as establishment of a national nutrition information system to regularly track key indicators; encourage citizen involvement in accountability processes</p>





## Chapter 5

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# The Right to Health and Survival

## 5.1 HEALTH

### 5.1.1 Introduction

A number of Bangladesh's health outcome indicators, particularly with regard to infant and under-5 mortality rates and to maternal mortality, have improved significantly in recent decades. For example, demographic factors such as declining fertility and a decreasing proportion of births to high-risk mothers have particularly contributed to the decline in maternal mortality since 1990, along with improved access to and use of health facilities. Improved educational achievement among women of childbearing age, higher incomes and reduced poverty rates also have contributed.

Critically, Bangladesh has made great strides in reducing under-5 mortality and, according to Government figures, has achieved the national MDG4 target of 48 deaths per 1,000 live births (see also Section 5.1.3). Adult health conditions as a whole also have improved, as is evident in much-reduced age-specific death rates above the age of 40 in 2011, compared to 1975, and above the age of 60 compared to 1991.<sup>298</sup> The combined effect of reduced infant and child mortality and lowered adult mortality has been reflected in the higher life expectancy noted in Section 2.1.

In addition, Bangladesh has achieved international recognition for its remarkable progress in several key health-related outcomes. It is one of a select group of countries included in a high-profile "Good Health at Low Cost" study published in the respected medical journal *Lancet* in 2014. As that study notes, Bangladesh "now has the longest life expectancy, the lowest total fertility rate, and the lowest infant and under-5 mortality rates in South Asia,

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298 DIS, op.cit.

despite spending less on health care than several neighbouring countries.”<sup>299</sup> In 2010, the United Nations also presented Bangladesh its MDG Award for reducing child mortality.

Widespread application of evidence-based interventions is a factor in Bangladesh’s success in maternal and child health. But technical interventions are only part of the explanation: Another is the strong record of community mobilisation, engagement and pro-poor development programmes by NGOs, offering a unique example of active collaboration between Government and civil society (see also Chapter 3).<sup>300</sup> In addition, maternal and child health enjoy a high level of bipartisan political commitment in Bangladesh, although this does not necessarily translate into the allocation of substantive resources.<sup>301</sup>

Overall, the challenges remains enormous: Still, 1 in every 26 children dies before reaching her/his first birthday, and 1 in every 22 children does not survive to her/his fifth birthday, with largely preventable health causes.<sup>302</sup> Despite tremendous efforts, significant inequities exist across geographical regions and between different wealth quintiles in terms of maternal mortality as well as U5MR. Factors contributing to the differences in equity across Divisions can be attributed to economic status, education level, behavioural and cultural practices, as well as differences in fertility rates.

The current burden of deaths for children under 1 year of age thus occurs within the first month of life, and particularly among newborns (see also Section 5.1.3). Moreover, the proportion of neonatal deaths to overall under-5 deaths has increased from 39 per cent in 1989-93 to 60 per cent in 2007-2011, largely due to a rapid reduction in post-neonatal mortality.<sup>303</sup> Thus, further reducing neonatal mortality represents an urgent priority to improve the health of Bangladesh’s children.

Like numerous nutrition indicators highlighted in Chapter 4, a number of reproductive health indicators also are low (see also Section 5.1.3), including births attended by skilled health personnel and adequate antenatal care coverage. In urban areas, particularly wide differentials exist in health service utilisation and outcomes between slum and non-slum areas. Disturbingly, drowning has emerged as the leading cause of death among children aged 1-4 years (see also Section 5.1.3).

Health challenges in urban slums are particularly acute. While the Urban Health Study 2013 found that 95 per cent of communities in slum areas had a health facility available within two kilometers, NGO facilities are the most commonly available health service providers and face issues of variable quality. Due to a high level of sharing of latrine facilities, access to improved sanitation is very low in slums (see also Section 5.2). About 13 per cent of households in slums had access to improved sanitation, compared with more than 50 per cent in non-slum and other urban areas. At the same time, almost half of all slum households dispose of garbage in open space, compared with a quarter in non-slum areas, illustrating the accelerating urgency of dealing effectively with solid waste.

In terms of maternal health, only half of women living in slums receive antenatal care from medically trained providers. In addition, this proportion has declined significantly between 2006 and 2013, from 62 to 54 per cent.<sup>304</sup> However, over the same period contraceptive prevalence increased substantially, from 58 to 70 per cent, compared to an increase in non-slums of only 2 percentage points (63 to 65 per cent).

299 Political Economy, *op.cit.*

300 *Ibid.* Moreover, routine programmes and services, including those implemented by NGOs, rely on Government-supported personnel, information and logistics, supply and distribution systems.

301 *Ibid.*

302 BDHS 2014. To save lives, necessary interventions involve a continuum of care throughout pregnancy, childbirth and after delivery, leading to care for children in the crucial early years of life. Delivering these interventions requires strengthening the underpinnings of service delivery at all levels.

303 Ministry of Health and Family Welfare. *Bangladesh Every Newborn Action Plan (BENAP)*. Dhaka, February 2015.

304 Urban Health Study, *op.cit.*



Skilled human resources represent a particularly serious issue in all areas of the country that constrains development results in health (see also Section 5.1.2). Like many countries, however, in Bangladesh the workforce challenge is not just about shortfalls in numbers of health workers; of equal importance is their distribution (rural/urban, primary vs. tertiary) and, critically, the quality of their performance. Compliance with standard quality of care remains a neglected intervention in the public health sector and requires particular attention.<sup>305</sup> The availability of quality infrastructure for delivery of key services also remains limited. Bangladesh has an average of just 0.2 hospitals per 10,000 people, far lower than the ratio for low-income countries globally (0.8/10,000).<sup>306</sup>

In particular, Bangladesh is lagging far behind other South Asian countries in terms of the ratio of nurses and midwives to population.<sup>307</sup> Depending on the year of measurement, India and Sri Lanka have between five and six times as many nurses and midwives as Bangladesh, and Pakistan has almost twice as many. Bangladesh has only 2.2 nurses and midwives per 10,000 population, less than half the global average for low-income countries. Further, in Bangladesh there appear to be fewer nurses than doctors, an unusual staffing situation that has persisted for a long time; despite improving trends over the past two decades, Bangladesh's doctor-to-patient ratio also remains low. Some estimates suggest that the total health workforce in Bangladesh is substantially smaller than in other countries, at 58 per 10,000 population. Overall, workforce density is well below the internationally recommended figure of 22.8 per 10,000 required to achieve relatively high coverage for essential health interventions in countries most in need.<sup>308</sup>

In addition, vacancies and absenteeism of service providers, coupled with especially poor infrastructure for mother, newborn and child health services in hard-to-reach areas, thus all place a burden on the system to render timely and quality services. For example, 24/7 comprehensive emergency obstetric care is seriously affected because of the high proportion of vacant posts at all levels of public health facilities, and particularly in hard-to-reach areas.<sup>309</sup>

Other key health system bottlenecks include a lack of access to health facilities, insufficient supplies, and inadequate supervision and monitoring. Economic barriers hamper the demand for and use of health services by the poor; lack of knowledge among caregivers is an underlying factor for this lack of use. High out-of-pocket expenditures and incomplete data within the national Health Management Information System (HMIS), along with inadequate knowledge regarding neonatal health and skilled care at birth, all exacerbate the issues (see Section 5.1.3 for further bottleneck analysis).

### 5.1.2 Health Institutions, Systems and Governance

The right to health care was enshrined in the Constitution of Bangladesh following independence. More than four decades later, the national public health care network is an intricate web of public health departments, NGOs and private institutions.<sup>310</sup> The Ministry of Health and Family Welfare (MoHFW) is responsible for formulating national-level policy, planning and decision making in the provision of both health care and health education.

A number of key health policies have been developed in recent years, including a multisectoral National Strategy for Maternal Health; a National Child Health Strategy integrating water/sanitation, child protection, HIV/AIDS, Early Childhood Care and

305 In eight low-performing UNDAF districts, quality improvement interventions are being introduced.

306 Political Economy, op.cit.

307 DIS, op.cit.

308 Political Economy, op.cit.

309 UNICEF MTR, op.cit.

310 Ministry of Health and Family Welfare. *Health Bulletin 2014*. Dhaka, August 2014.

Development (ECCD), and C4D programmes; a National Policy for Immunisation; and a National Child Injury Prevention Strategy, which gives strategic direction for addressing child injuries, including drowning prevention. Policy and strategic directions for newborn health care are provided by the National Neonatal Health Strategy and Guidelines 2009, as well as the Health, Population and Nutrition Sectoral Development Plan 2011-2016 (HPNSDP), which represents a largely successful model of a Sector Wide Approach (SWAp).<sup>311</sup> For ECCD, crucial milestones are found in the Preschool Framework 2008, new Education Policy 2010, Children's Policy 2011 and Comprehensive Early Childhood Care and Development Policy 2013.

Notably, Bangladesh has a very ambitious agenda for scaling up Universal Health Coverage (UHC) by 2032. In 2012, only 1 per cent of Bangladesh's population was covered by some form of health insurance.<sup>312</sup> The movement to UHC will affect the whole health system, and hence, effective services for children and women. At the same time, a scale-up of that nature is highly ambitious, requiring strong policies, regulations and increased health workers and supplies to meet increased demand. Scaling up UHC further likewise requires a strong and sustainable financing platform so as to collect and pool premiums, which will be particularly challenging given the extent of informal-sector employment and persistent poverty.

In all, governance systems for the health sector are already both large and complex. For example, within Government itself, parallel Directorates under MoHFW hold primary responsibilities, the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). DGHS comprises more than 100,000 officers and staff members, and is the largest implementing authority under MoHFW.<sup>313</sup>

However, issues result from the split responsibility of Government in terms of primary health care. For example, at least two major management information systems (MIS of DGHS and MIS of DGFP) are functioning under MoHFW, with a need for more effective coordination between them.<sup>314</sup> Data quality, data duplication and redundancy represent key bottlenecks in this regard. A total of nine other implementing authorities exist under MoHFW, along with five regulatory agencies, adding to the complexity of health governance.<sup>315</sup> Community clinics serve as the lowest-level health facilities, but their existence has been politicised; they are the flagship of the primary health care system under the present Government, but were closed down between 2001 and 2008 under the previous Government.<sup>316</sup>

Major components of the HPNSDP focus on (1) improving health services, including through development of an *upazila* health system and community clinic-led expansion of primary health care (PHC) services, and (2) strengthening health systems, including prioritising strengthened health governance, supporting local-level planning and demand-side financing, and capacity development of human resources for health.<sup>317</sup> Nevertheless, results-based monitoring remains a challenge; because of a need for a strengthened HPNSDP results framework, reporting at both output and outcome levels is limited.<sup>318</sup>

The presence of numerous development partners in the health sector also risks continued fragmentation and non-coordination of efforts to achieve effective coverage of results.<sup>319</sup> At the same time, as noted above in the Introduction to this Chapter, serious capacity

311 A Sector Wide Approach (SWAp) involves brings together Government, donors and other stakeholders within any sector. It is largely characterised by a set of "operating principles" rather than a specific package of policies or activities. The approach involves movement toward broadening policy dialogue; developing a single sector policy that addresses both private- and public-sector issues; and a common realistic expenditure programme; common monitoring arrangements, and more coordinated procedures for funding and procurement.

312 Political Economy, op.cit.

313 Health Bulletin, op.cit.

314 UNICEF MTR, op.cit.

315 Health Bulletin, op.cit.

316 Political Economy, op.cit.

317 Ministry of Health and Family Welfare. *Health, Population and Nutrition Sector Development Programme 2011-2016 (HPNSDP): Programme Implementation Plan Vol. 1*. Dhaka, July 2011.

318 UNICEF MTR, op.cit.

319 Ibid.

gaps exist in human resources in the public sector, and in health in particular, combined with limited progress in strategic guidance for human resources management; all of this exacerbates overall health governance issues.

The mid-term review of the HPNSDP, conducted in 2014,<sup>320</sup> ranked progress as “good” with regard to maternal, neonatal, child, reproductive and adolescent health; population and family planning; and research and development, with a focus on introducing an effective health information system. Progress was noted in overall governance, stewardship and the legal framework; nutrition and food safety; communicable disease control; disease surveillance; behaviour change communication; primary health care; and financial management.

Critically, however, progress was found to be “limited” with regard to (1) hard-to-reach populations and the disadvantaged; (2) environmental health and climate change; (3) secondary and tertiary health care; (4) human resources for health, training and nursing services; and (5) quality assurance, standards and regulation.

Equally important, poor progress was cited in urban health and in establishing linkages with and promoting alternative medical care (ayurvedic/homeopathic), which is frequently an affordable and preferred option, especially in rural areas. Urban health service delivery, particularly primary health care, remains particularly fragmented in terms of leadership and management; it is nominally under the responsibility of local bodies such as City Corporations and *pourashavas*. However, in practice the sector is heavily dependent on NGO partners reporting to various urban authorities, with a resultant lack of coordination and equitable development results.

A need for overall strengthened governance and legal frameworks (e.g., the need for a strengthened legal framework against child marriage), as well as insufficient institutional capacity of regulatory bodies both in and outside the health sector, all have weakened the stewardship role of the Government in health.<sup>321</sup> Reviewing and revitalising the structure and mandate of professional and parastatal associations such as the Bangladesh Medical Association, Bangladesh Medical Research Council and Bangladesh Medical and Dental Council also is key.

Although health development issues enjoy wide bipartisan support, as noted above, Bangladesh spends little on health in absolute and relative terms.<sup>322</sup> In all, Bangladesh spends less on health from all sources than other low-income countries globally, as well as other South Asian countries. Total per-capita health expenditure was US\$26 in 2012, lower than the \$30 average for low-income countries.

In 2013-2014, the Government allocated only 4.1 per cent of its total budget to the health sector. This is much less than the 10 per cent target laid out in the HPNSDP Results Framework, and also lower than the 7 per cent allocated in fiscal 2008-2009. The 4.1 per cent allocation also is lower than the share allocated to most other sectors, including education and technology (11.3 per cent), public administration (10.6 per cent), transport and communication (9.0 per cent), fuel and energy subsidies (6.9 per cent), rural development and local government (6.6 per cent), defense (5.6 per cent), social security and welfare (5.1 per cent), and energy and power (5.1 per cent).<sup>323</sup>

Even so, total health expenditure is increasing in absolute terms, but is driven almost entirely by increased household expenditure. Out-of-pocket expenditures for health care remain very high, at 64 per cent,<sup>324</sup> affecting care-seeking behaviour. To address disparities in resource

320 HPNSDP MTR, op.cit..

321 Political Economy, op.cit.

322 Ibid.

323 Ibid.

324 UNICEF MTR, op.cit.

allocation and increase health care access, especially by the most disadvantaged, the new Health Care Financing Strategy has targeted the reduction of out-of-pocket expenditures by half by 2032. It aims to achieve this not only through increasing the contribution of social health protection, but also by increasing the Government budget for health.<sup>325</sup>

At the same time, high household expenditures on health have implications for inequity and impoverishment: About 12 per cent of households in Bangladesh spend more than 10 per cent of household income on health, an often-used threshold above which health expenditures are considered to be catastrophic. A quarter of those who fell ill and did not seek care state that high cost was the reason for non-treatment.<sup>326</sup>

Like health governance overall, the health planning and budgeting system in Bangladesh is complicated, and requires strengthened strategic direction and cohesion.<sup>327</sup> Within MoHFW, the planning wing is responsible for the preparation of the development budget, but does so with little or no interaction with the financial management unit, which prepares the revenue budget. DGHS and DGFP each write their own Operational Plans, which are subsequently compiled by the planning wing. Currently at least 32 such Operational Plans cover different diseases and programmes under the HNPSDP.

Fragmentation of planning and budgeting across two different budget processes, and into 32 or more Operational Plans, reduces the capacity for scarce resources to be reprioritised and reallocated to meet the highest or emerging health needs, including those of children and women. In addition, each *upazila* receives an equal amount of resources based on criteria such as the number of beds and staff numbers, irrespective of the health status or needs of the catchment population and service utilisation.<sup>328</sup>

Lastly, the lack of an official role for local governments in planning of health services and the low budgets allocated to sub-national health authorities has potentially important equity implications (see also Section 2.4.2). For example, rapid urbanisation and the growth of urban slums require the creation of new services and related infrastructure, but there exists no mechanism for encouraging and enabling local governments to create them.<sup>329</sup>

Overall, however, gradual transition from a centralised planning process in health to a more decentralised one is under way. Critically, a pilot involving direct local-level, evidence-based planning and implementation in 29 districts and two City Corporations has been identified as a step forward in building the capacity of health managers and the health system as a whole, for more decentralised decision making. In the past, district and *upazila*-level health managers have experienced problems dealing with area-specific issues. This is being addressed through conducting of local-level evidence-based analysis and planning and taking action as per local priorities.<sup>330</sup>

For example, local-level managers now identify barriers to service availability and utilisation with regard to effective coverage, leading to more in-depth analysis. This model is expected to inform the Government at national level regarding the potential of capacity at district level for planning and equitable budgeting based on local needs and monitoring of results, and in the long run can be institutionalised within the system. Significantly, this has linked both the "supply" and the "demand" sides of the health system. Deployment of skilled human resources through local recruitment under LLP also has been found to be an effective

325 Ibid.

326 Polit Econ, op.cit.

327 Ibid.

328 Government documents confirm the lack of strategic planning in health financing. According to MoHFW's own Health Economic Unit, "Health financing interventions and programmes are either driven by supply-side pressures (salaries for nurses and physicians; medicines and supplies for facilities), while pilot activities often are initiated in response to emergencies or following international trends. A comprehensive health care financing strategy is critical to meet the challenges confronting the health sector, now and in the future."

329 Political Economy, op.cit.

330 UNICEF Bangladesh, "Local Level Planning Factsheet." Dhaka, January 2015.

strategy for addressing critical human resource shortages and gaps in the health system, at least as a short-term measure.<sup>331</sup>

Nonetheless, key challenges in implementation of local-level plans primarily arise from continuing limited human resources, with inadequate facility readiness and inadequate decentralised authority at local level. High turnover of managers at national and sub-national levels negatively affect implementation of LLP. In addition, although well-developed LLP creates a sense of “ownership” among sub-national managers and local communities, the funding disbursement for district health systems remains centrally managed. Coordination between national-level managers in the process of LLP also requires further strengthening.

In an important systems innovation at community (ward) level, capacity development of Community Support Groups in eight low-performing UNDAF districts is contributing to equip families and communities with the knowledge required to make informed decisions about positive social norms, behaviour and care-seeking practices. This has resulted, for example, in an increase in the knowledge of women/mothers/caregivers about the need for four ANC visits, delivery by a skilled birth attendant, post-natal care, and immunisation, and offers an important model for replication. Targeted communication interventions at community level, particularly in CHT and other hard-to-reach areas, also are leading to slow but noteworthy social norm change regarding key maternal and newborn care practices including colostrum feeding, wiping/wrapping of the newborn, and early initiation of breastfeeding (see also Sections 5.1.1 and 5.1.3).<sup>332</sup>

### 5.1.3 Key Indicators of Children’s and Women’s Health Status

#### **Neonatal, Infant and Child Mortality**

As already discussed in Section 1.2, Bangladesh has achieved remarkable progress in reducing under-5 mortality, from 94 per 1,000 live births as late as 1999 to 58 per 1,000 in 2013.<sup>333</sup> The DHS 2014 – which uses a different method of collecting information and estimating the indicator – records U5MR as 46 per 1,000 live births, better than the 47 needed to meet the MDG target. Trends in childhood mortality rates all show notable downward trends between 1993 and 2014.<sup>334</sup>

At the same time, however, wide disparities exist in U5MR between males and females (65 vs. 52 per 1,000 live births respectively) and between rural and urban areas (61 vs. 49 per 1,000 live births respectively). Similarly, regional differences are pronounced, for example, Khulna 41 and Sylhet 80. Children in the poorest households are far likelier to die before reaching 1 and 5 years of age compared to children living in the richest households, although the disparity has nonetheless been reduced significantly. Mother’s education also is associated with under-5 mortality, with the highest mortality rate among mothers with no education, a little over double that of mothers with secondary education or higher.<sup>335</sup>

Critically, as also highlighted in Section 5.1.1, it is notable that the reduction in neonatal mortality (54 per cent) is far lower than that of infant (71 per cent) or under-5 mortality (65 per cent), making it an urgent priority. In Bangladesh, each year 76,000 newborns

331 UNICEF MTR, op.cit.

332 UNICEF Bangladesh. *Country Brief on Newborn Health Situation in Bangladesh*. Dhaka, January 2015 (hereafter Newborn Country Brief).

333 MICS 2012-2013, op.cit.

334 DHS 2014, op.cit.

335 MICS 2012-2013, op.cit.



die, which mean almost 9 newborns every hour.<sup>336</sup> More than 80 per cent of these deaths occur within 7 days, 50 per cent within the first 24 hours; most of these deaths also occur at home, without care by a skilled birth attendant, and often are unregistered. Yet 23 out of Bangladesh's 64 districts do not have any newborn interventions.

The vast majority of newborn deaths worldwide stem from three largely preventable and treatable conditions – complications due to prematurity/LBW, intrapartum-related deaths (including birth asphyxia) and neonatal infections (sepsis, meningitis and pneumonia). Care during labour, around birth and in the first week of life, and for the small and sick newborn, have the greatest impact on ending preventable neonatal deaths and stillbirths. Even so, the LBW rate in Bangladesh, at more than 1 in 4 newborns (see also Chapter 4), is considerably higher than the 15 per cent international threshold indicative of a public health emergency.

Between 2011 and 2014, essential newborn care improved somewhat but remains very low.<sup>337</sup> The recommended practice of drying the newborn within 5 minutes of birth has risen dramatically, from 51 to 67 per cent. However, the recommended practice of applying nothing to the umbilical cord of the newborn has declined, from 59 to 48 per cent. Practices of delayed bathing of the newborn, like initiation of breastfeeding within 1 hour of birth (see also Chapter 4), have increased slightly during the three-year period. Overall, however, only 6 per cent of newborns receive all five recommended essential newborn care practices, with potentially critical implications for mortality.

In 2013, the Government pledged to end preventable child deaths by 2035 and renewed its commitment to reduce child deaths by an additional 108,000 annually through the national launch of the international initiative on child survival, A Promise Renewed. Further, it pledged to reduce disability, ensuring that no newborn is left behind. The goal is to bring down child deaths to 20 per 1,000 live births, with a special focus on substantially decreasing the neonatal mortality rate to 7 per 1,000 live births by 2035. The Bangladesh Every Newborn Action Plan (BENAP) has thus been developed to fulfil the global commitment made following endorsement of the Global Every Newborn Action Plan (GENAP) at the 67<sup>th</sup> World Health Assembly in May 2014.

To achieve Bangladesh's goals, particular attention is being given to: (1) Strengthening and investing in care during labour, birth, and the first day and week of life; (2) Improving the quality of maternal and newborn care, to reduce substantial gaps in the quality of care; (3) Reaching every woman and newborn to reduce inequities; (4) Harnessing the power of parents, families and communities through C4D strategies, including social mobilisation and community engagement; and (5) Counting every newborn, in terms of measurement, monitoring and accountability.<sup>338</sup> Bangladesh's declaration also emphasises the reduction of newborn deaths through universal coverage of priority evidence-based interventions, including four newly introduced newborn interventions,<sup>339</sup> with special emphasis on targeting underserved populations.

It is promising that the rate of reduction of neonatal deaths in Bangladesh since 2001 has risen to 3.3 per cent per year, compared to 2.4 per cent over the previous 10 years. However, "bending the curve" in reduction of neonatal deaths will still require a significant increase in the annual rate of reduction, to nearly 4 per cent or more, to achieve the goals of A Promise Renewed.<sup>340</sup> An emerging concern focuses on the growing disparities and inequity in neonatal mortality between the poorest and richest quintiles, not only across Divisions,

336 United Nations Inter-Agency Group for Child Mortality Estimation. *Levels and Trends in Child Mortality: Report 2013*. New York, 2013.

337 DHS 2014, op.cit.

338 Newborn Country Brief, op.cit.

339 Chlorhexidine cord care, Kangaroo Mother Care for preterm/LBW babies, antenatal corticosteroid for preterm birth, and neonatal sepsis management with antibiotics at primary health care level.

340 Newborn Country Brief, op.cit.

but also between and within districts/*upazilas*. Financial and geographical barriers also impede access to, and utilisation of, essential health services.

In 2013, a national consultation workshop involving the Government, United Nations Agencies, national and international NGOs, and other partners identified key bottlenecks in the health system for priority newborn interventions. Among others, “very major” bottlenecks were identified in terms of HMIS and community ownership/partnership with regard to management of premature birth/LBW. “Significant” bottlenecks were found in: (1) leadership and governance, particularly for management of premature birth/LBW, skilled care at birth, and basic and comprehensive emergency obstetric care; (2) health financing; (3) health workforce, in nearly all categories; (4) essential medical products and technologies; and (5) overall health service delivery.<sup>341</sup> All this indicates the scale of the challenges involved in further reducing neonatal deaths in Bangladesh.

Critically, establishing Special Care Newborn Units (SCANU) in 36 districts and four regional medical college hospitals, with UNICEF support, has demonstrated an effective model of full supportive care for managing sick newborns with serious complications. Initial results demonstrated a reduction in case fatality rates linked to effective coverage of SCANU services. However, wide variations in SCANU accessibility were found in an equity analysis of the 20 low-performing UNDAF districts,<sup>342</sup> ranging from more than 98 per cent in Nilphamari and Rangpur to only 30 per cent in the hard-to-reach area of Bandarban, largely due to difficult terrain. A state-of-the-art SCANU has been established at the Bangabandhu Sheikh Mujib Medical University (BSMMU) to transform it into a centre of excellence for national capacity development for scaling up newborn care services at both facility and community level.

Meanwhile, establishment of the Maternal and Perinatal Death Review (MPDR) in 2010 has strengthened local-level maternal and neonatal health planning/monitoring and adjustments in operation strategies by local health managers. Mortality data from the MPDR has been integrated with the web-based HMIS, and MPDR training has been included in the revised HPNSDP Operational Plan, an important milestone for sustainability and eventual nationwide scaling up. In all, the HMIS also has been strengthened with regard to immunisation, Integrated Management of Childhood Illness (IMCI) and emergency obstetric care, while facility-based and population-based information systems are still being enhanced.

As also noted in Chapter 4, diarrhoeal deaths among children have decreased substantially in recent years, but pneumonia remains the single most important cause of under-5 deaths, followed by neonatal causes (see also Common Childhood Illnesses sub-section below). The share of deaths due to drowning has recently risen sharply, however, and bears increased attention. [see also Child Issues of Injuries and Injury Prevention sub-section below].

### ***Maternal and Reproductive Health***

As with under-5 mortality overall, Bangladesh has made commendable efforts to reduce maternal mortality in the last decade, with the results that the Maternal Mortality Ratio (MMR) has declined from 550 per 100,000 live births in 1990 to 194 in 2010<sup>343</sup> and an estimated 170 per 100,000 in 2013.<sup>344</sup> Thus, it is showing good progress to achieve MDG5. Nonetheless, about 5,200 women die yearly due to complications of pregnancy, delivery

341 Ibid.

342 UNICEF MTR, op.cit.

343 National Institute of Population Research and Training (NIPORT), MEASURE Evaluation, University of North Carolina-Chapel Hill, USA, and iccdr, b. *Bangladesh Maternal Mortality and Health Care Survey 2010*. Dhaka, December 2012 (hereafter BMMS).

344 BMMS 2010

and the postpartum period. It is estimated that for each maternal death, 14 perinatal deaths occur, while three-fourths of the babies born to women who die, also die within the first year of life.<sup>345</sup>

Significant inequities exist across regions and among wealth quintiles. MMR is highest in Sylhet Division (425 per 100,000 live births) and lowest in Khulna Division, at 64 per 100,000, a difference of a factor of 7.<sup>346</sup> More than half of maternal deaths are due to haemorrhage (31 per cent) and eclampsia (20 per cent). While maternal deaths due to these two direct causes and to abortion have declined dramatically during recent years,<sup>347</sup> indirect causes of maternal deaths (jaundice, ischaemic heart disease, tuberculosis, anaemia and congenital heart conditions) rose concomitantly, now accounting for more than 1 in 3 such deaths. By age group, the highest reductions in MMR have been among the youngest girls (15-19 years) and among women aged 40-44; nonetheless, mortality among adolescents, at 49 per 100,000 live births, remains significant.<sup>348</sup>

Most maternal deaths are largely due to delivery by unskilled birth attendants at home and lack of comprehensive emergency obstetric care from a skilled provider at a facility. Nonetheless, care seeking for maternal complications from any service provider rose by 28 per cent between 2001 and 2010; care seeking from health facilities increased by a considerable 81 per cent.<sup>349</sup> Care-seeking behaviour for obstetric complications is still 3.3 times higher among the richest than the poorest women, at 47 per cent and 15 per cent respectively.<sup>350</sup>

At the same time, comprehensive emergency obstetric care relies heavily on the 24/7 availability of skilled human resources such as anaesthesiologists and obstetricians, equipment and infrastructure; major challenges exist in ensuring this coverage in hard-to-reach areas, where difficult terrain and poor transport combine with overall human resource and financial constraints to lower coverage rates.<sup>351</sup> Adjacent districts also were found to have significant disparities in terms of coverage of comprehensive emergency obstetric services, suggesting the need for continued advocacy and support for district-level bottleneck analysis and planning.

Overall, the single most critical intervention for safe motherhood is to ensure that a competent health worker or skilled birth attendant (SBA: doctor, nurse, midwife) is present at every birth, and in case of emergency, that transport is available to a referral facility for obstetric care. Yet in Bangladesh, with its high proportion of home births, only about 43.5 per cent of births in the two years before the MICS 2012-2013 survey were delivered by skilled personnel; nonetheless, this represents a significant improvement from 20.1 per cent of births delivered by skilled personnel in 2006. Fewer than 1 in 3 births (31 per cent) take place in a health facility, but still nearly double the number recorded in 2006 (16 per cent); the likelihood of an institutional delivery is much higher with urban residence, higher levels of educational attainment, and higher wealth.<sup>352</sup> Trends in facility births also show a marked rise.<sup>353</sup>

345 Ministry of Health and Family Welfare. *National Neonatal Health Strategy and Guidelines for Bangladesh*. Dhaka, October 2009.

346 UNICEF MTR, op.cit.

347 Ibid.

348 BMMS 2010, op.cit.

349 UNICEF MTR, op.cit.

350 Ibid.

351 Ibid.

352 MICS 2012-2013, op.cit.

353 DHS 2014, op.cit.

Having said that, however, hard-to-reach areas like CHT report significantly worse development indicators in general, again underscoring continuing wide disparities among children and women: In terms of delivery with a skilled birth attendant, for example, the rate is only 2.8 per cent in Bandarban, 15.5 per cent in Khagrachhari and 15.9 per cent in Rangamati, all far below the 43.5 per cent nationally noted above. Likewise, childbirth in an institutional setting in Bandarban also stands at just 2.8 per cent, compared to 31 per cent nationally.<sup>354</sup>

Women with no education and living in the poorest households are far less likely to be assisted by a skilled attendant; in particular, only slightly more than 1 in 3 women living in slums (37 per cent) deliver with a medically trained provider, compared to 68 per cent in non-slums.<sup>355</sup> At the same time, nearly 1 in 5 women (19.1 per cent) had a caesarean section,<sup>356</sup> a very rapidly increasing trend in delivery over the last decade, particularly among institutional deliveries.<sup>357</sup>

In terms of reproductive health, and as also highlighted in Section 2.1, the Total Fertility Rate (TFR) in Bangladesh stands at 2.3 births per woman, and is considerably higher in rural areas (2.4 births per woman) than in urban areas (2.0).<sup>358</sup> Higher rural fertility is prevalent in all age groups. In large part because of the continued prevalence of child marriage (see also Sections 2.4.5 and 2.4.3), the adolescent birth rate (15-19 years) also is high, at 83 per 1,000 live births; this is surpassed only by the rate among women aged 20-24, at 146 births. Further evidence also demonstrates that childbearing begins early, with nearly 1 in 5 women aged 15-19 (18.7 per cent) already beginning childbearing and 24.4 per cent of women aged 20-24 years having had at least one live birth before age 18;<sup>359</sup> however, early childbearing has gradually declined over the last 10 years, particularly in urban areas.<sup>360</sup>

The adolescent birth rate is significantly lower in urban areas compared to rural areas (76 vs. 85 per 1,000 live births) and varies strongly between Divisions, at 45 in Sylhet and more than twice that in Rajshahi (99). A strong inverse correlation is found between adolescent births and women's education and wealth level; for example, the adolescent birth rate stands at 126 in women with no education, remains at 114 for those with primary education and 92 for secondary incomplete, and then drops sharply, to 37, among women who complete secondary education.<sup>361</sup>

Overall, 63 per cent of married women aged 15-49 do not want any more children.<sup>362</sup> Use of contraception was reported to be 61.8 per cent among women currently married, with the most popular method being the pill, used by 1 in every 3 married women in Bangladesh;<sup>363</sup> the next most popular method is injectable, used by 14.7 per cent of women. Nearly 30 per cent of contraceptive users stop using a method within 12 months of starting,<sup>364</sup> a significant decrease from the 49 per cent recorded in 2004. Contraceptive prevalence is highest in Rangpur Division (72.9 per cent) and lowest in Sylhet, at only 46.5 per cent. Overall, adolescents are less likely to use contraception than older women.

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354 MICS 2012-2013, op.cit.

355 Urban Health, op.cit.

356 MICS 2012-2013, op.cit.

357 DHS 2014, op.cit., and Ministry of Health and Family Welfare, *Health Bulletin 2014*, Dhaka, August 2014 (hereafter Health Bulletin). According to MoHFW, in 2013 a total of 599,373 institutional deliveries were reported in public facilities, of which normal delivery accounted for 57.5 per cent, caesarean section for 40.7 per cent, and vaginal breech and forceps delivery for 1.8 per cent.

358 MICS 2012-2013, op.cit.

359 Ibid.

360 DHS 2014, op.cit.

361 Ibid.

362 Ibid.

363 MICS 2012-2013, op.cit.

364 DHS 2014, op.cit.

The total unmet need for contraception is 13.9 per cent; this indicator is higher among urban women, women with higher education, and more wealthy women. However, it is notable that young women aged 15-19, with lower rates of contraceptive use, report the highest age-related rate of unmet need for contraception (17.4 per cent). Trends in contraceptive use show little variation in recent years;<sup>365</sup> trends in unmet need for family planning services have decreased slightly.

Coverage of ANC, by a doctor, nurse or midwife, remains low in Bangladesh, with only 58.7 per cent of women receiving ANC from any skilled provider during the pregnancy.<sup>366</sup> More strategic focus and investment are needed to strengthen facilities for improved mother, newborn and child health services.<sup>367</sup> Urban areas have much better ANC coverage than rural areas (72.1 vs. 55.1 per cent respectively), and Divisions vary significantly, with the lowest coverage in Barisal, at 40.3 per cent, and the highest in Khulna, at 74.6 per cent. Women from the richest households and those with the highest education are more than twice as likely to receive ANC compared to those from the poorest households or having no education, further reflecting the extent of inequities in maternal health care.<sup>368</sup>

Notably, about two-thirds of mothers (65.7 per cent) received ANC at least once during the last pregnancy, but only 1 in 4 (24.7 per cent) received the recommended number of 4 ANC visits.<sup>369</sup> This is strongly associated with urban residence, as well as mother's education and wealth; only 12.8 per cent of women living in the poorest households reported 4 or more ANC visits, compared with 55.2 per cent among those in the richest households. Significantly, however, women living in urban non-slums are much more likely to receive at least four ANC visits compared to women in slums, at 48 per cent compared to 29 per cent, again underscoring the challenges of receiving quality basic services in urban slum areas.<sup>370</sup>

In an equity analysis of the 20 low-performing UNDAF districts in Bangladesh, almost all districts have skilled service providers for ANC, but wide disparities exist in adequate coverage,<sup>371</sup> from 77 per cent to as low as 9 per cent.<sup>372</sup> Effective coverage of ANC services across all UNDAF districts was zero, due to the fact that calcium supplementation, which reduces the risk of pre-eclampsia, the second-leading cause of maternal deaths, is yet to be scaled up in the ANC package. Analysis also reveals that low uptake of ANC from a trained provider in these districts arises largely from lack of awareness regarding the need to go and where to go, as well as the poor quality of ANC services. Indicating additional challenges in the quality of care, figures for three internationally recommended components of ANC visits (blood pressure, urine sample, blood sample) also remain low, with only 38 per cent of women having all three factors checked.<sup>373</sup>

Likewise, post-natal health checks of mother and newborn can deliver lifesaving interventions for both. However, only about 36.8 per cent of mothers and newborns in Bangladesh both receive health checks within 2 days of birth, with neither having a health check in more than half of cases;<sup>374</sup> in hard-to-reach areas like Bandarban (CHT), the rate falls to as low as 3.3 per cent. Again, this reflects the overall low level of appropriate care practices with regard to maternal and child health.

365 Ibid.

366 MICS 2012-2013, op.cit.

367 Newborn Country Brief, op.cit.

368 MICS 2012-2013, op.cit.

369 Ibid.

370 Urban Health Survey, op.cit.

371 Adequate coverage is defined as four ANC visits.

372 UNICEF MTR, op.cit.

373 Ibid.

374 MICS 2012-2013, op.cit.



## **Adolescent Health**

The Committee on the Rights of the Child, in its 2009 Concluding Observations, has noted with concern the inadequate attention to the health of adolescents, especially females. The Committee also was concerned that the decision to incorporate policies for adolescents into the Children's Policy could obscure the necessary distinctions between the needs of the different age groups (see also Section 2.4.4). Of urgent concern for adolescent health, the Committee said, are issues arising from violence against girls, child marriage, undernutrition, and access to separate and appropriate sanitary facilities in schools (see also, respectively, Chapter 7; Section 2.4.5; Chapter 4; and Section 5.2 for details).<sup>375</sup>

The Committee highlighted its concern that the population, in particular adolescents and young people, are not sufficiently aware of the consequences of unprotected sexual activity, sexually transmitted diseases, HIV/AIDS or treatment available to them (see also Section 5.3). It also highlighted HIV risk factors such as the low use of contraceptives and risky behaviour. Lastly, the Committee noted inadequate facilities and counselling services for mental health and reproductive health for adolescents. It recommended a comprehensive study to understand the nature and extent of adolescent health issues, to be used as a basis for the formulation of adolescent health policies and programmes, and with particular attention to female adolescents. It also recommended special attention to the psycho-social needs of adolescents, especially girls, and the provision of appropriate and confidential counselling services in schools and clinics.

## **Children with Disabilities**

Overall, the rights of children with disabilities to quality health care are not yet realised in Bangladesh (see also Section 2.5.1).<sup>376</sup> Most areas of progress thus far concern children with developmental and neurological impairments. The Global Autism Public Health Bangladesh Initiative, begun in 2011 with high-level support, is taking systematic steps to address issues related to autism and other neuro-developmental disabilities. One report from MoSW estimates that around 280,000 children in the country, or 1 in every 500 children, face autism-related health problems.<sup>377</sup> Meanwhile, MoHFW, recognising the importance of addressing psycho-social disabilities and ensuring the rights of people with these disabilities, also is formulating a law relating to mental health.<sup>378</sup>

While notable progress also is being made in prevention of impairments (see also Early Childhood Care and Development sub-section below), the main causes of preventable disabilities in Bangladesh continue to be related to undernutrition of mothers and children (see also Chapter 4); disease, delivery and congenital conditions; and accidents (see also Injuries and Injury Prevention sub-section below). Children with disabilities generally also receive limited attention in health sector plans and reports, and disaggregated data are difficult to find or do not exist.<sup>379</sup>

Challenges in the health care system as a whole further contribute to the barriers faced by children with disabilities to realise their right to quality health care.<sup>380</sup> As reported by the Government, these include lack of sufficient drugs, staff shortages (especially in remote facilities due to staff retention difficulties), poor prioritisation of spending, and pervasive problems of management and coordination. In addition, many medical professionals and health care workers are not yet sensitised and educated on disability issues. Community

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375 CRC Concluding Observations, op.cit.

376 Disability Situation Analysis, op.cit.

377 Health Bulletin, op.cit.

378 Disability Situation Analysis, op.cit.

379 Ibid.

380 Ibid.

workers report that caregivers of children with disabilities often face humiliation and even rejection when seeking health care, especially from public-sector clinics near their homes.<sup>381</sup> Stigma and discrimination remain key issues for children with disabilities and their families. It also is unclear whether immunisation campaigns are reaching children with disabilities. For some children with disabilities, NGOs are helping to provide health services and to advocate for them to receive mainstream health care.

Overall, most quality health services for children with disabilities are specialised and not mainstreamed. Many children with disabilities do not yet have access to appropriate rehabilitation services, which are called for in the CRPD. Rehabilitation services in Bangladesh are provided by the Government, under the direction of MoSW, and by NGOs. They are, however, separate from mainstream health services and vary greatly in quality, often having limited coverage and financing.<sup>382</sup> Therefore, such services tend to reach a smaller number of children, primarily in wealthier population groups, and are often available only in urban areas (see also Section 2.5.1).

Community-based rehabilitation programmes, while more accessible, are mostly supported by NGOs, have limited geographic coverage, and often lack the resources to respond to the immediate rehabilitation needs of children with disabilities. Thus, a priority will need to be for children with disabilities to have access to the health services they require, in the most inclusive settings in their communities, and with recognition that appropriate steps be taken to prevent impairments.

### ***Early Childhood Care and Development***

Evidence shows that early stimulation, caregiving, attachment, bonding and creating safe contexts for children have a positive influence on their brains and can help children grow, learn and thrive (see also Chapter 6). Since the foundation of the brain's architecture is put into place during the first 5 years of life, experience during this period leaves one of the strongest influences on its development.<sup>383</sup> Evidence also shows that with investment in the early years of a child's life, children perform better in schools, are more socially aware, grow into balanced individuals, and as adults, participate productively in the economy and live more fulfilling lives.<sup>384</sup> Many countries divide responsibility for ECCD between health providers for children aged 0-3 years, and education for children above 3 years.

Access to ECCD services for 0 to 3-year-olds in Bangladesh remains to be further developed, with much of the attention focused on pre-primary education services for slightly older children. However, stronger efforts are needed to significantly expand the coverage of ECCD services for this younger age group and to gather additional information, while also ensuring sustainability of efforts. Globally, numerous positive effects on very young children with ECCD experience have been noted, including with regard to language development, oral communication skills, cooperative behaviour, development of self-help skills, overcoming shyness or aggression, improved personal hygiene, skills in observation, and skills in listening to and creating stories.

In Bangladesh, however, only 63.9 per cent of children aged 36-59 months are developmentally on track<sup>385</sup> across four key development indicators (literacy-numeracy, physical, learning, social-emotional). The ECCD Index is slightly higher among girls (66.1 per cent) than boys (61.8 per cent), and generally is associated with age, mother's education and wealth quintile. While nearly all children are on track in the physical and

381 Ibid.

382 Ibid.

383 MICS 2012-2013, op.cit.

384 UNICEF. "Why Early Childhood Development," July 2013, available at [http://www.unicef.org/earlychildhood/index\\_40748.html](http://www.unicef.org/earlychildhood/index_40748.html).

385 MICS 2012-2013, op.cit.

learning domains (92.2 and 87.5 per cent respectively), this figure drops to only 68.4 per cent in the social-emotional domain.

Parenting education and support require significant strengthening to raise self-confidence and competence of caregivers; improvement of the home environment through education, supplies and services; and ensure access to clean water and sanitation, health care services, early child care centres with comprehensive services, and adequate care and feeding practices. In turn, these can help to ensure good nutrition, particularly iron, iodine, breastfeeding, and adequate growth before birth and in the first 2 years of life (see also Chapter 4).

A major initiative has been the establishment of Child Development Centres in Government tertiary medical colleges for early assessment, diagnosis and intervention for children identified with potential development delays. It will be beneficial to ensure their scope remains broad enough to enable identification of a wide range of disabilities (see also Section 2.4.4 and Children With Disabilities sub-section above); these centres also offer training and support for parents of children with disabilities.

### **Common Childhood Illnesses**

Universal immunisation of children against major vaccine-preventable diseases is globally recognised as one of the most cost-effective ways to reduce infant and child mortality. The Expanded Programme on Immunisation (EPI) is a priority programme for the Government, and immunisation is considered a significant contributor to the decline in child and infant deaths in Bangladesh. In 2014, the country was certified as polio-free, which has been achieved through the introduction of polio vaccination with an efficient surveillance system.

According to information from both vaccination cards and mother's reports, 84 per cent of children aged 12-23 months are fully vaccinated,<sup>386</sup> while only 2 per cent of children in this age group have not received any vaccinations. Coverage for measles vaccine is slightly lower than for BCG, three doses of pentavalent vaccine, and three doses of polio vaccine.

Overall, 78 per cent of children age 12-23 months had received all recommended vaccinations before their first birthday; however, this represents a 5-percentage-point decrease between 2011 and 2014 and is of concern.<sup>387</sup> For example, immunisation has decreased from more than 80 per cent to less than 70 per cent in at least five of 64 districts.<sup>388</sup> On a positive note, equity-focused EPI Reach Every District (RED) micro-plans have reduced the gap in immunisation coverage in some low-performing areas. Since 2012, the annual evidence-based micro-plans have become an integral part of budget allocation and overall planning. Nonetheless, strengthening coverage levels will need to receive further attention in the coming years, given that the expected introduction of new vaccines will require significant increases in vaccine storage capacity.

At the same time, Bangladesh has recorded notable trends of reduction in some of the major causes of under-5 deaths, including diarrhoea and pneumonia.<sup>389</sup> Of children with diarrhoea during the two weeks before the MICS survey (3.9 per cent), 64.6 per cent received oral rehydration therapy (ORT) and continued feeding during the episode, as per international recommendations. However, although increasing the intake of fluids during an episode of diarrhoea is critical, fewer than 1 in 4 children (23 per cent) were given more than the usual amount to drink, while about 1 in 3 (32.6 per cent) were given the same amount,

386 DHS 2014, op.cit.

387 Ibid. Rumours of sickness and death caused by immunisation for measles appeared in social media and on TV in Bangladesh in 2013 and 2014.

388 Children and 7FYP, op.cit.

389 MICS 2012-2013, op.cit.

indicating a continued lack of knowledge of effective care and feeding.<sup>390</sup> Similarly, nearly 4 in 10 children with diarrhoea (38.4 per cent) were given somewhat less to eat than normal, with another 2 in 10 (19.3 per cent) given much less or nothing to eat.

Urban children were more likely than rural children to receive oral rehydration salts (ORS) or a recommended homemade fluid (81.5 vs. 77.9 per cent respectively); Divisions varied significantly, with Dhaka Division recording 84.4 per cent of children receiving ORS/fluid, but Barisal showing only 69.5 per cent. About 64.6 per cent of children – particularly boys and those living in urban areas – received both ORT and continued feeding. Trends in use of both ORT and zinc for treatment of diarrhoea also show a significant upward shift since 2007.

Case management of pneumonia has been scaled up through a national IMCI programme, supported by UNICEF, using clinical and community-based approaches. About 3.2 per cent of children under 5 showed symptoms of pneumonia in the two weeks preceding the MICS survey, of whom only 1 in 3 (35.8 per cent) were taken to an appropriate health provider. Boys were more likely to be taken than girls (38.8 vs. 31.9 per cent).

Even so, 74.3 per cent of children with pneumonia received antibiotic treatment; a very high usage of antibiotics without a prescription is prevalent across Bangladesh, across all dimensions of education and wealth. Yet disturbingly, only 10.8 per cent of mothers or caretakers actually recognised the two danger signs of pneumonia (fast breathing, difficulty in breathing), while 46.9 per cent knew at least one of them.<sup>391</sup> Among Divisions, wide variations were observed in knowledge levels on care-seeking, ranging from 39 per cent in Dhaka to 57.4 per cent in Sylhet. Again, accessibility varied widely in the 20 low-performing UNDAF districts, from more than 90 per cent in 14 of the districts to as low as 70 per cent in hard-to-reach Bandarban and Rangamati (CHT).

### ***Childhood Issues of Injuries and Injury Prevention***

The Government has included injury prevention as one of five priority areas for public health intervention. Children are the most frequent victims, comprising 43 per cent of a total of 70,000 injury-related deaths annually in Bangladesh. An estimated 13,134 children acquire permanent impairments due to injuries each year.<sup>392</sup> Mortality rates due to injury in all ages were found to be 43.6 per 100,000 people in 2012,<sup>393</sup> with the rate of injury-related mortality in children younger than age 18 standing at 37.8 per 100,000 that year.

However, among 1- to 4-year-olds, the mortality rate was much higher, at 56.6 per 100,000 in 2012, making this age group the most vulnerable to injury. The prominence of drowning as a cause of child death is worrying, more so in a country with significant areas that are waterlogged and/or increasingly vulnerable to flooding (see also Section 2.5.2). Dealing with drowning is an area where health, swim safe skills and practices, and other community actions will need to be prioritised as a collaborative effort among several sectors, with institutional accountability for coordination. While drowning is the leading cause of death among children aged 1-4, suicide was the leading cause for adolescents aged 15-17 (see also Chapter 7 and Section 2.4.4).

Leaving children alone or only in the presence of other young children is known to increase the risk of injuries. About 7.7 per cent of children aged 0-59 months were left in the care of other children during the week preceding the MICS 2012-2013 survey, while 9.1 per cent

<sup>390</sup> Ibid.

<sup>391</sup> MICS 2012-2013, op.cit.

<sup>392</sup> Disability Situation Analysis.

<sup>393</sup> Health Bulletin, op.cit.

were fully left alone. Disparities between Division and between urban and rural areas were moderately large. Some 15.4 per cent of children in urban areas were left with inadequate care, compared to 10.6 per cent in rural areas. In Divisions, the proportion ranged from 7.5 per cent in Khulna to 15.7 per cent in Chittagong.<sup>394</sup>

### ***Non-Communicable Diseases***

Control of NCDs has been given one of the top priorities under the HPNSDP 2011-2016. Conventional major NCDs in Bangladesh include cardiovascular disease, stroke, cancer, diabetes, pulmonary disease, arsenicosis (see also Section 5.2), renal disease, deafness, osteoporosis, congenital anomalies, oral health and thalassaemia. Those classified by the HPNSDP as “non-conventional” include road safety and traffic injury, child injury, suicide and related injury, and sports injury (see also Issues of Injuries and Injury Prevention sub-section above); gender-based violence, including violence against women and acid burn (see also Chapter 7); occupational health and safety, industrial and agricultural health hazards, climate change, air pollution, and water, sanitation and other environmental health issues (see also Section 5.2); and emergency preparedness and response, post-disaster health management and emergency medical services (see also Section 2.4.2). Critically, tobacco, alcohol and substance abuse also are important NCDs, with particular relevance for adolescent health (see also Adolescent Health sub-section above).

The national NCD risk factor survey 2010 revealed that NCDs may account for 61 per cent of the total disease burden.<sup>395</sup> Among the sampled adult population (older than 15), 97 per cent had at least one risk factor, and half had two risk factors. Disaggregated data were not available for women affected by NCDs, however. Overall, nearly 1 in 5 adults have hypertension, and 4 per cent have self-reported documented diabetes. The country also had 40 million adult smokers and smokeless tobacco users. Meanwhile, 64.5 million people were found not to be taking adequate fruits and vegetables (see also Chapter 4), and 17 million people are not getting adequate physical activity.

With the rise of NCDs – and their chronic and often expensive costs – a risk may exist that NCDs will divert already-limited public funding for unfinished priorities in maternal and child health care and undernutrition. Introduction of a well-funded and -designed Universal Health Care programme with a focus on affordable but effective treatments may help to mitigate this challenge – but possibly at the expense of further progress in maternal and child health.<sup>396</sup>

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394 MICS 2012-2013, op.cit.

395 Health Bulletin, op.cit.

396 Political Economy, op.cit.



#### 5.1.4 Root and Underlying Causes of Key Health Challenges

Based on the above analysis as well as a UNICEF capacity gap and role pattern analysis (see also Annex 3), a number of root causes for health-related challenges in Bangladesh, at different levels of duty bearers, have been identified:

- A need for strengthened Government stewardship, including in policy formulation, strategic planning and effective coordination, and particularly in light of an expected shift to Universal Health Coverage
- Limited numbers of adequately trained human resources for health, including skilled birth attendants, with adequate knowledge and skills in areas such as newborn care
- A need for improved access to and strengthened quality of services and infrastructure, especially in hard-to-reach areas, including urban slums
- Low status of women and adolescents, including the autonomy to take decisions for ANC, safe birth, and family planning
- Low public health expenditures, along with high out-of-pocket health expenditures and transport costs for seeking skilled care

All this results in a variety of underlying challenges, including:

- Fragmentation of health planning and budgeting at national level
- Vacant posts and absenteeism, especially in hard-to-reach areas
- Lack of awareness among health workers on critical issues, particularly with regard to effective newborn care and quality health services, including reproductive health services, for adolescents
- Inefficient and inequitable allocation/utilisation of resources (human resources, finance, supplies), especially in hard-to-reach areas
- Inadequate knowledge on and attitudinal barriers to good health practices and their benefits among family members
- Limited authority for decentralised planning and budget allocation, with inequitable allocation of resources

### 5.1.5 Recommendations to Improve Children’s and Women’s Health Status

The human right to health means that every child, every adolescent and every woman has the right to the highest attainable standard of physical and mental health, including access to all health services. It means that hospitals, clinics, medicines and doctors’ services must be accessible, available, and of good quality for everyone, on an equitable basis, where and when needed. To advance further toward this goal in Bangladesh, recommendations include:

Policy/Strategy	Support for increased resource allocations to hard-to-reach areas and urban slums to close the equity gap
Institutions/ Governance	Support for building of the decentralised capacity of the health system, including enhancement of the HMIS and planning capacities; institutionalisation of quality assurance; and promotion of a strong M&E culture  Increased focus on adequacy of numbers of skilled human resources at health facilities
Programme, Including Gender/Adolescents/ Child Marriage/Urban Slums	Promotion of low-cost, high-impact interventions  Promotion of neonatal health as an urgent priority  Increased focus on adolescent health, including strengthened counselling about suicide prevention and sexual/reproductive health in particular, including in adolescent clubs  Incorporation of the prevention of child injuries into ECCD and C4D strategies  Support to ensure sustainability is strongly reflected in programme/project design  Intensify C4D efforts to create demand for quality services, as well as to promote life-saving, healthy and preventive behaviours and conducive social norms for maternal, newborn and child health
M&E/Data/Knowledge Management/ Innovation	Demonstration of successful health models in areas of emerging challenges, e.g., neonatal interventions, drowning prevention, early disability detection and intervention services  Behavioural data generation to demonstrate progress in achievement of programme objectives

## 5.2 WATER, SANITATION AND HYGIENE (WASH)

### 5.2.1 Introduction

Water and sanitation services are vital for health of children and women, generate economic benefits, contribute to dignity and social development, and help the environment. Appropriate hygiene practices also can greatly improve health, ultimately helping to reduce child and neonatal mortality. Bangladesh has emerged as a leader in Asia in experimenting with and implementing innovative approaches to rural sanitation in particular, with the result

that there has been a dramatic reduction in open defecation, from 34 to 3 per cent.<sup>397,398</sup> Now, the challenge is for the water and sanitation sector to equip itself to meet the emerging challenges of providing improved equitable and sustainable services for all.

Unlike many other countries in South Asia, Bangladesh is reported to have relatively high rates of access to improved water sources, at 97.9 per cent. Since 1990, there has been strong improvement in the proportion of households collecting water from improved sources.<sup>399</sup> However, these figures mask stark variations in coverage and quality within districts and within unions, communities, schools and even households.

Key challenges in the sector include water quality and year-round access, inadequate sanitation facilities, and poor handwashing practices, all of which severely affect children's well-being and physical and mental development. Other factors, including rapid urbanisation, declining water levels, and vulnerability to climate change/natural hazards, compound a challenging situation. Most schools have access to water and sanitation facilities (see also section 5.2.3 and Chapter 6) but, critically, often these are unhygienic, not functional or unavailable for students' use, which impacts children's enrolment, attendance, retention and attendance rates.

Despite the significant progress that has occurred following a national sanitation campaign begun in 2003, access rates for improved sanitation remain only moderate (56 per cent), with a high proportion of shared facilities (28 per cent), particularly in urban slums. With regard to the WASH sector's considerable links to and affect on nutrition (see also Chapter 4), a strong correlation has been found between household drinking water with under-5 child stunting, waste and underweight.<sup>400</sup> Regular and prolonged bouts of diarrhoea as a result of poor hygiene practices and drinking water containing faecal coliforms continue to impede children's physical development, contributing to stunting and malnourishment.

A total of 22 per cent of under-5 children are stunted in households with unimproved drinking water sources, about the same proportion as those in households with improved sources; however, 22 per cent also were severely stunted, compared to 15 per cent in households using improved drinking water sources.<sup>401</sup> Similarly, 18 per cent of children were wasted in households using unimproved drinking water sources, compared to 10 per cent in households with improved sources. Overall, children from households with unimproved drinking water sources are significantly more at risk: Altogether, 57 per cent of these children were found to be stunted, wasted or underweight, compared to 31 per cent in households with improved drinking water sources.<sup>402</sup>

Critically, a very high 44 per cent of under-5 children were found to be stunted in households with unimproved sanitation, with the proportion of stunting ranging from 18 per cent with improved sanitation to 23 per cent with improved but shared sanitation, 23 per cent with unimproved sanitation and 29 per cent in households that practice open defecation.<sup>403</sup> Strong correlations also were found between severe stunting or underweight and use of unimproved sanitation. Overall, the proportion of children stunted, wasted or underweight is much higher for those from households using unimproved sanitation or practicing open defecation (48 and 64 per cent respectively) than those living with improved sanitation (37 per cent).

397 JMP 2014

398 Follow-up in 2010-2011 in 53 of the unions that achieved a goal of "100 per cent" sanitation coverage revealed many comments about the "revolutionary" nature of changes in defecation practices. Hanchett, Suzanne. *Sanitation in Bangladesh: Revolution, Evolution and New Challenges*. Dhaka, March 2015 draft

399 MICS 2012-2013

400 UNICEF Bangladesh. "WASH Section Innovation in Programme: WASH and Nutrition" (PowerPoint presentation). Dhaka, November 2014.

401 Ibid.

402 Ibid.

403 Ibid.

Inadequate sanitation also has substantial economic impacts in Bangladesh, estimated at US\$4.23 billion.<sup>404</sup> This is equivalent to 6.3 per cent of GDP, although high-case estimates reach up to 17.2 per cent of GDP. Losses related to health, including premature deaths, productivity losses, and treatment costs, are by far the single largest contributor to the economic impact due to inadequate sanitation and hygiene. This includes significant impacts with regard to diseases including diarrhoea, helminthes (intestinal worms), measles, and malaria.

Yet climbing the “sanitation ladder” is difficult: One-fourth of pit latrines have only a slab, without a water seal, flap or lid; these latrines are not totally able to block disease transmission routes. Moreover, experience has shown that once a single-pit latrine is filled up, there is a tendency in many households to revert to open defecation, largely because of poverty that prevents improvements to sanitation facilities.<sup>405</sup> Socio-cultural beliefs and practices also represent key bottlenecks; these include a lack of awareness of the health impact of drinking contaminated water and a lack of awareness of water quality in source and drinking water. Monitoring gaps also have been identified with regard to sanitation;<sup>406</sup> the last Government-sponsored survey was conducted in 2003.

The Government has recently agreed to host the sixth biennial South Asia Conference on Sanitation (SACOSAN) in early 2016, which may give sanitation improvement renewed priority in the future. Every October also is celebrated as National Sanitation Month throughout the country; close cooperation is reported between Government and NGOs during the month, when the country’s larger NGOs organise events such as rallies and meetings. Other noteworthy changes also have occurred: The national school curriculum now raises children’s awareness of the importance of latrines. Thousands of trained volunteers, including adolescents and women, also are working to discourage remaining incidences of open defecation in their villages.<sup>407</sup>

Meanwhile, dual problems of water management exist: In the monsoon, for example, there is too much water, and in the dry season, a shortage of water creates drought situations. These two extremes dominate and influence the overall planning and management of the country’s water resources. Efficient use of water is further constrained by, among others, an intricate network of alluvial rivers carrying huge annual discharge and sediment loads, and unstable in nature. This is leading to issues related to river bank erosion (see also Section 2.5.2); the withdrawal of water by upstream countries, with serious effects on socioeconomic growth and the environment; and increased salinity of surface water, groundwater and soil in the coastal belt,<sup>408</sup> due to such factors as storm surge, sea level rise and estuarine tidal action.<sup>409</sup>

In terms of water quality, it has been recognised Bangladesh suffers from the worst case in the world of arsenic contamination of water, with a diverse disease burden from this known carcinogen ranging from characteristic skin manifestations to fatal heart and lung diseases and multiple cancers.<sup>410</sup> Some 22 million people – 14.5 per cent of the population – are exposed to water having arsenic contamination above the national standard, with half of this exposed population living in severely affected areas where more than 80 per cent

404 World Bank. *Economic Impacts of Inadequate Sanitation in Bangladesh*. Dhaka, 2011. The exchange rate at the time was US\$1 = Taka 70.

405 Ministry of Local Government, Rural Development and Cooperatives. *Sector Development Plan (SDP) for Water Supply and Sanitation Sector in Bangladesh (FY 2011-2025): Summary Version*. Dhaka, 2011 (hereafter SDP 2011-2025).

406 Hanchett, op.cit.

407 Ibid.

408 SDP 2011-2025, op.cit.

409 Ministry of Local Government, Rural Development and Cooperatives. *National Strategy for Water and Sanitation in Hard to Reach Areas of Bangladesh*. Dhaka, December 2011 (hereafter HTR).

410 Ravenscroft, Peter et al. “Effectiveness of Public Rural Water Points in Bangladesh, With Special Reference to Arsenic Mitigation,” in *Journal of Water, Sanitation and Hygiene for Development*, 2014.

of tubewells are contaminated.<sup>411</sup> Another 45 million consumed water in 2009 containing more than the internationally recommended amount of arsenic.<sup>412</sup> It has been estimated that arsenic is responsible for 42,000 deaths a year in the country.<sup>413</sup>

Evidence also shows that manganese levels in water that exceed the internationally recommended standards impair the intellectual development of children. Although definitive findings on impact are not yet available, it is understood that an estimated 61 per cent of water sources in the country supply an excess of the national standard for manganese.<sup>414</sup> From a CSR perspective, wet processing of textiles is a major polluter of surface and groundwater in the Dhaka region,<sup>415</sup> with pilot multi-stakeholder projects under way to identify potentials for systemic positive environmental change for the garment sector.<sup>416</sup>

Operation and maintenance of the water supply system remains inefficient, as reflected in high water losses of about 40 per cent.<sup>417</sup> Systems deteriorate quickly without proper maintenance, often within three to four years. Only Dhaka and Chittagong have water meters on a large scale, but without water meters, a full assessment of water use and demand is impossible.

Meanwhile, technological innovations emerging as important for WASH include smart handpumps using ICTs to measure, monitor and improve rural water security, and the engineering of water quality improvements through nanotechnology and biosensors.<sup>418</sup> Critically, opportunity exists to introduce a water-secure risk framework, using state-of-the-art integrated modelling from local to national levels, to predict water risks and consequences that inform improved investment for poverty reduction, child health and value for money. Other innovations include the piloting of alternative technologies such as managed aquifer recharge and solar pumps.<sup>419</sup>

Climate change directly affects water resources and water services for all economic, social and environmental functions that water supports; therefore, the impacts reach into many sectoral interest, such as health, tourism, agriculture and industry.<sup>420</sup> Due to climate change, the shortage of safe drinking water is likely to become more pronounced in Bangladesh, especially in the coastal belt and the drought-prone areas of the northwest. It also is likely that the saline water boundary will be pushed farther inland; saline water over much of the coastal area contributes to hypertension and is a significant health risk, particularly for pregnant women.

Already, the WASH sector is affected in many different ways by weather and climate events, including variability and seasonality. Extreme events also have a profound affect: Annual floodwaters submerge and contaminate tubewells and other water sources, and often wash latrines away (see also Section 2.5.3). Hygiene practice during and after disaster is further constrained due to the absence of safe water, latrines and places for waste disposal. Crucially, most actions are taken only during the emergency and recovery periods, with less attention paid to preparatory measures.

411 Ministry of Local Government, Rural Development and Cooperatives. *National Water Supply and Sanitation Strategy*. Dhaka, June 2014 (hereafter WSS Strategy 2014).

412 Ravenscroft et al., op.cit.

413 Ibid.

414 Bangladesh National Drinking Water Quality Survey, 2009

415 PaCT, op.cit.

416 Ibid.

417 SDP 2011-2025, op.cit.

418 UNICEF Bangladesh. "WASH Section Innovation in Partnership: UNICEF-Oxford University" (PowerPoint presentation). Dhaka, November 2014 (hereafter Innovation in Partnership).

419 UNICEF Bangladesh, "WASH Sector Overview – Bangladesh" (PowerPoint presentation). Dhaka, November 2014 (hereafter Sector Overview).

420 UNICEF and Global Water Partnership. *WASH Climate Resilient Development: Strategic Framework*. New York, 2014.



A need also exists for an integrated water resource management to ensure drinking water supply security in the context of competitive use of water by various sectors. Appropriate subsidies for very poor households, to upgrade or have latrines, likewise is an issue that is being debated, so that subsidies encourage a sense of self-help.<sup>421</sup>

Hygiene is frequently considered the overall “weak link” in the WASH sector,<sup>422</sup> with a high disease burden due to the use of unsafe water or inadequate supply of safe water. Knowledge of key messages is high, but practice of effective handwashing at key times is very low, at 26 per cent after defecation, 1 per cent before preparing food and eating, and 4 per cent before feeding a child.<sup>423</sup> Although water and soap are readily available across the country and in households, often the soap and water are not close to a latrine, which reduces the practice considerably.

Children suffer on average from three to five episodes of diarrhoea each year, resulting in severe dehydration and malnutrition.<sup>424</sup> Yet national hygiene promotion initiatives have yet to offer more than a limited impact on actual practice; some traditional beliefs, such as the belief that a young child’s stool is not harmful, remain strong.<sup>425</sup> In hard-to-reach areas, language may be a barrier to communicating effective hygiene messages; some ethnic minorities do not know Bangla, and remain largely excluded from national hygiene promotion campaigns through the mass media.<sup>426</sup>

The accelerating pace of urbanisation presents a particular challenge (see also Section 2.4.6). People in urban slums often lack basic water and sanitation services, along with other social services. The coverage by piped water supply in urban areas is low; only Dhaka has comparatively high coverage with piped water supply (83 per cent), whereas coverage in most other cities and towns is far lower, at about 40 to 50 per cent.<sup>427</sup> Piped water systems in urban areas are generally characterised by leakages in the pipelines, such that water is supplied only during a few hours of the day; during non-supply hours, the absence of pressure in the pipelines allows contaminated water to seep into the pipes, so that water quality in many piped supply systems also is at high risk.

Likewise, inadequate and inappropriate urban sanitation is a major challenge. Conventional sewerage systems are absent in all urban areas except Dhaka, where only about 1 in 5 people is served by a sewer network.<sup>428</sup> All other urban areas use on-site options like septic tanks, pit latrines, unhygienic latrines or none at all. On-site options are especially difficult to manage in large cities in terms of safe faecal sludge disposal, which represents an urgent emerging issue, with waste frequently dumped in canals, rivers or fields. Moreover, many septic tanks, especially those of high-rise buildings, may not be emptied in a timely fashion or at all, causing faecal matter to overflow and putting public health at high risk. Some professionals have stated that the critical urban sanitation issue now is not the proportion of people using latrines, but rather, the lack of sewer systems and sludge management, given that sludge from the latrines is polluting the environment.<sup>429</sup> Drainage also is an issue, with cities and towns regularly flooded.

In all, an effective faecal sludge management system remains to be established. In addition, with rapid urbanisation the disposal of solid waste has become a major environmental concern. Changes in lifestyle that generates excessive waste, along a shift in thinking about the value of waste (i.e., that it can be a resource as well), are essential.

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421 Hanchett, op.cit.

422 Ibid..

423 MICS 2012-2013, op.cit.

424 Ibid.

425 UNICEF MTR, op.cit.

426 SDP 2011-2025, op.cit.

427 Ibid.

428 WSS Strategy 2014, op.cit.

429 Hanchett, op.cit.

Other areas of acute deprivation besides urban slums also have received very little attention because of their geographic, socio-cultural and economic situations.<sup>430</sup> Overall, some 1,144 unions are classified as very hard to reach or extremely hard to reach for water and sanitation, with another 30 rated moderately hard to reach;<sup>431</sup> the unions are located in 257 *upazilas* of 50 districts. This comprises about 21 per cent of the total area of Bangladesh, with some 28.6 million people living in these areas (see also Section 2.5.3).

For example, WASH coverage in CHT is far lower than that in the rest of the country, with water supply coverage at only 59 per cent and sanitation coverage at 40 per cent overall.<sup>432</sup> The practice of open defecation in Khagrachari district remains at almost 15 times the national average. The hydrogeology diarrhea prevalence is complex in CHT, and finding suitable water sources is often difficult; because of scarcity of drinking water sources, women and girls may have to walk long distances to collect water over hilly terrain. Most parts of *char* areas, largely inhabited by the poor and marginalised, are regularly inundated by flooding.<sup>433</sup>

*Haors* (wetlands) also present a special challenge; any intervention in these areas needs to be done with the utmost care because of their ecological, hydrological, and hence, economic importance. Biologically these are the most productive ecosystems; these are the breeding and spawning grounds of numerous fish and other faunal species, and the habitat of many species of indigenous and migratory waterfowl. Inaccessibility to services in these areas by poor families and children is compounded by the absence of adequate road networks, large fluctuations in water levels, and widespread arsenic contamination in groundwater.<sup>434</sup> Families and children in drought-prone *barind* tract areas, by contrast, suffer severe water scarcity for four to five months out of the year; the potential there for rainwater storage has yet to be given due attention.

Overall, women need to have more mainstream involvement in WASH sector activities, since they are generally the managers of water and sanitation in families, as well as the guardians of hygiene enforcement. Involving women in planning, implementing and operation and maintenance of WASH services will need to be complemented by interventions contributing to the empowerment of women and an increase in their representation in community-based organisations and various committees involved in the sector. Technological options may be promoted that are suitable for women of various socioeconomic groups and their special needs, such as menstrual hygiene management.

### 5.2.2 WASH Institutions, Systems and Governance

The WASH sector in Bangladesh benefits from several important opportunities, including supportive sectoral, national and international policies, strategies, plans and goals.<sup>435</sup> Since the launch of the national sanitation campaign in 2003, the Government has encouraged a partnership approach with local Government bodies, NGOs, development partners and civil society, which has provided a wide platform for multi-stakeholder partnerships and created a synergistic effect in increasing sanitation coverage in particular.<sup>436</sup> Initiatives also

430 Hard to Reach, op.cit.

431 WSS Strategy 2014, op.cit.

432 SDP 2011-2025, op.cit.

433 Hard to Reach, op.cit.

434 Ibid.

435 These include the National Policy for Safe Water Supply and Sanitation 1998, which enshrines the value of water as a core principle; National Sanitation Strategy 2005; National Policy for Arsenic Mitigation 2004; Pro-Poor Strategy for Water Supply and Sanitation 2005; National Water Policy 1999; Local Government Acts 2009; WASA Act 1996; Water Safety Framework 2011; National Water Management Plan 2004; National Sector Development Plan 2011-2025 for the Water Supply and Sanitation Sector (SDP 2011-2025); National Water Supply and Sanitation Strategies for Hard-to-Reach Areas of Bangladesh; and Hygiene Promotion Strategy 2012. Cross-sectoral policies and strategies related to WASH include the Sixth Five Year Plan, Vision 2021, Bangladesh Climate Change Strategy 2009 and Environmental Conservation Rules 1997.

436 SDP 2011-2025, op.cit.

are under way to establish Bangladesh as one of three global water security research observatories to design, test and scale up evidence-based innovations for national, regional and global benefits.<sup>437</sup>

Between fiscal 2007 and 2011, public-sector budget allocations to the WASH sector more than doubled, from 2.3 per cent to 5.6 per cent, but remain low.<sup>438</sup> The Government has made a number of public commitments, including 60 per cent of the people using improved sanitation by 2016, and 0 per cent using unimproved sanitation by 2021. The private sector also continues to make valuable contribution to the development of the WASH sector by supplying goods and services; it installs around 300,000 handpump tubewells and 1 million toilets each year.<sup>439</sup>

A number of successful community-based WASH delivery approaches at grassroots level are supported by local government bodies and NGOs alike, with potential for scaling up; critical among these has been the highly successful Community-Led Total Sanitation (CLTS) campaign, supported by the Government, UNICEF and other partners, which focuses on the social and behavioural changes needed to discourage open defecation.

Five Ministries (Local Government, Education, Health, Disaster and Water Resources) are responsible for water- and sanitation-related policies, with a number of Government line agencies – including the Department of Public Health Engineering (DPHE), Department of Primary Education, Department of Higher Secondary Education, Directorate General-Health Services, Policy Support Unit (PSU) and Water Supply and Sewerage Authority (WASA) – planning and implementing projects and holding financial authority. This underscores the complexity of the sector and the acute need for effective coordination.

Moreover, the need for institutional strengthening remains key. The Government has traditionally followed a “project” intervention outlook, although it is being encouraged to move toward a more forward-thinking sectoral overview. It has made a number of highly public commitments to increase expenditure; however, many have not yet been fulfilled, highlighting the need for more direct advocacy and follow-up. In addition, there has been a need for more targeted sectoral investments to address sectoral bottlenecks. An additional need for enhanced segregation of duties of key sectoral partners likewise has been reported, a factor that inhibits the implementation of the necessary oversight at both national and local levels.<sup>440</sup>

Moreover, not all WASH-related Government Acts are congruent. For example, the Water Act 2013 requires further harmonisation with the existing WASA Act, various Local Government Acts, and other Acts, rules and regulations. At the same time, key sectoral data gaps are found in areas of hygiene behaviour, water quality, sanitation, school WASH and inter-sectoral data (for example, on WASH and nutrition, WASH and health, and WASH and education/schools).<sup>441</sup>

Establishment of sector coordination and monitoring mechanisms continue to be vital, as are expanded coverage, increased service levels and ensuring of sustainability. Major bottlenecks include a lack of awareness and implementation of policies on water quality in particular, along with absence of a national water quality monitoring system. Overall, water quality testing systems and capacity remain limited. In addition, research activities in the WASH sector are few, fragmented and limited to only a few organisations,<sup>442</sup> although the innovations noted above are aimed at beginning to address this gap.

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437 Innovations in Partnership, op.cit.

438 SDP 2011-2025, op.cit.

439 Ibid.

440 UNICEF MTR, op.cit.

441 Sector Overview, op.cit.

442 WSS Strategy 2014, op.cit.

DPHE is being restructured to address new/increased roles and responsibilities with regard to more support to the urban sub-sector; climate change, environment and disaster management; research and development; groundwater monitoring; private sector participation; handwashing and hygiene promotion; and planning and implementation, including social development issues such as participation and empowerment of communities, women and vulnerable groups. At the same time, the capacity of the DPHE will need to be strengthened based on a comprehensive human resources development plan, logistics, improved systems, procedure and guidelines to carry out its new roles.

In particular, a Sanitation Secretariat within the DPHE requires further strengthening to effectively carry out the expected job of monitoring sanitation progress; in 2015, this unit did not have any dedicated staff, with all staff having competing responsibilities in other units.<sup>443</sup> The National Sanitation Forum also meets infrequently. The Government is reportedly planning to set up a separate commission for water and sanitation, as an independent regulatory body emphasising water tariffs in urban areas. A draft bill was under preparation in early 2015 to create this commission.

The Government also is giving more attention to undertaking an integrated and accountable development approach with regard to WASH. Learning from successful SWAp in the health and education sectors (see also Section 5.1 and Chapter 6), the Government also is considering initiating a gradual WASH SWAp, starting with simple and small steps like sub-sector SWAp for WASA and the rural sub-sector.

Further development and implementation of a robust coordination, monitoring and evaluation system will be crucial to determine whether the sector is on track to achieve its goals. Enhancing the coordination and monitoring systems will provide many other benefits, such as avoiding duplication and creating synergy between various Ministries; strengthening mechanisms for identifying the causes of good or poor performance; enabling service providers to be more easily accountable for their performance, in a transparent manner; and providing improved information for assessing the effectiveness of policies and strategies.<sup>444</sup>

In support of local WASH planning, local Government bodies are expected coordinate the planning and development activities of Government projects and those of other sector partners like NGOs and the private sector.<sup>445</sup> At sub-national levels, however, the issue of insufficient human resources, along with a need for strengthened technical solutions, remains acute. At community level, water user groups, community latrine user groups, Water and Sanitation Committees, School Management Committees, and community health promoters all are duty bearers, although the latter frequently focus more on health issues and less on hygiene promotion. Many of these duty bearers may lack full skills on water quality, issues, latrine infrastructure, and necessary operation and maintenance mechanisms.

Additional administrative and financial powers remain to be delegated to local governments, such as for staff recruitment, water tariff fixation and demarcating, and protecting and maintaining water bodies. Specific tripartite agreements also remain to be developed between the Local Government Division of the Ministry of Local Government; DPHE; and various local Government bodies specifying their roles and responsibilities regarding the improvement of WASH services.<sup>446</sup>

Critically, duty bearers are still unable to ensure a separate WASH budget line in the national budget, although Ministry of Finance action is expected shortly on a proposal of separate budget lines for water, sanitation and hygiene. Also at national level, funding gaps exist for

443 Hanchett, op.cit.

444 WSS Strategy 2014, op.cit.

445 WASH Sector Overview – Bangladesh, op.cit.

446 WSS Strategy 2014, op.cit.

sectoral research and development, as well as for operation and maintenance. Insufficient initiatives exist to disseminate sector policies and regulations to local level, while ambiguity surrounds duty bearer roles after service delivery, for example, with regard to such critical issues as solid waste management.

In all, the national WASH budget is anticipated to rise from US\$4.9 billion in 2010-2015 to US\$6.8 billion for the period 2016-2020. Of this, urban water supply is expected to receive US\$3.6 billion, with urban sanitation allocated \$2.2 billion. This compares to US\$555 million for rural water supply and US\$359 million for rural sanitation.

### 5.2.3 Key Indicators of Children's and Women's WASH Status

#### **Safe Water**

Safe drinking water is a human right and a basic requirement for good health. Unsafe drinking water can be a significant carrier of diseases such as cholera and typhoid. In addition, nearby access to drinking water is particularly important for women and girls, especially in rural areas; they bear the primary responsibility for carrying water, often long distances.

Almost all people in Bangladesh (97.9 per cent) use water from improved drinking water sources.<sup>447</sup> Nevertheless, as also noted in Section 5.2.1, issues of reliability and year-round availability of safe water remain in many areas, including urban slums and other hard-to-reach areas.<sup>448</sup> Differences between overall urban and rural areas are small, at 99.1 per cent vs. 97.6 per cent. Among Divisions, Sylhet particularly is lagging, especially when arsenic contamination is factored in, reducing access to improved water sources there to only 68 per cent.<sup>449</sup>

In all, more than 90 per cent of people use a tubewell or borehole as the source of their drinking water, although in urban areas, about 1 in 4 people have drinking water piped into their dwelling. About 3 in 4 users of improved drinking water sources have a source directly on their premises, which is associated with higher use, better family hygiene and better health outcomes, while another 20.4 per cent take less than 30 minutes to get to improved drinking water sources.<sup>450</sup>

In urban slums, however, the precarious land tenure system inhibits the extension of municipal water networks. Instead, many vulnerable families are forced to buy their water from local vendors at an estimated seven times the cost of the municipal water supply (see also Section 2.4.6), and often highly contaminated.<sup>451</sup>

Among those using unimproved drinking water sources, only 1 in 4 (25.6 per cent) were using an appropriate water treatment method. Variations are extremely significant between different Divisions (45.1 per cent in Barisal, compared to 0 per cent in Rajshahi and Rangpur). About 45 to 55 per cent of the population with higher education levels of household head or from the richest households used appropriate water treatment methods, compared with only 18 to 19 per cent in those with the least education level or from the poorest households.<sup>452</sup>

Nearly one-fourth of the population (24.8 per cent) have drinking water with arsenic content above the international guideline of 10 parts per billion (ppb), and 12.4 per cent exceeded

447 MICS 2012-2013, op.cit. Improved sources include piped water (into dwelling, compound, yard or plot, to neighbour, public tap/standpipe), tubewell/borehole, protected well, protected spring, and rainwater collection.

448 Urban WASH Scoping Survey, op.cit.

449 WASH Household Assessment 2014: DPHE-UNICEF

450 MICS 2012-2013, op.cit.

451 Ibid.

452 Ibid.



the national standard of 50 ppb.<sup>453</sup> About 2 per cent of the people are exposed to 200 ppb of arsenic or more. When arsenic contamination is taken into account, the rate of households with access to safe drinking water falls to 85 per cent overall, a decline of more than 12 percentage points. Improved water sources are much more likely to have arsenic contamination than non-improved sources, since arsenic is mainly found in groundwater and most unimproved sources are surface water.

Nonetheless, a lack of understanding and acceptance of the actual health impact of drinking arsenic-contaminated water persists. The cumulative number of arsenic patients between 1996 and 2012 stood at 65,910, with exponential growth since 2008. By Division, Chittagong shows nearly 1 in 2 of the identified arsenicosis patients, followed by 1 in 5 patients in Khulna and 1 in 6 in Dhaka.<sup>454</sup>

About 800,000 water points in Bangladesh are arsenic-contaminated (8 per cent of 10 million water points);<sup>455</sup> people in rural areas are nearly twice as likely to use drinking water containing arsenic above 50 ppb compared to people in urban areas. A recent examination of the effectiveness of rural public water points using various technologies found wide variations in water point effectiveness, based on functionality and arsenic testing.<sup>456</sup> While 92 per cent of water points overall were functional, with notable differences in terms of types, locations and age, testing yielded proportions of ineffectiveness from 11 per cent to 46 per cent. Tubewells, the predominant water source for most rural families, are the most contaminated source, at 13.8 per cent.<sup>457</sup>

Meanwhile, 61.7 per cent of the population had household water with detectable *E. coli* contamination, with 13.5 per cent having water containing very high levels. Only about 1 in 3 households in Bangladesh (34.6 per cent) have water meeting the standards for both arsenic and *E. coli*, while 9.1 per cent of households have water that meets neither standard.<sup>458</sup> Negligible differences are found between urban and rural areas. Meanwhile, other adverse water effects are caused by excessive levels of iron and chloride.

### **Improved Sanitation**

About 77 per cent of people in Bangladesh live in households using improved sanitation facilities (86.3 per cent urban, 74.4 per cent rural); moreover, while the average rate for access to an improved sanitation facility is much lower than that for water, the variation in average rates of access to improved sanitation, per Division, is much higher.<sup>459</sup>

Use of improved sanitation facilities is strongly correlated with wealth; these facilities are used in 95.8 per cent of the richest households, but less than half that figure (45.6 per cent) in the poorest households. The type of facilities varies widely: In rural areas, 47.3 per cent use a pit latrine with slab, while in urban areas 42 per cent use flush toilets with connection to a sewage system or septic tank. The percentage of population without any toilet facility, though low overall at 3.9 per cent, remains significant among the poorest households (13.5 per cent) and in Rangpur Division (15.5 per cent), among others.<sup>460</sup>

Global evidence shows that having both an improved drinking water source and an improved sanitation facility brings the largest public health benefits to a household. Overall, only 55.1

453 Ibid.

454 Health Bulletin, op.cit.

455 UNICEF Bangladesh. "WASH Section Innovation in Products: Arsenic Mitigation" (PowerPoint presentation). Dhaka, November 2014.

456 UNICEF Bangladesh. "Effectiveness of Public Rural Water Points in Bangladesh, With Special Reference to Arsenic Mitigation" (PowerPoint presentation). Dhaka, November 2014.

457 MICS 2012-2013, op.cit.

458 Ibid.

459 Ibid.

460 Ibid.

per cent of people in Bangladesh benefit from both these features; differences between overall urban and rural areas are modest (58.2 vs. 54.3 per cent), and the differences also are limited between Divisions. Again, wealth status overall is a crucial determinant: Some 79.4 per cent of people in the richest households use drinking water from improved sources and improved sanitation facilities, compared to only 25.3 per cent in the poorest households.

Again illustrating the acute challenges faced particularly in urban slums, none out of more than 5,000 low-income communities surveyed in one study had 100 per cent safe drinking water and improved sanitation.<sup>461</sup> Rapidly emerging key WASH issues in urban slums, as highlighted in Section 5.2.1, include not only access to a hygienic latrine, but also, critically, management of faecal sludge, solid waste, wastewater and drainage.

Lastly, inadequate disposal of human excreta (see also Hygiene sub-section below) is associated with a range of diseases, including diarrhoeal diseases, and represents an important determinant for stunting. Evidence shows that improved sanitation can reduce diarrhoeal disease significantly. In Bangladesh, the stools of only 38.7 per cent children aged 0-2 years were disposed of safely; the percentage was much higher in urban areas than rural areas (60.2 vs. 33.1 percent), and significant differences were found in different Divisions (Rangpur, 21.4 per cent; Dhaka, 46 per cent). The percentage of safe disposal of children's stools progressively improved with the education level of mothers and wealth status of the household.<sup>462</sup>

Given the frequency of natural disasters in Bangladesh (see also Section 2.5.2), a huge number of sanitation facilities are damaged or destroyed by floods and cyclones in particular. This results in a very large demand for flood-resistant, appropriate, socially and culturally accepted technological options for safe disposal of human excreta in flood-prone areas.<sup>463</sup> Only 51 per cent of households report that they can use/access their latrine during the rainy season.<sup>464</sup>

## **Effective Hygiene**

Globally, evidence indicates that handwashing with water and soap is the most cost-effective health intervention to reduce both the incidence of diarrhoea and pneumonia in under-5 children. In Bangladesh, an estimated 20,000 children each year in Bangladesh die from diarrhoea.<sup>465</sup> The MICS 2012-2013 found that 82 per cent of households had a specific place for handwashing; 3 in 5 of these households had both water and soap or other cleansing agent present at the specific place, while another 35 per cent had only water available. Very significant variations between Divisions were found, from 98 per cent in Rangpur to 65.7 and 65.5 per cent in Chittagong and Khulna respectively. Availability of a proper handwashing facility is correlated with richer households and more education among household heads; overall, 94 per cent of households had soap available somewhere in the house.<sup>466</sup>

As also noted in Section 5.2.1, high-level knowledge with regard to the benefits of handwashing frequently does not translate into practice: Despite high-level knowledge, for example, only 28 per cent of students washed both hands with soap during school demonstrations.<sup>467</sup>

Menstrual hygiene in schools for adolescent girls remains a key challenge, with impacts on health and on school absenteeism among girls. Most surveyed students used old cloth (82

461 Urban WASH Scoping Study, op.cit.

462 MICS 2012-2013, op.cit.

463 Government of Bangladesh. *National Hygiene Promotion Strategy for Water Supply and Sanitation in Bangladesh*. Dhaka, November 2011 (hereafter National Hygiene Promotion Strategy).

464 WASH Household Assessment 2014; DPHE-UNICEF

465 National Hygiene Promotion Strategy, op.cit.

466 MICS 2012-2013, op.cit.

467 iccdr, b. *Bangladesh National Hygiene Assessment*. Dhaka, March 2014.

per cent), but reported good cloth washing practices, with only 5 per cent washing cloth with only water. Only about 6 per cent of schools had a separate toilet for girls with facilities for menstrual management.<sup>468</sup>

Up to 1 in 4 girls reported that they miss school during menstruation, often for three to five days per month; this equates to up to 20 per cent of school time, which has a demonstrated detrimental impact upon learning – and subsequently, opportunities – for girls. The lack of adequate segregated, clean and functional facilities, and the almost-complete absence of menstrual hygiene facilities, often is regarded as a reason for parents to remove their daughter from school, reducing their development opportunities and increasing the likelihood of child marriage.<sup>469</sup>

As discussed in Section 5.2.1, most schools (84 per cent) had a functional improved toilet for students; however, in less than half of schools (45 per cent) were these accessible to pupils.<sup>470</sup> It appears that most schools do not have facilities that can be safely used by children with disabilities, although no nationwide data are available.<sup>471</sup> At the same time, 80 per cent of schools had an improved functional drinking water source.<sup>472</sup>

In hospitals and other health centres, the WASH situation is highly challenging. A total of 30 per cent of hospitals had more than one water source, and 97 per cent of all water sources were improved sources; however, for drinking water in urban hospitals, only 39 per cent of staff drinking water sources were improved. At the same time, only 1 in 4 rural hospitals had piped water, compared to half of urban hospitals. In addition, 30 per cent of water sources had no drains or broken drains. A total of 5 per cent of hospitals had no water source whatsoever for staff, and 7 per cent had no water source for patients/caregivers.<sup>473</sup>

A critical lack of functioning toilets in hospitals has been noted. For example, the number of hospitals with no toilets available on spot check for a specific doctor, other staff, or common use was quite high: 19 per cent of hospitals had no toilets designated for doctors, 27 per cent had no toilets designated for nurses/other hospital staff, and 46 per cent had no toilets for common use.<sup>474</sup> Handwashing stations with available water were mostly located within 10 feet of hospital toilets, but these facilities usually lacked soap. Although between one-third and one-half of hospitals had alcohol hand sanitiser available for staff, this was used in only 1 per cent of handwashing opportunities. General environmental hygiene in hospitals also was found to be poor.

Further, soap was not prioritised for handwashing by staff in other critical public areas. In restaurants and street food stalls, very low levels of handwashing, at less than 14 per cent, were found among restaurant cooks, and less than 20 per cent among food vendors.<sup>475</sup> Less than 25 per cent of food sold by restaurants and less than 42 per cent of food sold by vendors was kept in a covered, clean pot or container.

468 Annual Sector Performance Report 2014

469 Ibid.

470 National Hygiene Assessment, op.cit.

471 UNICEF MTR, op.cit.

472 National Hygiene Assessment, op.cit.

473 Ibid.

474 Ibid.

475 Ibid.

## 5.2.4 Root and Underlying Causes of Key WASH Challenges

Based on the above analysis as well as a UNICEF capacity gap and role pattern analysis (see also Annex 4), a number of root causes for WASH-related challenges in Bangladesh, at different levels of duty bearers, have been identified:

- Low capacity of public institutions, including local Government institutions, and need for strengthened monitoring mechanisms
- Lack of knowledge about WASH impact, particularly water quality, poor sanitation and poor hygiene impact, on health and nutrition
- Widespread contamination of water by arsenic and *E. coli*
- Rapid urbanisation and issues of access in hard-to-reach areas
- Acute vulnerability to climate change and natural disasters
- Poverty
- Social norms and cultural beliefs that influence WASH practices

All this results in a variety of underlying challenges, including:

- Need for strengthened coordination, capacities and monitoring among sectoral stakeholders
- Competing use of water resources (agriculture, drinking water, land tenure issues in urban slums)
- Consideration of sanitation as a secondary need of life and limited funding to sanitation projects, particularly in rural areas and urban slums
- High levels of WASH-related health issues among children and women
- Inability to translate hygiene knowledge into practice
- Accelerating issues of human sludge management in urban areas, along with lack of technology and systems for solid waste management
- High proportion of shared sanitation facilities
- Lack of climate-resilient technologies and frequent destruction of WASH infrastructure from natural disasters
- Inability to upgrade or have latrines
- Lack of low-cost water quality testing facilities and maintenance of household-level handwashing technologies
- Lack of gender-sensitive and disability-focused sanitation or hygiene products

## 5.2.5 Recommendations to Improve Children's and Women's WASH Status

Access to safe water and access to decent sanitation are human rights,<sup>476</sup> both included within the human right to an adequate standard of living and explicitly recognised in 2010 by the United Nations General Assembly and the Human Rights Council. These human rights are in themselves essential for life and dignity, but are also the foundation for achieving a wealth of other human rights, including the right to health and the right to development.

<sup>476</sup> The United Nations Special Rapporteur on water and sanitation argued in 2014 that water and sanitation should be treated as two distinct human rights with equal status. All too often, when water and sanitation are mentioned together, the importance of sanitation is downgraded because of the political and cultural preference given to the right to water. Defining the human rights to water and sanitation as separate and distinct allows governments, civil society and other stakeholders to create standards specifically for the human right to sanitation and for its realisation. Distinguishing between these two rights also makes it easier for States and other stakeholders to understand the distinct responsibilities, obligations and roles implicit in the realisation of each of them. Critically, the situation of people who lack sanitation differs from that of people who lack water. One household's lack of adequate, safe and hygienic sanitation can have a negative impact on the health not just of the people in that dwelling, but also on others living nearby, even where these neighbours do have access to sanitation. This means that people have a responsibility to improve their sanitation, for the sake of those around them as well as their own. One household's lack of access to water, on the other hand, would not generally have such an impact on the health and access to water of its neighbours.

Around the world, the real challenge now is to translate these human rights obligations into meaningful action on the ground. For Bangladesh to further achieve this, recommendations include:

Policy/Strategy	<p>Promotion of WASH sector coordination and harmonisation of policies, particularly including a harmonised approach for arsenic mitigation</p> <p>Additional priority to Integrated Water Resources Management</p>
Institutions/Governance	<p>Institutional capacity development at national and sub-national levels</p> <p>Strengthening of overall sector monitoring and reporting system, with an increased focus on equity</p> <p>Support for a nationwide water quality surveillance and reporting system</p> <p>Support for equitable resource allocation for hard-to-reach and water quality-challenged areas; sanitation and hygiene; and urban slums</p>
Programme, Including Gender/Adolescents/Child Marriage/Urban Slums	<p>Sectoral approach to scaling up of WASH delivery</p> <p>Intensified efforts for provision of WASH facilities, including menstrual health management facilities, in schools and health centres</p> <p>Intensified efforts on hygiene promotional and other C4D activities, including the use of safe water, improved sanitation, and handwashing with soap at critical times, for improved utilisation rates, behaviour and social change (including incorporation of WASH messages into health structures)</p> <p>Piloting of a “100 per cent” approach to improved WASH services (safe drinking water, hygienic sanitation) in selected urban slums, potentially employing public-private partnerships</p> <p>Strengthening of linkages between improved sanitation, handwashing and solid waste management</p> <p>Improved emergency preparedness, including piloting of more disaster-resilient designs of water and sanitation facilities and strengthening of local-level capacity, coordination and preparedness mechanisms</p> <p>Intensified support for increased involvement of women in planning, implementing and operation and maintenance of WASH services</p> <p>Support for mandatory provision of facilities for persons with disabilities with regard to public water supplies and toilets</p>
M&E/Data/Knowledge Management/Innovation	<p>Promotion of climate-resilient WASH technologies</p> <p>Increased support for research on new technologies to address challenges relating to water quality, year-round access, operation and maintenance, and scaling up of pilot initiatives on alternative technologies</p> <p>Building of a strengthened evidence base on the health impact of arsenic, manganese, salinity and faecal contamination for more effective advocacy</p> <p>Real-time data generation to capture changes in knowledge, practices and norms change processes</p>



## 5.3 HIV AND AIDS

### 5.3.1 Introduction

New HIV infections among adults and children have declined substantially worldwide, but not in Bangladesh. Although HIV prevalence in the general population in Bangladesh is low, at 0.1 per cent,<sup>477</sup> a 25 per cent increase in new HIV cases in the country has been reported over the period 2001-2012.<sup>478</sup> Moreover, reported new infections have increased by a factor of about 1.5 within the last five years alone.<sup>479</sup> Bangladesh is thus one of four countries in the Asia-Pacific region where the epidemic continues to increase. Main routes of transmission are through heterosexual unprotected sex and sharing of used needles and syringes.<sup>480</sup>

Higher rates of infection are particularly being recorded among key population groups:<sup>481</sup> According to the ninth national Serological Surveillance Round in 2011, the HIV prevalence among people who use drugs, female and male sex workers, males who have sex with males, and transgender people stood at 0.7 per cent, seven times higher than the nationwide prevalence rate. A concentrated epidemic exists in Dhaka among people who inject drugs, where the HIV prevalence rate stands at 5.3 per cent,<sup>482</sup> while an epidemic also may be emerging among female sex workers in border towns and needs careful attention.<sup>483</sup>

At the end of 2013, it was estimated that 9,545 people were living with HIV, an increase from the 8,000 estimated in 2012; however, because of low reporting, the number potentially could be as high as 977,000.<sup>484</sup> In 2014, there were 433 new reported case of HIV in the country, while 91 people died.<sup>485</sup>

There appears to be a decrease in the estimated number of children aged 0-14 years living with HIV, to 291 in 2013 from 400 in 2012, which may be attributed to AIDS-related mortality, a decrease in new paediatric HIV infections resulting from successes in Prevention of Mother to Child Transmission (PMTCT) programmes, and/or improvements in available data. A total of 2,389 children were affected by HIV and AIDS in Bangladesh at the end of 2013.<sup>486</sup>

Key reasons for containment of the HIV epidemic in Bangladesh until now include the early initiation and subsequent expansion of targeted interventions for key populations; the near-universal rate of male circumcision; successful interventions in harm reduction services for people who inject drugs;<sup>487</sup> and dramatically increased condom use among female sex workers, the transgender/*hijra* population, and males who have sex with males.<sup>488</sup>

477 National AIDS/STD Programme, 2009. Ninth HIV Sero-Surveillance in Bangladesh

478 Ibid.

479 UNAIDS. "Bangladesh 2014 Fact Sheet." Dhaka, 2014.

480 National AIDS/STD Programme. *Third National Strategic Plan for HIV and AIDS Response 2011-2017 (Revised)*. Dhaka, April 2014.

481 UNICEF MTR, op.cit.

482 National AIDS/STD Programme. *National HIV Serological Surveillance: 2011: Ninth Round Technical Report*. Dhaka, 2011. No comprehensive official statistics are available on the number of drug users in the country; however, various sources indicate that the estimated number stands at about 4.5 million.

483 National AIDS/STD Programme. *National HIV Risk Reduction Strategy for Most at Risk and Especially Vulnerable Adolescents to HIV and AIDS in Bangladesh 2013-2015*. Dhaka, December 2013 (hereafter HIV Risk Reduction for MARA/EVA).

484 Global Fund to Fight AIDS, Tuberculosis and Malaria. *Standard Concept Note: Bangladesh*. Dhaka, March 2014 (hereafter Global Fund).

485 UNAIDS. "HIV in Bangladesh: Epidemiology and Response" (PowerPoint presentation). Dhaka, April 2015.

486 UNICEF Bangladesh. *Comprehensive Mapping of Children Infected and Affected by AIDS (CABA) in Bangladesh*. Dhaka, 2014 (hereafter CABA).

487 It has been estimated that if no harm reduction interventions were in place, HIV prevalence among people who inject drugs would stand at 23.8 per cent in Dhaka. (National AIDS/STD Programme, UNAIDS, iccd; b and Save the Children, "Key Findings From Assessment of Impact of Harm Reduction Interventions Among People Who Inject Drugs (PWID) in Dhaka" (PowerPoint presentation). Dhaka, November 2014)

488 Global Fund, op.cit.

Women comprise about 35 per cent of the estimated population of adults (15 years and older) living with HIV.<sup>489</sup> Critically, migrants (see also Section 2.4.1) now constitute from 25 to 42 per cent of annual cases; a significant increase likewise is reported in infections among spouses of migrants.<sup>490</sup> Other emerging risk groups include non-injecting drug users, clients of sex workers, and especially vulnerable adolescents (EVA).<sup>491</sup> Additional groups among whom higher vulnerability is suspected but supporting evidence is not strong include garment, tea garden and transport workers; refugee and displaced persons; and some ethnic minority populations. A general lack of data and information on emerging populations renders it challenging to plan and monitor appropriate responses.

Limited coverage of services and low rates of HIV testing both contribute to the overall low case detection rate.<sup>492</sup> For example, only 1 in 5 among people who inject drugs is reached by HIV testing and counselling at national level; nevertheless, this is significantly higher than the 10 per cent recorded among female sex workers and 9 per cent among males who have sex with males/male sex workers and transgender people/*hijra*.<sup>493</sup> About 75 per cent of people living with HIV are unaware of their status, and a large majority of people belonging to key populations have never been tested.<sup>494</sup>

Overall, limited treatment facilities exist for people living with HIV in Bangladesh, and mechanisms to ensure quality of treatment service provision are largely absent.<sup>495</sup> Capacity is extremely limited to provide more complex HIV treatment needs (paediatric HIV, drug resistance, Hepatitis C or tuberculosis co-infection, opportunistic infections, elevated risk of other morbidities such as cervical cancer or diabetes). A need for establishment of at least one well-equipped specialist facility able to deal with treatment failures, complicated cases and paediatric infections has been identified.<sup>496</sup> Key gaps in HIV counselling and testing<sup>497</sup> include poor distribution of counselling and testing centres across the country, with most concentrated in a few locations; lack of national guidelines for counselling and testing, along with cumbersome testing procedures; and considerable “lag time” between HIV testing and availability of test results.

HIV surveillance and detection among adolescents and young people in the country is particularly in need of strengthening. It was estimated that 905 young people aged 15-24 years were living with HIV in 2013, among whom 56 per cent were females. However, a large number of adolescent key populations – more than 75,000,<sup>498</sup> according to one estimate – are at higher risk of HIV, including transgender adolescents, men having sex with men or male sex workers, non-injecting and people who inject drugs users (PWID/IDUs), and female sex workers.<sup>499</sup> Overall, the key populations of most-at-risk adolescents (MARA) and young people present a very diverse profile and an extremely complex picture of behaviours with implications for risk and vulnerability.<sup>500</sup>

489 Global AIDS Reponse Progress Report, 2013

490 Global Fund, op.cit. In two Divisions – Sylhet and Chittagong – more than 50 per cent of all cases are migrant-related.

491 National Strategic Plan 2011-2017, op.cit. EVA include, among others, adolescents of different sexual orientation and gender identity; sexually or physically abused adolescents; adolescents in child marriages; orphans and those without any adult supervision and care, i.e., children on the streets; children, siblings or friends of those who use drugs and/or sell sex; juvenile offenders; school dropouts; and runaway, homeless or migrant adolescents, including those in institutional care centres or prison.

492 UNICEF MTR, op.cit.

493 The Government has officially recognised the transgender/*hijra* population as a third gender since November 2013.

494 Global Fund, op.cit.

495 NSP 2011-2017, op.cit.

496 National AIDS/STD Programme and UNICEF Bangladesh. “Working Paper Series on HIV and AIDS in Bangladesh #1: HIV Testing, Treatment, Care and Support.” Dhaka, 2014.

497 Ibid.

498 This estimate was constrained, however, by social and legal implications related to accessing and surveying adolescent key populations, and the national estimate is expected to be much higher.

499 UNICEF MTR, op.cit.

500 HIV Risk Reduction for MARA/EVA, op.cit.

A major drop in coverage appears to lie in access to HIV counselling and testing services by adolescents, associated with policy barriers in age of consent to medical services among adolescents and legal barriers that criminalise behaviours of key populations (see also 5.3.2); AIDS-related stigma and discrimination; and the limited capacity of service providers to scale up interventions for adolescents.<sup>501</sup> Specific coverage of HIV counselling and testing is not known for adolescent/young males who have sex with males, including transgender persons (age 10-24). Disaggregation of data for adolescents aged 10-19 years across all key population groups is unavailable. In addition, low comprehensive knowledge of HIV prevention among adolescents (see also Section 5.3.3), especially adolescent key population groups, contributes to this low coverage.

Despite the achievements noted, different levels of key disparities have been found to exist: With regard to PMTCT, there are geographic disparities in access, use and effective coverage as a result of weak integration and varying capacities for HIV and maternal, neonatal and child health services, resulting in overall low coverage of PMTCT services. These constraints are exacerbated by structural challenges to identification and enrollment of pregnant and breastfeeding women from special population groups<sup>502</sup> into PMTCT and institutional capacity to offer early infant diagnosis of HIV-exposed infants.<sup>503</sup> Strong gender-based disparities also exist in effective coverage of HIV counselling and testing among adolescent and young people who are injecting drug users, at 51 per cent among males and 31 per cent among females. Other disparities in access and use of HIV counselling and testing among adolescent and young female sex workers (ages 10-24) related to the location of their sex work, whether brothel-, hotel-, street- or residence-based. Counselling and testing coverage was higher among residence-based female sex workers than others, at 55 per cent.<sup>504</sup>

In response, the Government has developed an innovative “dual delivery” approach for PMTCT and congenital syphilis. This approach combines geographic targeting with the targeting of women in special populations groups and has resulted in the mainstreaming of PMTCT services into maternal, neonatal and child health care in three designated public health facilities for the first time. Coverage of HIV counselling and testing at ANC and delivery (34 per cent) and syphilis screening at ANC (56 per cent), have improved, but require significant strengthening, as do coverage of antiretroviral (ARV) prophylaxis (60 per cent) and cotrimoxazole preventive therapy in HIV-exposed infants.<sup>505</sup> Even so, women in need of PMTCT are still not identified nationally.

Coverage of anti-retroviral treatment (ART) in adults and children has been aligned with international criteria for treatment eligibility in 2013 and largely funded through the national budget. At the end of 2013, 29 per cent of eligible adults and 37 per cent of eligible children were on ART; nonetheless, the fact that only about one-third of eligible HIV-positive children are being treated has disturbing implications for mortality.<sup>506</sup>

An increase in the coverage of early infant diagnosis, from 0 per cent in 2012 to 88 per cent in selected sites in 2014, has occurred. Moreover, the nationwide rollout of paediatric ART has been enabled through the availability of anti-retroviral drugs.<sup>507</sup> Major bottlenecks to effective coverage of paediatric AIDS treatment and care still exist, however, lying in the limited coverage of HIV diagnosis in children to inform their enrolment into treatment programmes. In addition, gaps occur in the coverage of HIV-positive children who are assessed for treatment eligibility.

501 Ibid.

502 These include female sex workers, female who inject injecting drugsdrug users, female partners of male who inject drugs injecting drug users, regular female partners of male sex workers, adolescent girls exploited in the sex industry, and female migrants and regular female partners of male migrants.

503 National AIDS/STD Programme and UNICEF Bangladesh. “Working Paper Series on HIV and AIDS in Bangladesh #3: Prevention of Mother to Child Transmission of HIV (PMTCT).” Dhaka, 2014.

504 National AIDS/STD Programme (NASP), Directorate General of Health Services, Ministry of Health and Family Welfare, UNICEF. Mapping and Behavioral Study of Most at Risk Adolescents to HIV in Specific Urban/semi Urban Locations in Bangladesh. Dhaka 2012.

505 Ibid.

506 Ibid.

507 Ibid.

A central factor in Bangladesh constraining open discussion about HIV and AIDS, sex and sexuality, sexually transmitted infections, drug use, child sexual abuse and exploitation, and related issues arises from the social and cultural reality, which remains largely conservative. These topics remain highly taboo within both the public and private spheres and inhibit the degree to which HIV risk behaviours can be addressed, particularly among adolescents; the traditional assumption has been that information about sexuality will encourage adolescents to have premarital sex or behave promiscuously. The National HIV Risk Reduction Strategy for Most at Risk and Especially Vulnerable Adolescents (MARA/EVA) acknowledges that MARA are not officially included in ongoing targeted interventions, including for people who inject drugs, female sex workers, and males who have sex with males and *hijra*. Government-provided free condoms are only accessible to married individuals, irrespective of age, for family planning, not for prevention of sexually transmitted infection.

Moreover, even words to describe male and female sexual organs or different sexual acts are reported to be largely uncommon and, in some cases, unknown to health workers and counsellors alike.<sup>508</sup> Talking about sexual issues with girls may be further constrained because of traditional gender roles and expectations, as well as harmful gender norms.<sup>509</sup> This – along with biological vulnerabilities, unequal economic opportunities, child marriage and early pregnancy, inability to negotiate terms of sexual relations, and inadequate access to sexual/reproductive health services – increases girls' risk of contracting HIV. In addition, an estimated 500,000 girls have been trafficked to work in brothels in neighbouring countries in the last 10 years (see also Chapter 7), which puts them at higher risk of violence and exposure to HIV. Furthermore, married women who have contracted HIV from having unprotected sex with their husbands often are scorned, mistreated and even evicted from their home when their HIV status becomes known.<sup>510</sup>

At the same time, gender violence with regard to *hijras* and males who have sex with males also is very high. A study of male and transgender sex workers in Bangladesh, many of whom are adolescents, found that 27.8 per cent had been raped and, of that, 21.9 per cent by regular sex partners/clients. Violence against *hijras* and males who have sex with males also may include police abuse.<sup>511</sup> Similarly, more than 40 per cent of *hijra* respondents had been beaten in the last year, according to a 2011 study in Dhaka.<sup>512</sup>

In all, people living with HIV in Bangladesh face high levels of stigma and discrimination. One study in the country regarding health providers and stigma<sup>513</sup> showed that 80 per cent of nurses and 90 per cent of doctors' behaviour with HIV-positive people were discriminatory, such as talking to patients while standing far from them. Moreover, another recent study found that nearly half of HIV-infected parents in Bangladesh did not disclose their HIV status to their children.<sup>514</sup> More than half of surveyed children of these parents had experienced stigma and discrimination following the death of their parent, from family members, neighbours, friends and schoolmates. In the same study, 1 in 5 HIV-positive parents stated that their HIV-positive children were deprived of health services due to stigma and discrimination.

508 National AIDS/STD Programme. *National Counselling Guidelines for Children and Adolescents Most at Risk of or Affected by HIV and AIDS (Revised)*. Dhaka, June 2013 (hereafter National Counselling Guidelines).

509 Ibid.

510 National AIDS/STD Programme and UNAIDS. *Gender Assessment of the National HIV Response in Bangladesh*. Dhaka, 2014.

511 iccdr,b. *Counting the Number of Males Who Have Sex With Males (MSM), Male Sex Workers and Hijra in Bangladesh to Provide HIV Prevention Services*. Dhaka, May 2012.

512 HIV Risk Reduction Strategy for MARA/EVA, op.cit.

513 Ahsan Ullah, A.K. "HIV/AIDS-Related Stigma and Discrimination: A Study of Health Care Providers in Bangladesh," in *Journal of the International Association of Physicians in AIDS Care*. Chicago, USA, March-April 2011.

514 CABA, op.cit.

### 5.3.2 HIV and AIDS Institutions, Systems and Governance

Bangladesh responded early to the AIDS epidemic: The National AIDS Committee was formed in 1985 as a policy advisory body, while the first case of HIV in Bangladesh was detected only in 1989; the Committee has been credited with playing a role in the endorsement of an extended National Sector Plan, national monitoring and evaluation plan, and ART guidelines. However, the Committee also meets irregularly, which has negatively affected policies and strategic planning as well as resource mobilisation.<sup>515</sup>

The National AIDS/STD Programme (NASP), under the Directorate General-Health Services of MoHFW, is the main Government body responsible for overseeing and coordination of HIV prevention, treatment and care efforts. However, the NASP works on an ad hoc basis; the organisation is not adequately staffed, and key knowledge/skills require significant strengthening, particularly with regard to programme management, coordination and leadership, with high staff turnover. Funding also is irregular. All these issues present key constraints to effective planning and coordination of the national response, as well as to service delivery, availability of commodities, and issues of accountability. Nonetheless, the NASP has provided important leadership by efficiently guiding civil society implementers and management agencies to address programmatic gaps.<sup>516 517</sup>

Other Ministries also are involved in various strategic directions linked to HIV prevention, including Home Affairs, Local Government, Finance, Religious Affairs, Education, Information and Broadcasting, Women and Children Affairs, and Youth and Sports. HIV focal persons have been appointed in 16 key Ministries and departments, but until their roles are further clarified, the focal persons are yet to be implemented effectively.

The Government has recently revised the duration of the Third National HIV and AIDS Strategic Plan until June 2017 to allow the country to consolidate current progress while addressing emerging challenges. Critically, however, the low HIV prevalence in Bangladesh, low population estimate of people living with HIV, and competing health and social development challenges all continue to represent risks to sustaining the current national AIDS response. The main challenge has been to translate numerous well-formulated policy and programme strategies<sup>518</sup> into effective implementation.

Among international partners, the funding situation for HIV and AIDS is declining because of reduced priority given to the issue, with some major international support ending altogether. This urgently necessitates alternate funding streams and effective advocacy for increased Government investment. Critically, there exists limited evidence on how funding for HIV and AIDS programmes – most of it still from international partners – is transferred or spent at various levels, either by funding sources, funding agents or service providers. It is an equally urgent priority to harmonise institutionally the resource tracking system for the national HIV and AIDS response to enable the monitoring of financial resource flows at regular intervals.

515 National AIDS/STD Programme and UNICEF Bangladesh. "Working Paper Series on HIV and AIDS in Bangladesh #10: Coordination, Management, Technical Support and Knowledge Management." Dhaka, 2014 (hereafter Working Paper #10).

516 National AIDS/STD Programme, UNAIDS et al. *Global AIDS Response Progress Report: Country Progress Report for Bangladesh 2014*. Dhaka, May 2014 (hereafter GARPR).

517 Working Paper #10, op.cit.

518 Relevant legislation and strategies include: National Risk Reduction Strategy for Young Key Populations and Most at Risk Adolescents 2013; National Guidelines for the Prevention of Vertical Transmission of HIV and Congenital Syphilis 2013; National HIV Testing and Counselling Guidelines 2013; Nutritional Guidelines for People Living with HIV 2012; National Anti Retroviral Therapy Guidelines 2011; Training Manual on the Reduction of Stigma and Discrimination Related to HIV/AIDS 2010; HIV/AIDS Stigma and Discrimination Toolkit, 2011; National Strategic Plan for HIV/AIDS 2011-2015; National AIDS Monitoring and Evaluation Plan 2011-2015; Standard Operating Procedures for Drop-In Centres for PWIDs Injecting Drug Users and Female Sex Workers 2010; Standard Operating Procedures for Services to People Living with HIV and AIDS 2009; Clinical Management of HIV and AIDS: Doctors' Handbook 2009; various training manuals and guidelines on counselling and peer education for PWIDs/injecting drug users, female sex workers and people living with HIV, 2008 to 2011; National Policy and Strategy for Blood Safety 2007; National Curriculum on HIV/AIDS (for students of Classes 6-12), 2007; National Standards for Youth Friendly Health Services 2007; National Sexually Transmitted Infection Management Guidelines 2006; Safe Blood Transfusion Act 2002; National Harm Reduction Strategy for Drug Use and HIV 2004-2010; and National HIV Advocacy and Communication Strategy 2005-2010.



This would improve coordination and assure that resources are channelled where most needed; for example, significant inefficiency in the use of resources has been found, with spending of resources only 18 per cent of total allocated funds of Govt. in 2012-2013.<sup>519</sup> The inability to track the flow of financial resources and expenditures affects the district level in particular; disaggregation by district not only would ensure local needs are being met, but also would reduce duplication and overlapping of efforts.

Mainstreaming HIV into Government multisectoral programmes has shown very slow progress, while the platform for knowledge sharing is limited to a few annual events. A country-level monitoring and evaluation system has been operationalised for key population interventions, but similar efforts need to be strengthened for people living with HIV. Collection and collation of data through surveillance, surveys and research likewise is progressing slowly, with the latest serological surveillance conducted in 2011. A holistic national size estimation is yet to be conducted.

Critically, no functional and established linkages exist between HIV and sexual/reproductive health programmes; other policy instruments also have the potential to address broader social and economic conditions that increase vulnerabilities related to HIV. Government focal points meet irregularly and do not appear to receive follow-up technical and financial support from parent organisations.<sup>520</sup> At the same time, considerable challenges exist with regard to ensuring effective and timely funding flow mechanisms through different tiers of Government. It is considered particularly important for the Ministry of Home Affairs, which manages law enforcement officers, to have a strong HIV component as part of efforts to address reported violence, abuse and harassment of key populations, including adolescents, by the police.<sup>521</sup>

As noted in Section 5.3.1, adolescents face considerable legal and policy issues with regard to accessing quality services. The current legal framework to address issues of consent for HIV testing and disclosure of HIV test results is the National Policy on HIV/AIDS and STD Related Issues. This policy was developed in 1996 and has not been revised to address changes in the country's HIV and AIDS situation, particularly with regard to ensuring privacy and confidentiality for MARA and EVA; it sets the age of consent at 18 years,<sup>522</sup> thereby leaving out many of the key risk populations.

Some aspects of sex work and males having sex with males are criminalised. In addition, sections of the Narcotics Control Act 1990 allow arrest and punishment for possession of drug paraphernalia. This law limits the ability of service providers to deliver services in the open due to fear of being apprehended by law enforcement agents. Because of these punitive laws, communities of key populations report facing frequent arrest and arbitrary harassment; the Dhaka Metropolitan Police Ordinance 1976 is often used against key populations, especially sex workers.<sup>523</sup> These not only discourage key populations from accessing needed services, but criminalisation also means that they cannot receive legal recourse even if their basic rights are violated.<sup>524</sup>

The legal infrastructure to address child sexual abuse and exploitation in the country also requires revision and updating to ensure that counsellors can help the children they serve to access legal support and protections that they may need (see also Chapter 7). The scale

519 National AIDS/STD Programme and UNICEF Bangladesh. *National AIDS Spending Assessment 2010-2013*. Dhaka, January 2015.

520 Working Paper #10, op.cit.

521 Ibid.

522 The national policy states: "Informed consent and pre-test counselling of the mother or principal guardian of the child must be carried out. The mother or the principal guardian of the child has the right to know the results. The health workers directly involved in the care of the child also have the right to know the results. The counsellor is responsible for counselling and follow-up of the mother."

523 UNAIDS Asia-Pacific. "HIV Epidemic and Response in Asia and the Pacific: Country Posters Prepared for the 11<sup>th</sup> UNAIDS Asia-Pacific Regional Management Meeting." Bangkok, 25-28 October 2014.

524 Nonetheless, a newly established initiative by the National Human Rights Commission is at the forefront of increased efforts to provide legal education and legal access to key populations in case of such violations.

and capacity of the operational infrastructure of HIV and AIDS services likewise remains to be further developed to ensure that gaps in counselling, testing, care and support services, particularly for adolescents, are filled.<sup>525</sup>

A number of key recommendations to strengthen institutions, systems and governance related to HIV have been offered following a recent comprehensive analysis on health system and community services (see also Section 5.1). These include: (1) An urgent need for technical capacity development and human rights orientation of the national health system, with competent, efficient and non-discriminatory staff to successfully scale up testing and treatment and ensure access to maternal and reproductive health services for people living with HIV and key populations; (2) Extension of the HMIS to include more providers and create a better evidence base on HIV and AIDS; (3) Integration of HIV and AIDS services with tuberculosis screening and reproductive health services; (4) Using PMTCT as a tool to reduce barriers to access by teaching providers more about HIV medicine as well as associated social and human rights issues; (5) Decentralisation of services and establishment of community- and home-based HIV testing, which may be a way to reach out to people with “hidden” identities, including many males who have sex with males and residence-based sex workers; and (6) Expanded laboratory capacity.<sup>526</sup>

### 5.3.3 Key Indicators of Children’s and Women’s HIV and AIDS Status

HIV has been detected in 60 out of Bangladesh’s 64 districts;<sup>527</sup> however, 21 districts have had only a few sporadic cases, and 75 per cent of cases are concentrated in only 12 districts. The most heavily affected districts are Sylhet, Munshiganj, Moulvibazar, Dhaka, Khulna and Cox’s Bazar.<sup>528</sup>

Although one of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission, comprehensive knowledge among of HIV among women and adolescent girls in Bangladesh remains alarmingly low. Only 55.8 per cent of women aged 15-49 years had heard of AIDS, while only 23.2 per cent know two ways to prevent HIV, such as having one faithful, uninfected sex partner or using a condom every time.<sup>529</sup> Moreover, other recent surveys<sup>530</sup> show a slight decline in knowledge of HIV prevention methods, from 37 to 34 per cent between 2011 and 2014. Only 11.1 per cent of women can identify the two most common misconceptions regarding HIV and know that a healthy-looking person can have HIV. Overall, only 6.6 per cent of women had comprehensive knowledge with regard to HIV transmission.<sup>531</sup>

Knowledge about prevention of HIV transmission is much higher in urban women, in younger women and in never-married women. Although the rate of comprehensive knowledge of HIV transmission is higher among adolescent women aged 15-19 than among women 15-49 as a whole, it still remains very low at 10.2 per cent. Results in Divisions vary considerably, from 14 per cent in Sylhet to 30.1 per cent in Khulna. Education and wealth have a strong positive influence on knowledge about HIV prevention; 56 per cent of women with secondary complete or higher education knew both ways to prevent HIV, for example, compared to only 4.6 per cent of women with no education.<sup>532</sup>

525 National Counselling Guidelines, op.cit.

526 Global Fund, op.cit.

527 UNAIDS. “HIV in Bangladesh: Epidemiology and Response” (PowerPoint presentation). Dhaka, April 2015.

528 Global Fund, op.cit.

529 MICS 2012-2013, op.cit.

530 DHS 2014, op.cit.

531 MICS 2012-2013, op.cit.

532 Ibid.

Only about 17.7 per cent of young people of both sexes aged 15-24 have comprehensive knowledge on HIV, the lowest in the Asia-Pacific region. MARA have particularly low knowledge, ranging from 1 per cent of transgender adolescents with comprehensive knowledge about HIV to 2.3 per cent of adolescent female sex workers and 3 per cent of adolescent PWIDs/injecting drug users.<sup>533</sup> Meanwhile, among adolescent female sex workers, the mean age at first sex ranged from 13.8 to 14.8 years, depending on location of sex work. Extremely high rates of group sex with clients also have been recorded among these female sex workers.<sup>534</sup>

Knowledge of mother-to-child transmission of HIV also is an important first step for women to seek HIV testing when they are pregnant to avoid infection in the baby. Overall, 43.8 per cent of women in Bangladesh know that HIV can be transmitted from mother to child. About 1 in every 5 women knows all three ways of transmission (pregnancy, delivery, breastfeeding), with 12.1 per cent not knowing of any specific way. Knowledge is strongly associated with women's education and wealth levels, with higher levels of knowledge found in urban women, younger women, and never-married women. Strong variations between Divisions also are found.<sup>535</sup>

Knowledge of a place for HIV testing and counselling likewise is important for women to protect themselves and to prevent infecting others. Underscoring the issues noted in Section 5.3.1 on testing and counselling, only 11.3 per cent of women knew of a place for testing.<sup>536</sup> Education and wealth have strong positive correlations with knowledge of an HIV testing place; some 33.6 per cent of women with secondary or higher education knew of such a place, compared with only 2.2 per cent of women with no education. Divisions vary considerably, from 6.2 per cent in Sylhet to 16.4 per cent in Khulna. Nonetheless, this indicates the serious challenges remaining in effectively tackling HIV in the country, despite an overall low prevalence.

Among women who had given birth in the two years preceding the survey, about 58.7 per cent had received ANC from a health care professional, but only 2.5 per cent received HIV counselling during this care (see also Section 5.1). Women from Barisal Division have the lowest percentage of HIV counselling during antenatal care, at 1.4 per cent.<sup>537</sup>

As also discussed in Section 5.3.1, sexual abuse appears to be extremely common among MARA and EVA of any gender, and particularly among children living on the streets. In addition, the percentage of Bangladeshi men that procure sex from commercial sex workers is significantly higher than elsewhere in Asia, while condom usage in commercial sex encounters is the lowest in the region. The syphilis rate also is high, and has been recorded at up 40 per cent among some groups of female sex workers.<sup>538</sup>

Recent evidence also indicates stigma and discrimination with regard to HIV status remain strong in Bangladesh.<sup>539</sup> A total of 92.7 per cent of women aged 15-49 agreed with at least one of four accepting attitudes about people living with HIV, while only 37.2 per cent of women expressed accepting attitudes on all four indicators measured (e.g., are willing to care for a family member with AIDS in own home; would buy fresh vegetables from a shopkeeper or vendor who is HIV positive; believe that a female teachers who is HIV positive and is not sick should be allowed to continue teaching; and would not want to keep secret that a family member is HIV positive). Among adolescents aged 15-19, the percentage of

533 UNAIDS Asia-Pacific, op.cit.

534 HIV Risk Reduction for MARA/EVA, op.cit.

535 MICS 2012-2013, op.cit.

536 Ibid.

537 Ibid.

538 UNICEF Bangladesh and Bandhu Social Welfare Society. "Initiating Small-Scale Funding Arrangement (SSFA) With Non-Government Organisations (NGOs) and Community-Based Organisations (CBOs): Proposal for Innovation to Upscaling." Dhaka, January 2014.

539 Ibid.

those agreeing with all four accepting statements rose to 43.5 per cent, still well under half of those surveyed. Urban women also have more accepting attitudes on all four indicators.

### 5.3.4 Root and Underlying Causes of Key HIV and AIDS Challenges

Based on the above analysis, as well as a UNICEF capacity gap and role pattern analysis (see also Annex 5), a number of root causes for HIV- and AIDS-related challenges in Bangladesh, at different levels of duty bearers, have been identified:

- Continued low priority to HIV as a national development issue
- Limited institutional capacities, including for scaling up of interventions for adolescents or for special populations of women
- Policy/legal constraints to access for services, particularly with regard to adolescents and people who inject injecting drugs users
- High population mobility, both within the country and across the border to neighbouring countries
- Social norms with regard to issues of sexuality, including with regard to gender identity, and drug use, and linked to stigma and discrimination
- Overall low status of women/girls, adolescents and *hijras*, along with widespread gender-based violence

All this results in a variety of underlying challenges, including:

- Inadequate resources for scaling up of national response, including at community level
- A need for strengthened awareness and skills of local Government officials and local service providers in particular to effectively carry out their role on HIV and AIDS activities
- Very low level of comprehensive knowledge of HIV and insufficient safe behaviours with regard to HIV and sexual/reproductive health, particularly among adolescents
- Lack of data on emerging risk groups

### 5.3.5 Recommendations to Improve Children's and Women's HIV and AIDS Status

The rights of children, adolescents and women in Bangladesh are inextricably linked with the spread and impact of HIV on individuals and communities. A lack of respect for human rights fuels the spread and exacerbates the impact of the disease, while at the same time HIV undermines progress in the realisation of human rights for all. This link is apparent in the disproportionate incidence and spread of the disease among certain population groups in the country, including MARA and EVA, with profound implications for sustainable development. To further strengthen an equitable HIV response on behalf of children, adolescents and women, the following recommendations include:

Policy/ Strategy	<p>Address policy and legal barriers to access to and use of HIV interventions, particularly by adolescents</p> <p>Support leveraging of the national budget, international funding and partnerships to scale up HIV interventions for children, adolescent key populations at risk of HIV, and HIV-positive pregnant women in high-risk populations</p>
Institutions/ Governance	<p>Support strengthening of NASP capacity in terms of human resources to manage the HIV response, coordinate multiple HIV stakeholders as well as non-HIV partners, and facilitate various advisory and coordination committees</p>
Programme, Including Gender/ Adolescents/ Child Marriage/ Urban Slums	<p>Support further mainstreaming of PMTCT into maternal, neonatal and child health care, including training of health workers</p> <p>Support universal testing of Syphilis and HIV at ANC with a goal of elimination of vertical transmission</p> <p>Promote provider-initiated HIV testing and counselling, particularly for exposed infants and children (including children affected by AIDS) in child health care settings and networks of people living with HIV</p> <p>Intensify C4D to focus on uptake of protection, care and support practices for adolescents and youth; create awareness of and increase demand for quality services; address negative social norms, stigma and discrimination toward infected and affected youth and adults; and foster self-efficacy based on new knowledge acquisition that is critical for behavioural transformations</p> <p>Promote innovation in prevention, care and treatment, including the use of ICTs to address the identification, enrolment and retention of adolescents and women in high-risk populations in HIV programmes</p>
M&E/Data/ Knowledge Management/ Innovation	<p>Support strengthened HIV M&amp;E and knowledge management, including standardised monitoring and reporting tools/systems on HIV and AIDS among adolescents/MARA and children; support for a more effective, regular platform for sharing knowledge on HIV and AIDS-related matters; and investigation of further vulnerability and risk among adolescents exposed to new pathways of addiction</p>





## Chapter 6

# The Right to Education and Development for Children

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### 6.1 INTRODUCTION

Bangladesh has made significant progress in primary education for both girls and boys by increasing enrolment, closing the gender parity gap and reducing the dropout rate. The MDG target for gender parity is considered to be achieved and now stands in favour of girls; gender parity for the primary school-adjusted Net Attendance Ratio (NAR) is 1.07, indicating an advantage in the attendance of girls over boys (75.7 vs. 70.8 per cent). The ratio rises even higher, to 1.30, for secondary education adjusted to include higher levels. The advantage of girls remains clear among almost all categories of children, and particularly in children with mothers of less education and children from poorer households.<sup>540</sup>

More than 7.9 million primary school children benefit from Government stipends for the disadvantaged, which are intended to target 40 per cent of the poorest families in the country, as well as children with disabilities;<sup>541</sup> girls in secondary education also receive Government stipends. In addition, introduction of a national Grade 5 Primary Education Completion Examination (Terminal Exam) in 2009 has provided an incentive to parents to retain their children in school and obtain a recognised national primary school completion certificate, so that survival rates to Grade 5 have increased rapidly. Further, decentralised school-level improvement planning (SLIP) has contributed to creating enabling school environments.

Critically, some good pre-primary education (PPE) models also have been developed, piloted, enriched with field knowledge and are undergoing wider replication at national level. Curriculum and learning materials developed by NGOs are being acknowledged by the Government and used in the national curriculum for pre-primary education. A significant allocation of human and financial resources exists under the Third Primary Education Development Programme (PEDP3) to attach PPE to all public primary schools.

<sup>540</sup> UNICEF MTR, op.cit.

<sup>541</sup> Ibid.

Numerous challenges remain, however, with regard to completion of primary education, quality of overall education, and female literacy levels (see also Section 6.3). Primary dropout rates have fallen sharply but remain high, while repetition rates show little change. Children in the poorest households are twice as likely to suffer from education deprivation (27 per cent) compared to those from the wealthiest households (13 per cent). Moreover, some 6.2 million children are out-of-school, particularly in urban slums and hard-to-reach areas, with 1.1 million of pre-primary school age and 2.6 million of primary school age. Wide geographical disparities are found.<sup>542</sup>

Effective coverage or learning outcomes of a standard quality represents the greatest challenge of primary education in Bangladesh, and an area that requires even further attention. Quality of learner achievements remains a central issue, with unqualified teachers and inadequate infrastructure, including numerous other factors, continuing to affect the quality of learning in classrooms. Most schools run double shifts, which reduces contact hours of teachers and pupils in Bangladesh to only about half the international norm.<sup>543</sup> Many primary schools also are still not able to maintain the standard student-teacher ratio of 46:1.

Teacher supervision, monitoring and accountability requires particular strengthening, given that Bangladesh has not had a system of pre-service primary teacher education/training; instead, it provides one year of in-service training.<sup>544</sup> Development of a robust institutional structure for teacher education represents a further key concern, given that many faculty at the National Academy of Primary Education (NAPE) are not specialists in primary education.<sup>545</sup>

Many schools, particularly in hard-to-reach areas, are very old and overcrowded, which requires more classrooms. Further concerns highlight the inaccessibility of schools in hard-to-reach areas, inadequate numbers of teachers and teacher quality, and school infrastructure. Overall, around 17 per cent of all types of primary education institutions – about 1 in 6 – do not have at least one functioning toilet, a downward trend since 2012.<sup>546</sup> It is unclear why this indicator is decreasing (see also Section 5.3). More schools are reporting positively on having functional water points (72 per cent of Government primary schools in 2013 vs. only 31 per cent in 2010), but there has been little change in the proportion of schools with potable water and in those with a functioning water point that also have potable water.<sup>547</sup>

Children younger than age 5 are yet to be fully and effectively covered with appropriate early childhood care and development services (see also Section 5.1), including early learning; PPE is officially offered to 5- and 6-year-olds only. As a result, a very low total of 13.4 per cent of children aged 36-59 months in Bangladesh are attending early learning facilities as part of an organised early childhood education programme.<sup>548</sup> Traditional religious education (*maktab*/temple education) also occurs even at an early age, although communities have yet to utilise opportunities to transform the current structure of this education.

No gender differential exists at pre-primary level, but differences by socioeconomic status appear significant. Mother's education shows a strong association with the attendance rate; children of women who completed secondary or higher education are twice as likely to attend early learning facilities. Older children also attend early learning facilities more; only

542 Ibid.

543 Ministry of Primary and Mass Education. "PEDP3 Economic Analysis" (PowerPoint presentation). Dhaka, January 2014 (hereafter PEDP3 Economic Analysis).

544 An in-service Diploma in Primary Education is expected to be fully scaled up to all primary teacher training institutes by 2017.

545 UNICEF MTR, op.cit.

546 Ministry of Primary and Mass Education, Directorate of Primary Education, Monitoring and Evaluation Division. *Bangladesh Primary Education Annual Sector Performance Report 2014*. Dhaka, August. 2014 (hereafter Primary Sector Performance Report).

547 Ibid.

548 MICS 2012-2013, op.cit.

5.6 per cent of children aged 36–47 months are in such facilities, compared to 21.2 per cent of children aged 48–59 months.<sup>549</sup>

Other key early learning and pre-primary issues include an acute need for specialised human resource development, along with an overall need for strengthened strategic planning and coordination in the sub-sector. In addition, parents and caregivers may not have the knowledge, skills or resources to provide early learning and stimulation; high cost of education materials likewise is key.

Children also frequently do not enter school at the right age, especially in deprived areas, although starting formal schooling at an older age makes children more likely to repeat grades and/or drop out. For example, among children who are at the primary school entry age of 6 years, only 33.1 per cent were attending the first grade of primary school, with notable differences between urban and rural areas. Meanwhile, some low-performing districts like Khulna, Rangpur and Cox's Bazar show 40 per cent or less primary school completion rates, exacerbated in the case of boys.<sup>550</sup>

Overall, more than 1 in 4 children are out of school (26.8 per cent),<sup>551</sup> primarily due to a very low attendance rate for children aged 6; early-grade dropout can largely be prevented by ensuring students' on-time enrolment.<sup>552</sup> As many as 45 per cent of children are out of school in the worst-performing *upazilas*; this proportion not only clearly indicates deprivation in general, but also the need for strengthened quality of primary education.<sup>553</sup> In hard-to-reach areas such as CHT, meanwhile, access to education services is compounded by small population size, scattered settlements, weak communications systems, lack of transport facilities and high transport costs, security hazards, seasonal inaccessibility, and low parental awareness of the critical importance of education; linguistic and cultural barriers also are prominent.

Bangladesh also has the highest proportion of children out of school at lower secondary level in the South Asian region; a recent study indicates that a major cause of non-enrolment and dropout at both lower and higher secondary education is child marriage, with 60 per cent of girls who did not enrol in Grade 9 identifying child marriage as the main cause (see also Section 2.4.5).<sup>554</sup> Significantly more boys than girls remain out of school overall, however, often because they are withdrawn for child labour (see also Chapter 7); girls' share of out-of-school children falls from 44.6 per cent at primary level to 33.7 per cent at secondary level.

In addition, urban children overall are more likely to be attending school (77.2 per cent) compared to rural children (72.3 per cent). At the same time, household surveys exclude important groups of children from households with no fixed address, including children on the streets, a group known to suffer from very low levels of school participation.<sup>555</sup> Key lessons learned indicate that Second Chance Education/Non Formal Education (SCE/NFE) must be flexible and relevant to attract out-of-school children. It also is critical to make it equivalent with formal education.

At the same time, population trends because of declining fertility in Bangladesh – whereby growth will slow in the population younger than age 14 in the coming decades (see also Section 2.1) – will have important implications for education. The relative stability of the

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549 Ibid.

550 Ibid.

551 MICS 2012–2013, op.cit.

552 PEDP3 MTR Economic Analysis, op.cit.

553 Child Equity Atlas, op.cit.

554 UNICEF Bangladesh. *Girls' Access to Secondary and Higher Secondary Education in Bangladesh: An Analysis of Bottlenecks* (draft). Dhaka, 2014.

555 UNICEF MTR, op.cit.

youngest population will reduce pressure on institutions that cater to the needs of children and very young adolescents. Thus, education facilities may need to be adapted and reoriented to address the needs of older, secondary school-age children, whose numbers will still be rising.<sup>556</sup> An effective secondary education system is one able to provide adolescents and young people with the higher-level academic knowledge and cognitive skills required for entry into the labour market and/or tertiary education and training. To achieve this, teacher training in particular will need to be reoriented toward secondary school level. In addition, funds saved by having to teach fewer young students could be used to increase the quality of education, including to better prepare primary-level students to reach secondary level.

Empowerment of adolescents to protect themselves from vulnerable circumstances and harmful social norms and practices also will be critical; integration of Life Skills Based Education (LSBE) into the secondary school curriculum provides such opportunities. Meanwhile, additional pressure on secondary and tertiary levels can be averted by greater investment in technical and vocational training facilities, as well as in professional and higher education.<sup>557</sup> An important step forward is represented by the development of a model on vocational skills training for low-education adolescent groups, in line with National Technical Vocational Qualification Framework. In addition, the drafting of a framework for integrating Disaster Risk Reduction (DRR) and Education in Emergencies (EiE) into education sector planning is under consideration by three line Ministries, which will help to lower children's vulnerability to disaster; nonetheless, integrating this into PEDP3 has been challenging.

Indicating the urban face of deprivation in schooling, a recent study in Dhaka City Corporation found that more than half of children aged 5 do not attend school, significantly higher than the national rate, with more than two-thirds of 5-year-olds out of school in some wards.<sup>558</sup> Overall, the proportion of out-of-school children aged 6-10 years also was high in Dhaka City Corporation, at 21.7 per cent; in some wards, as many as 1 in 3 of these slightly older children were not attending school. Moreover, net attendance in secondary education, although standing at around 46 per cent nationally, falls to only 18 per cent in urban slums.<sup>559</sup>

In particular, urban education will need to increase the number of Government primary schools in the slum areas, while also prioritising the expansion and strengthening of SCE/NFE for out-of-school children and dropouts by allocating adequate resources and establishing institutional capacities. In addition, a need exists to establish informal apprenticeship skills training systems to empower out-of-school urban slum children older than age 14 with skills that can provide them with a decent livelihood and help to build their aspirations.

Among women, 1 in 4 ever-married women aged 15-49 has never attended school, while only 14 per cent have completed secondary or higher education. Overall, younger women aged 15-24 have a much lower rate of non-enrolment (24.5 per cent) compared to those aged 40-49 (68.7 per cent);<sup>560</sup> this shows a positive inter-generational change in attitudes and practices toward education. A similar pattern emerges when the proportion of young (15-24) vs. adult (40-49 years) women who complete secondary or higher education is compared, at 21.3 per cent vs. 7.1 per cent respectively.

Educational levels also have been found to vary significantly between married and unmarried young women aged 15-24. Overall, unmarried young women achieve higher levels of education as compared to married young women (see also Section 2.4.5).<sup>561</sup> While about 1 in 3 unmarried young women is able to complete secondary and higher education,

556 DIS, op.cit.

557 Asian Development Bank. *National Education Policy 2010: Implementation Strategies With a Secondary Schooling Emphasis*. Dhaka, July 2012.

558 Child Equity Atlas, op.cit.

559 Children and 7FYP, op.cit.

560 Child Equity Atlas, op.cit.

561 Ibid.



only 1 in 7 married women completes the same level of learning, demonstrating the adverse consequences of child marriage on education outcomes for young women in Bangladesh.

In Bangladesh as in other countries, children with disabilities also have been among the most marginalised when it comes to education (see also Section 2.5.1). As recently as 2002, only 4 per cent of an estimated 1.6 million children with disabilities of primary school age had access to education in areas with no disability services; most were children with mild to moderate physical impairments.<sup>562</sup> However, since then there have been some achievements. Inclusive education was introduced in the Primary Education Development Plan II (PEDP2, 2005-2010), and efforts were initiated to address some of the barriers faced by children with disabilities; priorities for PEDP3 (2011-2017) include making schools more accessible. The Annual Education Sector Performance Report in 2013 reported that the number of children with disabilities enrolled in Government primary schools and registered NGO primary schools had increased significantly.

Despite these achievements, the inclusive education concept and practice remain at a nascent stage of development in the country. Awareness and understanding of inclusive education is limited, and does not fully encompass children with key social disabilities, e.g., poor or ethnic-minority children, as well as children with physical/intellectual disabilities. The mainstream school system requires significant strengthening to meet the diverse needs of children with disabilities.<sup>563</sup> In particular, fewer initiatives are visible for secondary students with disabilities; secondary school enrolment overall tends to be lower among children with disabilities.

A key issue is that of barriers to access and assistive devices: Many schools are not accessible to children with disabilities, especially physical disabilities, preventing them from attending or causing them to drop out. While most primary schools are on the ground floor, secondary schools tend to be multi-storeyed. Lack of accessible toilets also forces many children with disabilities to drop out, especially girls (see also Section 5.3). Moreover, while Bangladesh has a number of excellent training programmes, operated primarily by private institutions and NGOs in cooperation with the Government, most mainstream service providers lack adequate training to implement policies for inclusive education services, perpetuating the exclusion of children with disabilities.<sup>564</sup>

Lastly, a strong factor for many families in Bangladesh with regard to the education of their children is related to the cost; parents are often dependent on the Government education subsidy, and cost considerations, both indirect and opportunity costs, are overwhelmingly cited as reasons for keeping children out of school. Per-capita annual household educational expenditures are nearly three times higher in urban areas than rural areas (Taka 22,427 vs. 8,334),<sup>565</sup> and slightly higher for boys than for girls. About 3 in 5 households in Bangladesh spend from Taka 1,000 to 14,999 annually on education, the equivalent of US\$14 to nearly US\$200; however, a far higher percentage of rural households fell in this category than urban households. In contrast, nearly half of urban households spend Taka 20,000 (about US\$256) to more than 50,000 (more than US\$640) annually. In nearly 1 in 4 urban households, more than 20 per cent of total annual income is spent on education.<sup>566</sup>

It has been found that both school feeding and primary education stipends can be implemented more efficiently if they are better coordinated and better targeted, since many children receive both interventions.<sup>567</sup> At the same time, a recent report<sup>568</sup> shows that not all

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562 Disability Situation Analysis, op.cit.

563 Ibid.

564 Ibid.

565 Bangladesh Bureau of Statistics. *Education Household Survey 2014*. Dhaka, 2014 (hereafter Education Household Survey).

566 Most often for coaching/tutoring fees, admission/registration/examination fees, or transport/tiffin.

567 PEDP3 Economic Analysis, op.cit.

568 Education Household Survey, op.cit.



stipends go to the poorest students, with about 30 per cent to students in the lowest wealth quintile, about the same proportion to the second-lowest quintile, and 24 per cent to those in the middle quintile. A total of 16 per cent of overall stipends are to children in the highest and second-highest quintiles; in urban areas, this rises to more than 52 per cent of stipends among wealthier children, indicating the need for better targeting.

## 6.2 EDUCATION INSTITUTIONS, SYSTEMS AND GOVERNANCE

The strategic education priorities outlined in Vision 2021 remain relevant, but need to be revalidated to include more strategic and inclusive coverage of children living in urban slums and environmentally degraded/hazard-prone areas, children with disabilities, and ethnic minorities, among others. While some policy interventions have propelled Bangladesh forward to universalism in primary school enrolment, as noted above, learning remains challenged by quality and ineffective coverage.<sup>569</sup>

The education system in Bangladesh is largely managed and administered by two key Ministries in association with attached departments and Directorates, as well as a number of autonomous bodies. The Ministry of Primary and Mass Education (MoPME) is responsible for primary and non-formal education, while the Ministry of Education (MoE) covers secondary and higher secondary education. However, the primary education system is highly fragmented, with five further different authorities, principally including the Directorate of Primary Education (DPE). Additionally illustrating the complexity of systems strengthening in the education sector, 16 Ministries are involved in Early Childhood Care and Development alone at the national level, including MoWCA, MoPME, MoHFW and MoSW.

Approved policies include the long-awaited National Education Policy 2010, which features cornerstones of inclusive learning opportunities for all; an integrated and unified system in which all students are exposed to shared knowledge; equity of approach to the school environment; and quality of learning. Particular emphasis is given to the secondary education sub-sector. Under the Education Law, a new policy also exists to extend primary education from Grade 5 to Grade 8, which means that massive teacher training, curriculum alignment, infrastructure support and establishment of a regulatory framework will be necessary.

No consensus appears to yet exist on how to realise this policy, which could involve significant recurrent and capital expenditures, estimated at up to US\$9.7 billion over a five-year period. Continuing to use double shifts in schools has been suggested as an effective option to save infrastructure costs, but with the concomitant hiring of 120,000 new teachers to ensure the use of different teachers during morning and afternoon sessions.<sup>570</sup>

Other key policies include the NFE Act 2014 and NFE Policy 2006, as well as the Comprehensive ECCD Policy 2013, which underscores the significance of integrating child services with ECCD's multisectoral network and scope. To create quality human capacity for Bangladesh, the ECCD programme will need to focus from pre-conception through the critical first 1,000 days of life and well into primary and post-primary education levels. In addition, both the Education and ECCD policies address children with disabilities, with emphasis on inclusion beginning with early learning centres/preschools and other childhood development centres (see also Section 2.5.1). A National Strategy for Inclusion of Persons with Disabilities in Skills Development was drafted in 2013 and is expected to assist in strengthening disability inclusion; however, concerns exist that even after training, students with disabilities may have difficulty finding jobs because of continuing stigma and discrimination.

569 Children and 7FYP, op.cit.

570 PEDP3 Economic Analysis, op.cit.

Full implementation of all education policies and strategies remains problematic, and a need for strengthened mechanisms for management of change and development contributes to delays in rollout and prevents the Government's full control over and sustainability of results. For example, the ECCD Policy spells out roles of concerned Ministries and line departments for ECCD, but these are yet to take proper shape because of the absence of a National ECCD Plan of Action, directives from the highest level of Government, consensus in Government about prioritisation for resource allocation, and need for strengthened inter-Ministerial coordination.

PEDP3, the framework for primary education in the country, offers a model of a largely successful SWAp between donors and Government, as in the health sector (see also Section 5.1). Among other objectives, it aims to establish an integrated school system under a framework that unifies public, NGO and private providers; to improve quality through reduced class size, improved teaching practices, and a focus on ICT literacy; to decentralise primary education administration and management; and to engage in wider partnerships with NGOs and the private sector. PEDP3 also aims to deliver efficient, inclusive and equitable primary education and reduce social and regional disparities in education.<sup>571</sup> In turn, this has contributed to a sense of momentum in the education sector and provided an opportunity to introduce more innovation and equity-focused design of interventions. However, important delays in expenditure of the PEDP3 budget have occurred, affecting quality and involving substantial economic cost.<sup>572</sup>

At the same time, the approved school effectiveness framework presents a good decentralised planning model for school development planning that links SLIPs and Upazila Primary Education Plans (UPEPs) to drive local-level planning.<sup>573</sup> A total of 10 per cent of *upazilas* are preparing UPEPs and 60 per cent of schools will prepare SLIPs.<sup>574</sup> School-level leadership development also is being given more importance, particularly in academic supervision.

As indicated in Section 6.1, numerous education bottlenecks, at all levels, remain to be addressed. In primary education at national level, issues of institutional/system strengthening include (1) a need for effective management and monitoring structures; (2) development of technical assistance strategies to ensure institutional capacity development; (3) strengthened coordination mechanisms; (4) effective addressing of bottlenecks in coverage and service delivery; and (5) improved assessment of children's competencies/learning achievement. In many of these areas, additional support and advocacy may be necessary; for example, both national and sub-national levels particularly require enhanced capacities to engage in bottleneck analysis. The Government also requires support to develop teacher capacity and institutions to assess and monitor children's competencies. Among development partners, sector coordination and strategies for promoting national technical leadership represent priorities.

With regard to SCE/NFE at national level, national strategic direction and ownership is a central issue. A community can initiate SCE/NFE learning for never-enrolled or dropout children, but for an entire community learning system to run, it requires Government or private sector assistance, including with regard to management and supervision, educational materials, and training and monitoring of human resources. Duty bearers are struggling to select a workable model for SCE/NFE; adopt the appropriate methodologies; create a responsible division of labour to oversee SCE implementation; and develop a database on the number of out-of-school children. A need for strengthened institutional structure and for more timely decision making has significantly impeded progress.

571 Claussen, Jens. *Primary Education Development Programme: Mid Term Review*. Dhaka, November 2013 (hereafter PEDP3 MTR), and Ministry of Primary and Mass Education, *Primary Education Development Programme III (PEDP3) Revised Programme Document: Programme Overview and Implementation Guide*. Dhaka, January 2015 (hereafter PEDP3 Revised Programme Document).

572 PEDP3 Economic Analysis, op.cit.

573 UNICEF MTR, op.cit.

574 Ministry of Primary and Mass Education. *Primary Education of Bangladesh: Results-Based Annual Operational Plan: 2012-2013 Strategy Paper*. Dhaka, June 2012.

Enhanced coordination also is required among SCE/NFE providers, as well as development of an equivalency framework between formal and non-formal education. Lastly, an institutional deficiency to provide technical/vocational education exists in the informal sector. In addition, international partners have shrunk the resource envelope for SCE/NFE in recent years, so that large NFE programmes are now largely absent in the country. At the same time, Government-NGO coordination mechanisms offer new opportunities for planning and scaling up of SCE/NFE.<sup>575</sup> For example, SCE/NFE learning centres are to be established under a new Government-NGO mechanism introduced under PEDP3.

Meanwhile, in secondary education at national level, convergence among different streams of secondary education (mainstream, vocational and *madrassa*) requires further support. Development of a secondary-level SWAp is being undertaken, but this may entail reinforcement for the Government to take up the responsibility; increased political commitment to bring in institutional changes; and continuous dialogue and planning among the Government, United Nations System and development partners for collective actions. Strengthening of management and monitoring structures also will be necessary, as will increased coordination among relevant Ministries and implementing agencies.

In all, institutional capacity development and capacities in knowledge, including bottleneck analysis, require further enhancement at secondary level, as do skills and human/material resources. It must be noted that among international development partners, most focus on primary education and less on secondary education, adding to the challenges at this increasingly important education level.

### 6.3 KEY INDICATORS OF CHILDREN'S AND WOMEN'S EDUCATION STATUS

Overall, education indicators are improving, albeit sometimes slowly. Attendance in overall early childhood education remains very low, comprising only about 1 in 10 children.<sup>576</sup> Slightly more than 40 per cent of children have the readiness to attend primary school, and only 1 in 3 children of primary school entry age have actually entered Grade 1. About three-quarters of children attend primary school, and almost all reach the last grade of primary education. Although the primary completion rate is higher among girls than boys (86 vs. 74 per cent), the transition rate to secondary level is almost the same (about 94-95 per cent). However, as also noted in Section 6.1, a higher proportion of girls than boys attends secondary education (52 vs. 40 per cent).

#### 6.3.1 Early Childhood Care and Development

Key indicators of early childhood care and development related to learning indicate some family support for learning among very young children.<sup>577</sup> For about three-fourths of children age 36-59 months (78 per cent), an adult household member engaged in four or more activities that promote learning and school readiness. The mean number of activities that adults engaged in with children was 4.6.

However, fathers' involvement in such activities was rather limited, at only 10.1 per cent for four or more activities, whereas mothers' involvement stood at 40.8 per cent. Urban areas show a higher percentage of adults' involvement than rural areas. Mothers' and fathers' education is positively correlated with their engagement in activities with children; similarly,

575 UNICEF MTR, op.cit.

576 MICS 2012-2013, op.cit.

577 Ibid.

the wealth status of the household also represents an influence on adult engagement.<sup>578</sup>

Meanwhile, only 8.8 per cent of children aged 0-59 months are living in households where at least three children's books are present; the proportion of children with 10 or more books declines to a negligible 0.3 per cent. Yet exposure to books in the early years is important for later school performance.<sup>579</sup> Urban children have more than twice the rate of access to children's books (15.4 per cent) than those living in rural areas (7.2 per cent). Similarly wide variations are found between Divisions. Overall, the presence of children's books is positively correlated with mother's education, family wealth levels and child's age.

Lastly, some 60.3 per cent of children aged 0-59 months had two or more types of playthings in their homes, including homemade toys, toys from a store, and household objects for play (pots/bowls) or objects and materials found outside (sticks, rocks, leaves). A total of 74 per cent of children play with toys from a store, while only 60 per cent play with household objects/objects found outside, and 37 per cent with homemade toys. The proportion of children having two or more types of playthings varies considerably between Divisions, ranging from 44.7 per cent in Chittagong to 73.5 per cent in Rangpur. The percentage of children playing with toys from a store also is positively correlated with household wealth level and mothers' education. Gender or rural-urban differences are not pronounced.<sup>580</sup>

### 6.3.2 Pre-Primary Education

Attendance at preschool is important for the readiness of children for school, and coverage of PPE among Grade 1 students, while still low, is expanding notably (see also Introduction to this Chapter). A total of 43.5 per cent of children who attended Grade 1 in 2012-2013 had attended preschool during the previous year,<sup>581</sup> although that figure is believed to have subsequently increased even further. While early childhood development (ECD) programmes were traditionally been based in the NGO sector in Bangladesh, the Directorate of Primary Education developed an operational framework for one year of PPE for children 5-6 years, followed by the approval of a PPE curriculum in 2011; the Government further developed a PPE expansion plan in 2013-14 to support its commitment to integrating PPE into all primary schools.

A key disparity exists in enrolment rates among the poorest families, which stand at only 11 per cent, highlighting both demand-side barriers such as a need for strengthened parental awareness and supply-side bottlenecks such as accessibility and effective coverage of this service. Regional differences also are significant, with more than double the proportion of first graders in Barisal Division who had attended PPE than their counterparts in Sylhet Division (76.4 vs. 29.2 per cent). Education of the mother appears to have a positive correlation with children's school readiness. Virtually no gender difference exists, although urban children are slightly more likely to have attended PPE than rural children (50.2 vs. 42.8 per cent).

Despite Government policy to provide ECCD programmes in general and PPE in particular, evidence indicates that institutional preparedness remains challenging. Availability of PPE services does not necessarily guarantee its utilisation, with only a little over a third of eligible children accessing services in 20 low-performing UNDAF districts. This calls for further investigation into causes of non-utilisation of the service.

Barriers found in field studies include low parental awareness on the benefits of PPE; distance of PPE from home in hard-to-reach areas; lack of adequate space in primary schools and

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578 Ibid.

579 Ibid.

580 Ibid.

581 Ibid.

lack of WASH facilities; lack of trained teachers; and a learning environment that is deemed not child-friendly.<sup>582</sup> A particular bottleneck exists in the non-availability of data, which constrains attempts to determine gaps in delivery of PPE services and appropriate planning to strengthen delivery. Meanwhile, assessment of the level of competencies acquired by children at the end of one year of PPE is crucial, since it can provide meaningful data for improving quality of services and thereby raising the performance of children in later years.

### 6.3.3 Primary Education

Bangladesh has 106,859 schools, comprising 24 types<sup>583</sup> and serving nearly 20 million students (boys and girls, 50 percent each). Of these schools, more than 1 in 3 is a Government primary school, where women comprise 2 in 3 teachers. For every 100 children who enter primary school in Bangladesh, more than 79 graduated, a considerable increase from the 50 recorded as recently as 2006.<sup>584</sup> Survival rates to Grade 5 also have increased rapidly, from 52.9 per cent in 2005 to 75.3 per cent in 2012; the MICS 2012-2013 reports that virtually all children entering first grade eventually reach the last grade of primary school (96.4 per cent), but calculates cumulative probability of survival and does not track a real cohort of children.

These dramatically improved rates have largely been a result of a number of Government initiatives to support equitable access to quality schooling. At the same time, the primary completion rate was considerably lower for boys than for girls, at 73.7 vs. 85.8 per cent, again confirming boys' disadvantage in education, and for urban compared to rural areas (73.2 vs. 81 per cent). Variations between Divisions also are significant, ranging from 71.2 per cent in Dhaka to 92.5 per cent in Rajshahi. Of those who completed primary school in the previous year, as many as 94.7 per cent were found to be attending the first grade of secondary school.<sup>585</sup>

A very high pass rate has been recorded on the Grade 5 Terminal Exam (98.5 per cent); however, the pass mark is set at a low 33 per cent, so that it is recognised that the pass rate does not necessarily reflect the extent to which children are acquiring the expected competencies. According to the 2011 National Student Assessment Survey, which measured learning outcomes of pupils in Grades 3 and 5 in Bangla and mathematics, two-thirds of Grade 3 students performed at their grade level or above in Bangla, whereas this proportion dropped sharply, to 25 per cent, by Grade 5. In mathematics, only around a third of students in Grades 3 and 5 achieved mastery levels.

Poor performance below grade levels represents a major cause of school dropout and repetition. Moreover, the same survey found that more children fall back to below their grade levels in both Bangla and mathematics as they progress to higher grades, clearly reflecting on the quality of teaching and learning processes. Mean scores differ significantly for all subjects across Divisions and between Government and non-Government primary schools, with the latter performing at lower levels. At the same time, children from poor families are at least three-fourths of a school year behind their richer counterparts in Bangla, and half a school year behind in mathematics.<sup>586</sup>

Ensuring timely delivery of some 100 million textbooks has been a major achievement under PEDP3; in 2010, only one-third of schools received their textbooks within the first month of school year. However, by 2013, 100 per cent of schools had received textbooks

582 UNICEF MTR, op.cit.

583 There are 13 main types of schools, including schools in the "others" category; these comprise schools/learning centres in mosques and temples, prisons, tea gardens, CHT, and for the hearing-impaired.

584 MICS 2012-2013, op.cit.

585 Ibid.

586 UNICEF MTR, op.cit.



within the first month of the school year, and 85 per cent received their textbooks before starting the academic calendar.<sup>587</sup>

### 6.3.4 Literacy Rates and Second Chance Education/Non-Formal Education

Precise information on SCE/NFE coverage is difficult to obtain. However, illiteracy remains a major issue in Bangladesh and a significant constraint on development, signifying a key lost opportunity and the urgent need for additional emphasis on SCE/NFE.

The overall adult literacy rate (15 years and older) has increased very slowly in the country, from 53 per cent in 1998 to 58.6 per cent in 2014, according to the Education Household Survey 2014. Census data show lower literacy rates and a slower rate of improvement, from 48 to only 53 per cent between the 2001 and 2011 censuses.

Literacy is much higher in urban areas, at 72.25 per cent (75.37 per cent male, 69.08 per cent female), than in rural areas, at 54.41 per cent (58.09 per cent male, 50.80 per cent female). Among persons with disabilities, the literacy rate falls sharply, to 32.59 per cent, indicating the continuing challenges in access to education for this important population group.<sup>588</sup> In general, adult literacy rises sharply according to wealth quintile, from 32.76 per cent among the poorest families to 82.83 per cent among the wealthiest.<sup>589</sup> Indicating wide geographical disparities, greater progress in literacy has been made in the western part of the country than in the east.<sup>590</sup> According to census data, national literacy is increasing faster among females than among males. Nevertheless, at district level, overall female literacy was as low as 29.3 per cent in 2011, meaning that 7 in 10 adult women were illiterate;<sup>591</sup> even male literacy is below 40 per cent in some districts.

Further illustrating the poor quality of primary education, the MICS 2012-2013 found that a third of women who have completed primary education (35.8 per cent) are still illiterate (see also Section 2.4.3). In addition, up to 44 per cent of boys and 36 per cent of girls who completed primary education in 2011 were functionally literate, according to the Bangladesh Literacy Assessment Survey 2013.

Among young women aged 15-24, about 82 per cent are literate in Bangladesh.<sup>592</sup> Literacy is only slightly higher among young women in urban areas than in rural areas; it does not vary greatly by different Divisions, although it is generally worst in the CHT district of Bandarban. At *upazila* level, however, differences are significant; in about 57 per cent of *upazilas*, female youth literacy rates are more than three percentage points higher than male rates, but in 12 per cent of *upazilas*, rates favour males. Interestingly, Dhaka is no longer a frontrunner in youth literacy rates, but rather, one of many districts with similar levels of youth literacy, indicating convergence in literacy levels and a sign of reducing inequality in this regard.<sup>593</sup> Nonetheless, the most deprived districts still have the worst progress in literacy, again indicating an enhanced need for SCE/NFE for many children, adolescents and adults alike.

Overall, education and wealth have strong impacts on the literacy of young women; just over half of young women are literate among the poorest quintile (56.9 per cent), whereas nearly all are literate among the richest (93.4 per cent).<sup>594</sup>

587 Primary Education Annual Sector Performance Report, op.cit.

588 Education Household Survey 2014, op.cit.

589 UNICEF MTR, op.cit.

590 Child Equity Atlas, op.cit.

591 Ibid.

592 MICS 2012-2013, op.cit.

593 Child Equity Atlas, op.cit.

594 MICS 2012-2013, op.cit.

### 6.3.5 Secondary Education

Fewer than half of children of secondary school age (46.1 per cent) are attending secondary school or higher. Some 33.7 per cent are still attending primary school, and 1 in 5 children are out of school (21.1 per cent).<sup>595</sup> Male secondary enrolment has been generally flat between 1999 and 2011 and only reached 50 per cent in 2012. Female secondary enrolment essentially leveled out between 2004 and 2008, but has increased at a faster rate since 2009. Nonetheless, secondary enrolment in Bangladesh has lagged well behind the South Asia region as well as other Asian countries such as China and Indonesia. In 2003, the secondary enrolment rate was equal to that of India, but by 2011 it was only 74 per cent of India's level.<sup>596</sup> While reasons for this fallback are not clear, continuing high rates of poverty, child marriage and child labour are all considered major factors (see also Section 2.4.5 and Chapter 7).

An interesting finding is the difference between attendance rates of male and female children of secondary school age when compared with attendance at primary education for that age. The male adjusted net attendance ratio is consistently much lower (40.1 per cent) than the female ratio (52.3 per cent). Again, this not only indicates that female children are making better progress in education appropriate to their age, but also that many more male children are eventually out of school (27.4 per cent vs. 14.4 per cent for females).<sup>597</sup>

Lastly, the proportion of university graduates in 2011 was very low, at 4.1 per cent for those aged 15 and over, rising only to 6.2 per cent among those aged 30-34. Overall, 30 per cent of the 595,000 university students in Bangladesh in 2011 were female (a 3:1 ratio), but in private universities the male/female ratio is as high as 27:1, and 9:1 ratios are not uncommon.<sup>598</sup>

## 6.4 ROOT AND UNDERLYING CAUSES OF KEY EDUCATION CHALLENGES

Based on the above analysis, as well as a UNICEF capacity gap and role pattern analysis (see also Annex 6), a number of root causes for education-related challenges in Bangladesh, at different levels of duty bearers, have been identified:

- Poverty and lack of parental/community resources to support children's education
- Inadequate understanding of child rearing and child development, especially the importance of early stimulation and learning, and insufficient development of ECCD services
- Inadequate understanding on the importance and value of education overall, including a need for strengthened understanding and awareness on the appropriate age for school entry and the importance of birth certificates
- Fragmentation of primary education system in particular and need for enhanced education system coordination in all sub-sectors
- Inadequate strategic directions and institutional arrangements for provision of SCE/ NFE services, particularly in urban slums and hard-to-reach areas, to serve large populations of out-of-school children
- Widespread vulnerability to disasters and hazards
- Deeply rooted beliefs, norms and practices with regard to both girls' and boys' socialisation

<sup>595</sup> Ibid.

<sup>596</sup> DIS, op.cit.

<sup>597</sup> MICS 2012-2013, op.cit.

<sup>598</sup> DIS, op.cit.

All this results in a variety of underlying challenges, including:

- High proportion of out-of-school children and significant numbers of adolescent boys and girls, particularly from among the poorest families, still being withdrawn from school, largely for child labour or child marriage respectively
- Poor school infrastructure, especially in hard-to-reach areas, including frequent lack of functional WASH facilities
- Need for strengthened education management, planning and monitoring structures in all sub-sectors
- Need for strengthened numbers of qualified human resources, particularly at PPE and primary levels
- Need for improved assessment of child learning achievements
- Inefficient targeting of school stipends
- Weak coordination and convergence at sub-national level in particular, across all sub-sectors, particularly SCE/NFE
- General inaccessibility of schools in hard-to-reach areas, particularly waterlogged areas
- Increasing disadvantage of boys at all levels of education, including because of withdrawal from school for child labour, and persistence of withdrawal of adolescent girls from school for child marriage

## 6.5 RECOMMENDATIONS TO IMPROVE CHILDREN'S AND WOMEN'S EDUCATION STATUS

Access to quality education is a fundamental human right and remains essential for the exercise of all other rights. It promotes individual freedom and empowerment and yields important development benefits; moreover, it is a powerful tool by which economically and socially marginalised people can participate fully as citizens. Yet millions of children, adolescents and adults in Bangladesh continue to be deprived of lifelong educational opportunities, many as a result of poverty. To move forward toward equitable education opportunities for all, recommendations include:

Policy/Strategy	<p>Support improved coordination at all levels for effective management and monitoring of the education sector</p> <p>Implement recommendations of National Policy on ECCD</p> <p>Support development of a SWAp-like mechanism to promote harmonised ECCD strategies for 3- to 6-year-old children</p> <p>Support the development of a national vision for SCE/NFE</p> <p>Support a secondary education SWAp to promote expanded secondary NFE/SCE</p>
Institutions/ Governance	<p>Support strengthened institutional capacities for sustainability of national programmes</p> <p>Support strengthened decentralised planning and decision making, school development planning and school quality standards</p> <p>Support regular resource allocations to ECCD in annual development plans</p>

	<p>Support the introduction of pre-service and strengthened in-service teacher training; continuous academic support and supervision at school cluster level; and strengthened child-centred classroom teaching/learning practices</p> <p>Support the development of an expanded NFE to Grade 8 and link with skills development/technical and vocational education and training (TVET)</p> <p>Support a flexible SCE/NFE model for working children</p>
<p>Programme, Including Gender/ Adolescents/ Child Marriage/ Urban Slums</p>	<p>Include hard-to-reach areas in programming</p> <p>Support further quality infrastructure development (WASH facilities et al.) to encourage the enrolment of girls and children with disabilities</p> <p>Support the strengthened quality of early learning and primary schools in urban slums, as well as linkages with SCE/NFE</p> <p>Support strengthened access to secondary education with expanded NFE</p> <p>Develop a partnership with the private sector for SCE/NFE apprenticeships, also serving as a catalyst for the prevention of child marriage</p> <p>Intensify implementation of C4D interventions to improve education sector priorities, including parenting education, reduction in dropout rates, enrolment rates, child-centred pedagogy and improved learning outcomes in relation to early childhood development and for those with disabilities; C4D will contribute to addressing the behavioural and social dimensions of education programmes through community engagement and social norm change among families and communities to create demand for quality education. Behaviour and social change principles also will be used to guide critical inputs into life skills education (e.g. individual decision making, value development et al.)</p>
<p>M&amp;E/Data/ Knowledge Management/ Innovation</p>	<p>Track the internal efficiency of PPE programmes and support a PPE-related information management system</p> <p>Track the overall transition to secondary education and, in particular, girls' survival to secondary school completion to prevent child marriage</p> <p>Data generation to demonstrate contribution of C4D interventions, particularly on community engagement (including strengthening role of School Management Committees)</p>





## Chapter 7

# The Right to Be Respected and Protected

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### 7.1 INTRODUCTION

As the previous chapters have amply illustrated, child deprivation and vulnerability represent serious concerns in Bangladesh. Numerous issues of child protection, many of which often disproportionately affect adolescents, are found across the country: Low rates of birth registration – such that some 10 million children younger than age 5 do not officially exist<sup>599</sup> – make it difficult to protect children from child marriage (see also Section 2.4.5) and child labour.<sup>600</sup> Issues of rapidly accelerating urbanisation (see also Section 2.4.6) also give rise to numerous child protection challenges. Violence against children (VAC), including corporal punishment as an “educational” and disciplinary measure, remains widespread, although Bangladesh offers important opportunities for its prevention.<sup>601</sup> Likewise, violence against women (VAW) remains the most visible and extreme form of the continuing need to strengthen the status of women and girls.

Sexual abuse of both girls and boys represents a largely neglected issue, as in many countries. Commercial sexual exploitation of girls may start as young as age 10 or 12,<sup>602</sup> and human trafficking is believed to be extensive both within the country and to other countries, including for sex work. The number of suicides among adolescent boys and, especially, girls has been reported to double for each year between ages 14 and 18.<sup>603</sup> Children living

599 Villeneuve, Pascal. “Evidence for Action: Making Invisible Children Visible Through Data,” in *The Daily Star*, Dhaka, 23 October 2014.

600 The National Child Labour Elimination Policy sets the minimum age for employment at 14 years and prohibits children’s engagement in hazardous work below the age of 18 years.

601 UNICEF. *Ending Violence Against Children: Six Strategies for Action*. New York, September 2014 (hereafter VAC Six Strategies). This can be achieved, for example, through support to parents, caregivers and families on children’s early development; helping children and adolescents manage risks and challenges; changing attitudes and social norms that encourage violence and discrimination; promoting and providing support services for children; implementing laws and policies that protect children; and carrying out data collection and research on violence.

602 UNICEF Bangladesh. *Sexual Abuse and Commercial Exploitation of Children: Elements for a National Strategy and Plan of Action*. Dhaka, March 2011 (hereafter Sexual Abuse Report).

603 Suicide Report, op.cit.



on the streets and other children, including orphans, lack critical parental guidance and are particularly vulnerable to abuse. Some children, especially in urban slums and border areas, also may be used in illicit activities, including being used as carriers in the production and trafficking of narcotics.<sup>604</sup> Key actors in juvenile justice may treat children in contact with the law, whether victims, perpetrators or witnesses, as adults. Children with disabilities or chronic illnesses suffer disproportionately in all these issues (see also Section 2.5.1).

Key bottlenecks relate to social beliefs, wherein the perception of what constitutes a “child” differs from the one implicit in the CRC (see also Section 2.3). This also favours harmful practices such as corporal punishment, child labour and child marriage; deviation from such practices, exacerbated by economic realities, may be subject to social sanction. For example, many families rely on the income generated by their children for survival, so child labour often is highly valued. Child marriage is justified, as highlighted in Section 2.4.5, by the willingness of parents to protect their daughters against loss of “honour” due to sexual relations outside marriage, and to ensure their capacity to pay a dowry, which increases with the age of the girl; should that “purity” be compromised, even if a girl is a victim of trafficking and/or sexual exploitation, some families may reject their daughters. Thus, integrating behavioural and social norm change within a minimum package of services to ensure the creation of demand for child rights and to promote child protection services is becoming increasingly critical.<sup>605</sup>

Adolescents and youth can be important agents of behavioural and social change to enhance and facilitate collective action within communities to reduce these harmful practices, particularly child marriage. A total of 98,522 adolescent girls and boys have been enrolled in adolescent clubs. Nonetheless, this still represents a very low level of opportunity, particularly for girls, to receive life skills-based education (LSBE), which represents an important component of the clubs, along with socialising, playing games and sports, reading books, and raising individual and collective social awareness.

In low-performing UNDAF districts, only an average of 5.5 per cent of adolescent girls and boys aged 15-19 years have adolescent club space made available to them, primarily because of limited financial resources.<sup>606</sup> Large disparities are found in availability of adolescent clubs/LSBE services, ranging from 21.5 per cent in some districts to 0 in others. At *upazila* level, a strong correlation is found between the lack of availability of adolescent clubs/LSBE services and overall composite deprivation, indicating important pockets of deprivation.<sup>607</sup>

Following LSBE, however, a dramatic increase has been found in the proportion of adolescents who reported they had taken action to prevent child marriage.<sup>608</sup> In intervention sites, this rose from 13.6 per cent in 2006 to 72.2 per cent in 2011, whereas that of adolescents in control sites increased only from 5.7 per cent to 16.5 per cent. In-depth interviews with adolescents for an end-line survey revealed a number of positive cases after their action. To try and stop individual child marriages, adolescents sought help from a variety of people, starting with peer leaders in their adolescent club and programme staff at the club. Based on these results, the Government also is encouraging adolescent club services in districts with high rates of child marriage.

604 Government of Bangladesh. *Fifth State Party Periodic Report Under the Convention on the Rights of the Child*. Dhaka, October 2012 (hereafter CRC State Party Report).

605 UNICEF MTR, op.cit.

606 Ibid.

607 Ibid. and Child Equity Atlas, op.cit.

608 UNICEF MTR, ibid.

## 7.2 PROTECTION INSTITUTIONS, SYSTEMS AND GOVERNANCE

Child protection involves multiple complex systems, and Bangladesh has witnessed a large number of initiatives to safeguard and protect the rights of children. These include legislative reforms (policies, new laws), and strengthened coordination among various Ministries, departments and institutions.

The passing of the Children Act 2013 (see also Chapter 3) was a key milestone for the children of Bangladesh, and represents an important shift from a responsive child protection to a more proactive, rights-oriented effort supporting a continuum of care. Effective implementation of the Act – which recognises those up to 18 years old as children in line with the CRC and introduces a more comprehensive and holistic legal framework for prevention and response to abuse, violence and exploitation as well as justice for children – will be a prerequisite for the Government to strengthen and update its institution-based protection system with more family- and community-based alternatives.

Torture and other forms of inhuman treatment are prevented under the Constitution; the Penal Code 1860; the Suppression of Violence Against Women and Children Act 2000, which for the first time considerably expanded the definition of rape, and made sexual assault and sexual harassment punishable offences; and the Acid Crime Prevention Act and Acid Control Act, both 2000. The commitment of the Government to protect the rights of children also is reflected in a number of other measures; this includes the National Children Policy 2011, which further elaborates child-focused planning efforts; prioritises children with disabilities, ethnic minority children and children affected by disasters and emergencies; and seeks to alleviate child poverty through a social safety net.<sup>609</sup>

The Birth and Death Registration Act 2004 provides the legal basis for mandatory birth registration within 45 days of birth, and the use of the birth certificate as a proof of age to access services, including, among others, admission into school, marriage registration and issuance of a passport.<sup>610</sup> Further important measures encompass the Prevention of Domestic Violence Act, the National Education Policy and the National Child Labour Elimination Policy, all from 2010. In addition, the Human Trafficking Deterrence and Suppression Act 2012 and its National Plan of Action, along with the Pornography Control Act 2012,<sup>611</sup> spell out special provisions to ensure the safety of children.

Regionally, Bangladesh has adopted the SAARC strategy to combat child sexual abuse and sexual exploitation of children. The Department of Primary Education has issued four circulars in recent years to prevent all types of corporal punishment in schools, while the Ministry of Education also has issued a circular prohibiting corporal punishment at secondary level. A National Strategy on Prevention of All Forms of Violence Against Children was developed in 2011. Lastly, the Adolescent Cluster development group, led by MoWCA, and decentralised adolescent sub-clusters provide an institutional opportunity for strengthened coordination and leveraging of resources on behalf of protection of adolescents.

In particular, the Government has gradually developed a significant social protection and social welfare programme, which by fiscal 2009-2010 accounted for 15.2 per cent of the national budget and 2.5 per cent of GDP.<sup>612</sup> In all, the number of people receiving benefits

609 While no budget exists for implementation of this policy, it has represented an important instrument to influence the development of a National Social Security Strategy, which has recently been adopted to strengthen the social safety net of vulnerable people, with a special focus on children.

610 The Act also mandates a registration structure within the existing decentralised local government administration and obliges service providers, particularly in the health and education sectors, to facilitate birth registration. An amendment to the Act in 2013 provides for the establishment of the Office of the Registrar General, the permanent Government structure to oversee birth and death registration activities; this is expected in 2015.

611 The Act defines pornography as including "production and dissemination of video documentary, audio-visual materials, graphics, books, periodicals, sculpture, cartoons, leaflets and imaginary statues using uncivil dialogue and pictures, body movement, naked dance etc. which may create sexual appeal."

612 DIS, op.cit. The share of GDP has started declining since fiscal 2010-2011.

from “shock-based” transfer programmes is higher than the number receiving benefits from age-based vulnerability transfer programmes and extreme poverty-based transfer programmes.<sup>613</sup>

Various social protection programmes that affect women and children include a 100-day employment generation programme, social poverty alleviation programme, microcredit programmes for self-employment, cash transfer programmes,<sup>614</sup> a food transfer programme, vulnerable group development programme for malnourished children and women, vulnerable group development programme for the extreme poor, vulnerable group feeding, maternity allowance, fund for supporting lactating working mothers in urban areas, and credit programme for poverty reduction. Available evidence suggests that social protection programmes have made a significant contribution to the decline in poverty in recent decades.<sup>615</sup> Nonetheless, coverage of social protection programmes is far from universal.

Critically, a transformation to family- and community-based alternative care is beginning to occur through piloting and modelling, and may be furthered through enhanced monitoring and quality assurance/evidence building. A minimum package of child protection services has been piloted, primarily in urban slums and disaster-prone areas, and more than 400 Community Based Child Protection Committees (CBCPC), with 4,000 members,<sup>616</sup> are helping to ensure that children at risk and in need of special protection are identified and referred to services at an early stage.

Services under these committees include outreach social work, case management, community-based child protection committees and child protection networks; provision of parenting skills and awareness, with a view to promote social norm changes; LSBE and stipends for adolescent girls and boys; catch-up courses and remedial schools, to prepare children for school reintegration to prevent dropouts; and provision of leisure and recreational activities, to promote physical, socio-emotional and cognitive development of children. The committees further are contributing substantively to public debates on harmful practices such as child marriage, child labour and corporal punishment.

Specific strengthening of national and field-level capacities on child protection in emergencies also has been undertaken, particularly with regard to Disaster Risk and Reduction (DRR), response to protection needs in emergency, mental health and psycho-social support, and monitoring and rapid assessment. Further highlighting the importance of child protection in emergencies, diploma and master’s courses on child protection in emergencies have been embedded in the curriculum offered by the Dhaka University Disaster Management Institute since 2012.

Lastly, a Child Protection Information Management System is being strengthened, with an online case management system developed and piloted; this offers reporting of disaggregated data on protection cases involving children. A Birth Registration Information System (BRIS) also has been in place since 2009. The system enables local registrars nationwide and in embassies abroad to register births and deaths and issue official certificates through a web-based application.

613 Ibid.

614 UNICEF MTR, *op.cit.* The Children Act 2013 provides the legal basis for conditional cash transfers (CCT). Transfers are provided to most-at-risk children in vulnerable families who are ready to change practices and behaviours harmful to children, including child marriage and child labour, but are faced with financial barriers. In 2014, a total of 3,835 vulnerable children were benefiting from CCT. New locations for CCT provision have been identified through a geographical equity lens and include urban slums, the coastal belt, and stone crushing and tea garden areas. Evidence shows that even after graduating from CCT programmes, 83.3 per cent of eligible families continued to keep their children in school, 92 per cent continued to keep their children out of child marriage, and 94 per cent continued to keep their children out of child labour. Case management guidelines and tools to ensure implementation of standards of CCTs, including beneficiary selection criteria, quality case management and monitoring, have been integrated into the draft of the Rules of the Children Act to ensure standards of continuum of care.

615 Ibid.

616 CBCPCs usually average 10 to 13 members; at least three must be women.

Despite these many notable achievements, however, considerable challenges remain. Overall, a lack of Government resources has been a barrier to progress in piloting the transformation of institutions with the introduction of gatekeeping, minimum standards and revised guidelines. Various provisions in existing legislation, in particular, the Child Marriage Restraint Act 1929 and the minimum age of criminal responsibility, require further harmonisation with international standards.

A critical risk exists that implementation of the Children Act 2013 could remain limited because of (1) a lack of dissemination and understanding by concerned professionals; (2) slow development of the Rules of the Act; and (3) unprepared systems, a need for further strengthening of political will, and potential resistance to undertake needed child protection system reforms, including with regard to logistics, training and budget. No legal provision exists for allocation of national revenue and budget to implement the Children Act. In addition, key Ministries such as MoWCA and MoSW do not yet have a strong evidence base to leverage budget and revenue in this regard.

In terms of access to adequately staffed services, facilities and information, MoWCA does not have dedicated human resources for children at grassroots level,<sup>617</sup> although the MoSW structure provides for staff at union level. Proactive social work is key to address child protection issues and to provide services to children and their families/caregivers, yet the number of social workers and the capacity of existing social workers remain limited; only about half of 5,000 unions are provided with Government social workers. Moreover, deployment priorities do not necessarily take disparities and vulnerabilities into consideration. Many social workers are reluctant to be posted in remote areas and areas not well-served by basic services.<sup>618</sup> Significant gaps in human resources also are found in the judicial sector.

Insufficiency of human resources is further affected by frequent internal transfers, affecting continuity of service provision. In addition, a substantial number of posts are vacant; Government practices tend to add responsibilities to posted civil servants rather than to recruit, resulting in multiple mandates that are difficult for staff to assume.

At local level, no mechanisms exist to provide regular capacity building to communities/professionals on child protection,<sup>619</sup> combined with the overall governance challenges of local-level planning and decentralisation (see also Section 2.4.2). Many institutional facilities in particular have been found to be becoming obsolete, are understaffed, and have poor living conditions. Concerns exist about repeated reports of abuses by police and their lack of responsiveness, such that more child-friendly investigation techniques are required among police, judges and law enforcement personnel. Each police station is supposed to have a trained women-/child-friendly police officer; however, evidence indicates that often there is no woman officer. Overall, local Government institutions are constrained by their own lack of knowledge regarding children's rights, limited capacity, large and growing case loads, low level of resources and coordination difficulties.

Although an initial stage of enhancing child protection mechanisms has occurred through the Adolescent Cluster and zonal sub-clusters, a continuing lack of overall coordination is resulting in fragmentation of resources and a need for strengthened quality of services. MoWCA is in charge of inter-Ministerial coordination to ensure implementation of the CRC; however, the structure that is supposed to fully implement the mandate related to children remains too limited and unbalanced compared to the well-developed one for the rights of women.<sup>620</sup>

617 Existing centres under the Bangladesh Shishu Academy, an autonomous body under MoWCA, are established at district level, but areas of work are restricted to preschool and cultural programmes and the Children's Parliament.

618 UNICEF MTR, op.cit.

619 UNICEF Bangladesh, *Child Protection Programme Theory of Change: Monitoring of Results for Equity System 2014-2016*. Dhaka, 2014 (hereafter Child Protection Theory of Change).

620 Ibid.

Coordination also represents a key gap with regard to effective birth registration, since the intended coordination between the health and registration sectors under the Birth and Death Registration Act to facilitate registration of children immediately after birth largely has not been sustained.<sup>621</sup>

Geographical coverage of the minimum package of child protection services ensuring continuum of care remains limited, although the two key Ministries for implementation have indicated they are convinced about its effectiveness and efficiency.<sup>622</sup> Training of key human resources (social workers, probations officers, police, lawyers) also does not provide enough content on child protection within the Government and NGO systems. This results in further low qualifications of staff and limited capacity for scaling up the minimum package.

In addition, the effectiveness of social protection programmes could be considerably strengthened. Different data sources, including the Household Income and Expenditure Survey 2011, suggest that only 10 to 24 per cent of the poor receive social protection benefits. A multiplicity of programmes under the “social safety net” umbrella also has contributed to poor implementation, arising in part from programme overlap and lack of resource allocation.<sup>623</sup> The amount of benefit per household at national level has been estimated at 483 Taka per month in 2011, according to the Household Income and Expenditure Survey, enough to purchase only a few kg of rice. In addition, the selection process of beneficiaries is lengthy and may be influenced by political considerations. Critically, most social protection programmes are focused in rural areas, and therefore the urban poor have no access to benefits.

National and international NGOs also play a substantial role in supporting all aspects of children’s right to protection, advocating for women’s and children’s rights, and providing services and covering any gaps in Government institutions. NGOs further support adolescent clubs throughout the country. However, delineation of the roles of NGOs vis-à-vis the Government in the provision of protection services is sometimes not well understood, thus hampering effectiveness. Another constraint facing NGOs is their financial dependence on donor funds, and therefore, on the priorities of donors.

Communities likewise are hampered in carrying out their child protection duties by lack of awareness, adherence to traditional beliefs and socio-cultural norms that are harmful to children, and limited organisational capacities. No systematic foundational training exists for CBCPC members on child rights, nor for the role they can play in enhancing the enabling environment and access to child protection services.

Lastly, lack of accountability and responsibility of duty bearers toward child protection issues is exacerbated by a need for strengthened monitoring of child protection systems, in particular, with regard to the minimum package of services delivery. Insufficient standards and uniform service provision are in place to ensure quality and equity.<sup>624</sup>

In summary, this analysis of child protection institutions, systems and governance shows that effective implementation of the Children Act has the potential to effectively address a number of child protection issues, but remains unfulfilled. To achieve this, the following priorities will be necessary:<sup>625</sup>

621 UNICEF MTR, op.cit. Nonetheless, evidence from two pilot unions with regard to strengthened coordination between immunization services and registration services, along with awareness raising campaigns and community mobilization, show that birth registration can be significantly enhanced. For example, adequate coverage in Joykalah Union, Sylhet, increased from 8 per cent in 2012 to almost 100 per cent in 2013 following these interventions.

622 Child Protection Theory of Change, op.cit.

623 DIS, op.cit.

624 Ibid.

625 Children and 7FYP, op.cit.



- Supporting MoSW to engage in reform at central and local levels and in the development of a costed implementation plan that reconsiders coverage and standards of child protection services
- Planning for the creation of additional mandated positions (e.g., probation officer) and allocating enough resources to cover the duration of the plan in order to fully conduct the necessary child protection reforms
- Reinforcing the role of union social workers and probation officers in managing cases of vulnerable children, those in need of special protection or in conflict with the law, and in facilitating family support and access to services through referral and coordination with Child Welfare Boards at district and *upazila* levels
- Strengthening the capacity of CBCPCs at union and ward levels to advocate for the abandonment of harmful practices, while also generating community resources to support vulnerable children and contribute to early identification of cases of abuse and/or exploitation
- Investing in educating families, caregivers and parents on their child's development which will increase the likelihood that they will use positive discipline methods; their understanding of the negative impact of harmful practices like child marriage or child labour; their capacity for early identification of a child with disability; and their adherence to child rights overall

## 7.3 KEY INDICATORS OF CHILDREN'S AND WOMEN'S PROTECTION STATUS

### 7.3.1 Birth Registration

Birth registration informs vital statistics for national planning, monitoring and budgeting, enabling children and adolescents to fulfil their rights. Registration is free, but it has been reported that many registration offices demand a fee to issue birth certificates. For many parents, especially from hard-to-reach areas, travel to registration offices also costs them, so they are reluctant to go.

Many parents also do not see the importance of reporting birth and obtaining certificates for their children within 45 days; they do so only when they need a birth certificate to prove the child's identity and age, which is usually at the time of school enrolment at age 6.<sup>626</sup> Some parents also do not choose a name for their children within 45 days of birth and thus delay reporting birth. In addition, reporting birth is perceived as the responsibility of male members of the family; if men are away, there would be no follow-up to obtain birth certificates. Even once a certificate is issued, parents or officials may create pressure to change the date of birth because of conflicting ages for the child with regard to school enrolment and sitting for examinations, or to "legitimise" an child marriage.

In Bangladesh, the percentage of children younger than age 5 whose births are reported has risen sharply in recent years, but remains low, at 37 per cent.<sup>627</sup> Overall, birth certificates were actually viewed among only 21.3 per cent of children. Improvements have been noted in all Divisions. Rangpur, a newly formed Division, is the best-performing, with almost half of under-5 children registered; Chittagong and Dhaka were the worst-performing Divisions as recently as 2006, but now are among the best-performing Divisions. However, Khulna, Barisal and Rajshahi Divisions all are lagging.<sup>628</sup>

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626 UNICEF MTR, op.cit.

627 MICS 2012-2013, op.cit.

628 Ibid.

Registration of birth becomes more likely as a child grows older and peaks around age 4, at 50.5 per cent. No significant variations in birth registration exist depending on the sex of the child, but urban children are more likely than rural children to have their births registered (42.9 vs. 35.5 per cent). Registration of birth is strongly associated with household living standard and mother's education, although even for children living in the wealthiest households or with the most educated mother, fewer than 50 per cent were registered.<sup>629</sup>

The lack of adequate knowledge on how to register a child can present another major obstacle to the fulfilment of a child's right to identity. Data show that only 3 in 5 mothers of unregistered children report even being aware of the registration process. Knowledge about registration varies significantly between urban (72.0 per cent) and rural areas (57.9 per cent) and also between Divisions.

In low-performing UNDAF districts, the overall availability of connected birth registration services is nearly 100 per cent; more than 70 per cent of parents know how and where or who can help them report birth and obtain birth registration certificates. However, only 11.7 per cent of them use such knowledge to actually apply for birth registration for their children, falling to as low as 6.0 per cent in Jamalpur. At the same time, some districts need more focused attention; for example, in Bhola district, knowledge of parents with regard to where and how to register a birth stands at only 46.3 per cent.<sup>630</sup>

The large gap between accessibility and utilisation represents the primary factor limiting overall performance of the country's birth registration system. A smaller gap exists between the application process and the registration/issuance of birth certificates by registration offices. However, effective coverage (proportion of children younger than age 1 who are registered and provided within a birth registration certificate within 45 days of birth) remains extremely low, at less than 2 per cent on average.<sup>631</sup>

Lastly, the Committee on the Rights of the Child has expressed its concern that Bangladesh has only agreed in principle to issue birth certificates to all children registered as refugees in the country.<sup>632</sup> It particularly cited the need to uphold the rights of Rohingya children from Myanmar and Bihari children, all of whom have difficult or no access to services. Bangladesh is not a party to any international or regional treaty relating to refugees, not does it have legislative or administrative provisions for refugees.

### 7.3.2 Violence Against Children

Global research shows that violence can negatively affect children's educational performance and achievement, which can have long-term economic consequences, including poverty.<sup>633</sup> Exposure to violence at an early age can impair brain development and is associated with a range of mental health issues. Violence also can lead to acute and long-term problems for children's physical, sexual and reproductive health, as well as their psychological well-being.<sup>634</sup> The global United Nations Study on Violence Against Children 2006 highlights that much violence directed toward children remains hidden or out of view, especially when sanctioned by powerful influences or persuasive community leaders as an inevitable and normal way of life.

In all its forms, violence is detrimental; in the worst cases, it can be fatal: Homicide took the lives of about 95,000 children and adolescents in 2012 – almost 1 in 5 of all homicide

629 Ibid.

630 UNICEF MTR, op.cit.

631 Ibid.

632 CRC Concluding Observations, op.cit.

633 VAC Six Strategies, op.cit.

634 Ibid.

victims. Around 6 in 10 children aged 2-14 – almost 1 billion worldwide – are subjected to physical punishment by caregivers on a regular basis. About 3 in 10 adults around the world believe that physical punishment is necessary to properly raise or educate children.<sup>635</sup>

In Bangladesh, violence against children takes many forms, including physical violence/corporal punishment, sexual violence, mental violence, and neglect or negligent treatment. Meanwhile, the South Asia Initiative to End Violence Against Children (SAIEVAC) – an apex body of SAARC since 2011 to which Bangladesh is a party – has identified corporal punishment, trafficking, child labour, child marriage, and sexual abuse and exploitation as its priority thematic areas for VAC.<sup>636</sup>

In the MICS 2012-2013, 82.3 per cent of children aged 1-14 years were subjected to at least one form of physical or psychological punishment by household members during the month preceding the study. While 74.4 per cent of children experienced psychological aggression, about 66 per cent experienced physical punishment. The most severe forms of physical punishment (hitting the child on the head, ears or face or hitting the child hard and repeatedly) are overall less common; nonetheless, 24.6 per cent of children were subjected to severe punishment.<sup>637</sup>

Boys and girls experienced virtually the same levels of violent discipline. Among different age groups, children aged 5-9 years were most likely to be subject to violent discipline, although the difference with other ages is not significant. The practice of violent discipline was found to be more common in rural areas than in urban areas (83.5 vs. 76.9 per cent); children living in the poorest households also were more likely to suffer from psychological aggression. For the number of homicide victims among children and adolescents aged 0-19 years in 2012, Bangladesh stood at 1 per 100,000, below the South Asian regional average of 2.<sup>638</sup>

While violent methods are thus extremely common forms of discipline, only 1 in 3 respondents to the MICS 2012-2013 believed that a child actually needed to be physically punished. This illustrates an interesting contrast between the actual prevalence of physical punishment and parents' stated beliefs about physical punishment, indicating an important scenario where the practice does not match the belief. Indeed, the use of violent punishment against children in all settings, including within the home, at school, in care institutions and within the framework of the justice system, is often so deeply embedded as an adult's "right" and responsibility related to the upbringing or disciplining of children that many people do not even consider it an issue of concern. Overall, parents with no educational attainment and those residing in poorer households are more likely to find physical punishment a necessary method of disciplining children, at 35.1 and 41.7 per cent respectively.<sup>639</sup>

Although the Government has issued strict orders for physical punishment to be eliminated from schools, the findings of the Child-Led Alternative Report to the Fifth State Party Report on the CRC showed that the practice continues. Although it identified a lack of awareness among teachers of the ill effects of physical punishment as a root cause for its continued use, the report also found that training for teachers to prevent such punishment was not well organised, along with a need to strengthen monitoring. The report stated that types of punishment "include beating the students by cane stick, scale, dusters or by hand, grabbing the students' ears, and using insulting words and other types of punishment." It further noted that "disabled students are being tortured even in their special schools, and as such,

635 Ibid.

636 South Asia Initiative to End Violence Against Children. "Background Document to the Third Technical Consultation on Eliminating Harmful Practices Affecting Children in South Asia, Thimphu, Bhutan, 24-29 September 2013." Kathmandu, August 2013 (hereafter SAARC VAC). SAIEVAC's workplan 2010-2015 includes the target that by 2015, all Member States will have raised the legal age of marriage for both boys and girls to 18 and fully implemented Article 4(3)(d) of the CRC.

637 MICS 2012-2013, op.cit.

638 UNICEF. *Hidden in Plain Sight: A Statistical Analysis of Violence Against Children*. New York, September 2014 (hereafter Hidden in Plain Sight).

639 MICS 2012-2013, op.cit.

their guardians are reluctant to send them to those schools.” Child domestic helpers, it said, “suffer from physical punishments, as do children who reside at children homes and adolescent development centres.”<sup>640</sup>

A Child Helpline has been established and has now been able to access toll-free mobile connectivity. As of February 2014, 10,773 calls had been received at the hotline, and a steady upward trend has been noted in the number of calls. However, in the first three years of its operation (2011-2014), the helpline barely reached 1 per cent of the covered population in Dhaka’s Old City, and less than 0.3 per cent of children<sup>641</sup>. More recently, there has been a decision to extend the Child Helpline in target areas around the country in coordination and collaboration with INGOs, i.e. Plan International, World Vision and Save the Children and a number of local NGOs.

Lastly, suicide remains the ultimate form of violence among children themselves; suicidal thoughts and ideas are often a manifestation of feelings of absolute helplessness and having no control over unpleasant situations. Critically, in developing nations such as Bangladesh, with widespread remaining poverty and gender disparity, suicide is considered to be the single largest contributor to mortality in adolescent girls. Compared with childhood and later adulthood, global evidence shows that adolescence is a time for increased risk for suicide, and the few studies investigating suicide in Bangladesh agree.<sup>642</sup> One retrospective study examining the causes of death of 28,998 women in Bangladesh, for example, found that the highest percentage of suicides was within the age group 20-29 (42 per cent), followed by the age group 10-19 (36 per cent) (see also Sections 2.4.3 and 2.4.4). In young women aged 15-19, more than 1 in 5 deaths were due to suicide.

At an overall level, adolescents in a national suicide study reported a lack of control over feelings/thoughts/emotions as the primary psycho-social change during adolescence, followed by an inability to realise their own faults, differentiate between do’s and don’ts, make the right decisions, and take proper judgments. They also stated that they faced various problems and issues during adolescence, both at family and societal levels.<sup>643</sup> At the family level, issues mainly stem from restrictions and/or strict guidelines imposed by parents/authority figures, followed by feelings of uncertainty or awkwardness due to psycho-social and physical changes. At the societal level, common problems faced by respondents during adolescence were harassment and “unnecessary interference” from others, followed by restrictions on movement and sexual harassment/eve teasing.

About 2 in 3 adolescents (65 per cent) stated that they often received both physical and psychological punishment from parents, guardians or family members; in turn, it was found that those who attempted suicide reported the highest rates of receiving both physical and psychological punishments (74 per cent) compared to those who had thought about suicide but not attempted it, or those adolescents in the “general” category.

Key factors responsible for the rise in adolescent suicides were identified as failures in love or rejection, sexual harassment, misunderstanding between parents and children, and financial or economic problems. Domestic violence, marital problems and child marriage also were strongly highlighted as factors with the highest suicide-inducing potential among adolescents.<sup>644</sup> Female respondents displayed a greater inclination to agree with negative statements about their self-worth, which can be understood by existing norms in Bangladeshi society, wherein males generally have more scope and freedom to achieve their dreams

640 National Children’s Task Force, with support from Save the Children, Plan International and Manusher Jonno. *Our Story: Child Led Alternative Report on Child Rights Situation in Bangladesh in Response to Fifth State Party Report, Bangladesh*. Dhaka, March 2013 (hereafter Alternative Report on Child Rights).

641 UNICEF Bangladesh. *Assessment of Child Helpline Bangladesh*. Dhaka, March 2014.

642 Suicide Report, op.cit.

643 Ibid.

644 Ibid.

and aspirations, and are frequently given priority over females in the family. Most attempters of suicide appeared uncertain of what the future holds for them.<sup>645</sup>

### 7.3.3 Violence Against Women

Violence against women is a global phenomenon that exists beyond cultural, geographical, religious, social and economic contexts. In Bangladesh, an accelerating trend has been seen since 2007 in the official reporting of incidents of rape, whether because of more incidents or more women becoming willing to report their violation (2,453 incidents in 2006, compared to 3,675 by 2011). VAW with regard to dowry also has increased sharply, from 4,061 incidents in 2009 to 7,079 incidents in 2011; likewise, reports of child abuse also have risen, to 1,719 in 2011.<sup>646</sup>

Nevertheless, all the figures noted above remain very low levels of reporting compared to the extremely widespread incidence of VAW unofficially reported in the country. A nationwide VAW survey in 2011 identified that some 87 per cent of currently married women had experienced any type of violence by their current husband, with 77 per cent reporting facing violence during the 12 months prior to the survey. Nearly 1 in 10 women subjected to violence as an adult also had been subjected to violence as a child. Importantly, discrimination or violence against *hijra*, many of them adolescents, also is notable in the country (see also Section 5.3). In the private sector context, the high prevalence of violence against women in the workplace remains an area of concern,<sup>647</sup> and may be an issue requiring particular focus in industries in which women comprise the majority of the workforce, such as the garment industry.

The most common form of violence against women in Bangladesh is psychological violence, experienced by 90 per cent of women; this includes controlling behaviours such as trying to restrict a woman's contact with her family of birth, insisting on knowing where she is at all times, often being suspicious that the woman is unfaithful, or being verbally abusive. A similarly high proportion of women (65 per cent) had experienced physical violence by their current husbands, and more than half of these women had received medical treatment.<sup>648</sup> More than 1 in 3 women (36.5 per cent) also had experienced sexual violence by their current husbands; the prevalence of sexual violence in rural areas was higher than in urban areas. A substantial proportion of women (53.2 per cent) also had experienced economic violence, such as the husband refusing to give the wife enough money for household expenses.<sup>649</sup>

About 1 in 4 women also reported they had experienced physical violence by non-partners. Further analysis of non-partner violence by type of perpetrator indicates that parents, step-parents and parents-in-law combined represent the most commonly cited perpetrator of physical violence, followed by other family members, including sisters-/brothers-in-law.

Almost 1 in 5 women subjected to violence said they were too afraid of their husband to seek treatment, while more than 1 in 7 said the husband did not allow them to seek treatment. Nearly 1 in 10 women said they did not seek treatment because they were concerned about harming their social prestige.<sup>650</sup> Meanwhile, almost 1 in every 7 maternal deaths in Bangladesh is caused by violence, according to the national MDG Progress Report 2005.

645 Ibid.

646 Bangladesh Bureau of Statistics. *Gender Statistics of Bangladesh 2012*. Dhaka, June 2013.

647 ILO, *Bangladesh Decent Work Country Programme 2012-2015*. November 2012, accessed at <http://www.ilo.org/public/english/bureau/program/dwcp/download/bangladesh.pdf>. See further: ILO, "Promoting Gender Equality and Preventing Violence Against Women at the Workplace," accessed at [http://www.ilo.org/dhaka/Whatwedo/Projects/WCMS\\_209111/lang-en/index.htm](http://www.ilo.org/dhaka/Whatwedo/Projects/WCMS_209111/lang-en/index.htm).

648 Bangladesh Bureau of Statistics. *Measuring Gender Based Violence: Results of the Violence Against Women (VAW) Survey in Bangladesh*. Dhaka, September 2014 (hereafter VAW Survey).

649 Ibid.

650 Ibid.



In terms of not taking legal action, 2 in 5 women believed such recourse was “not necessary,” while about 1 in 5 said they were “thinking of the future of the children” and 1 in 6 were “thinking of the family or [our] own defamation.”<sup>651</sup> Similarly, findings from 30 countries, including Bangladesh, confirm that most adolescent girls in particular who experience violence do not seek help.<sup>652</sup> At the same time, 7.1 per cent of victims of violence in Bangladesh had attempted suicide because of abuse by their current husband, while 12.9 per cent had resorted to attempting suicide because of their previous husband’s abuse.<sup>653</sup>

Disturbingly, more than 40 per cent of women who had been victims of sexual violence indicated that they had been forced into sex for the first time when they were younger than age 14; more than 75 per cent of women reported that their first forced sex occurred as an adolescent (41.8 per cent among 10- to 14-year-olds, 34.3 per cent as a 15- to 19-year-old).

Compared to other South Asian countries, Bangladesh also displays a much higher percentage of ever-married girls aged 15-19 who experience physical violence by their husbands or partners, at 40 per cent vs. 20-30 per cent in India and Pakistan and 10-20 per cent in Nepal. Likewise, Bangladesh also reports that about 20 per cent of ever-married girls age 15-19 have experienced sexual violence by their husbands or partners, compared to about 13 per cent in India and 12 per cent in Nepal.<sup>654</sup> Overall, nearly half of ever-married Bangladeshi girls age 15-19 have experienced physical, sexual or emotional violence by their husbands or partners, giving Bangladesh the 7<sup>th</sup>-highest proportion of these girls among 43 countries studied.<sup>655</sup>

Also across South Asia, dowry remains a common form of violence against women, although dowry is prohibited by law (see also Section 2.4.3). In the national VAW survey, 1 in 3 women reported having paid dowry for their current marriage. Perpetuating the notion that girls are economic burdens and something to be rid of, money, goods, services and even livestock may be exchanged between families for a girl. Because virginity also is highly valued, both lower age and, in some cases, “inspection” are favoured. Dowry causes extreme economic stress within families and, in some cases, other children must earn in order to help with the payment.

Dowry demands that remain unfilled also can result in horrific consequences for the young bride, including stove burning, beating, mental abuse and isolation, and acid attacks. Although legislation exists to prevent acid attacks, enforcement remains weak. One study estimated that 60 per cent of acid victims were aged 10-19, with the intention not to kill but to punish through disfigurement.<sup>656</sup> During one 12-month period ending in June 2005, some 266 acid attacks were reported, affecting 322 people. Of these, 183 were women, 76 were children younger than 18, and 63 were men.<sup>657</sup> Marital, family and land disputes, dowry, and refusing sex and/or marriage were the main reasons for the attacks. Special, speedier courts have been introduced to deal with acid attacks, which now carry the death penalty.

Use of an informal mediation system overseen by Islamic scholars or leaders also may take place, leading to a social *fatwa* against a woman. Although legislation prohibits the implementation of any punishment based on *fatwa*, women and girls may be subjected to different forms of financial, physical or other humiliating punishments imposed by the community, and sometimes leading to death. According to one recent estimate, there were 35 such *fatwa*-related incidents of violence committed against women and girls in Bangladesh in 2007.<sup>658</sup>

651 Ibid.

652 Hidden in Plain Sight, op.cit.

653 VAW Survey, op.cit.

654 Hidden in Plain Sight.

655 Ibid. Bangladesh’s rate were surpassed only by those in Equatorial Guinea, Democratic Republic of Congo, Gabon, Zimbabwe, Cameroon and Bolivia.

656 SAARC VAC, op.cit.

657 UNICEF Bangladesh. “Support to the Acid Survivors Foundation and the Kishori Abhijan Project in Bangladesh.” Dhaka, June 2005.

658 Ibid.

### 7.3.4 Child Marriage

Although child marriage has been slowly declining in Bangladesh, marriage before age 18 remains a reality for many young girls and a fundamental violation of their rights, as has been highlighted throughout this Situation Analysis (see also Section 2.4.5). A total of 23.8 per cent of girls and women aged 15-49 were married before they reached their 15<sup>th</sup> birthday and 34.3 per cent of adolescents aged 15-19 are married.<sup>659</sup> Divisional trends of child marriage remain largely unchanged;<sup>660</sup> Rajshahi remains the Division with the highest rate of child marriage (47.8 per cent), while Sylhet has the lowest rate. Notably, the rate of child marriage in Sylhet has fallen by almost half since 2006, from 25.6 per cent to 13.7 per cent. Because such a sharp decrease has not occurred in other Divisions over the same period, further analysis is being undertaken to offer insights that can accelerate overall results.<sup>661</sup>

Among women aged 15-49, close to 1 in 4 (23.8 per cent) were married before age 15 and, among women age 20-49, more than 3 in 5 (62.8 per cent) married before age 18. The proportion of married women aged 15-19 is lower in urban areas than in rural areas (28.1 vs. 36.1 per cent).<sup>662</sup> A strong negative correlation exists between child marriage and level of education: Women are much more likely to be subject to child marriage if they had no education (73.1 per cent) as compared to those having secondary or higher level of education (31.7 per cent). This disparity is even more pronounced when marriage happens before age 15.<sup>663</sup>

Nevertheless, data indicate that the prevalence of the proportion of women married or in union by age 15 and 18 has gradually declined over time: 67.2 per cent of women age 45-49 years were first married/in union by age 18, compared to 52.3 per cent of women age 20-24 years. The prevalence of child marriage has mostly dropped in recent years among the age groups 25-29 and 20-24.<sup>664</sup>

Evidence also shows important spousal age differences in Bangladesh, linked to rates of child marriage. About 1 in 5 women aged 20-24 is married to a man who is older by at least 10 years; equally, about 1 in 5 women aged 15-19 is married to a man who is that much older. In both age groups, more than 40 per cent are married to or in union with a spouse older by five to nine years. In all, only about 1 in every 3 married 15- to 24-year-old women in Bangladesh are with a spouse close to their own age (0-4 years older).<sup>665</sup> Interestingly, better-educated and richer women are much likelier to have older spouses, and they are also much less likely to be married to a spouse of their own age. Women aged 15-19 from the richest households, for example, are around three times as likely to be married to or in union with a spouse 10 or more years older, compared to women from the poorest households.

Lastly, the MICS 2012-2013 found that some 4.2 per cent of women aged 15-49 years in Bangladesh are in a polygynous marriage, with little difference between urban and rural areas. Women with no education are seven times more likely to be in a polygynous marriage than those who completed higher education. The practice is most common in Sylhet Division, where the prevalence, at 8.7 per cent, is more than double the national average.

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659 Ibid.

660 UNICEF MTR, op.cit.

661 MICS 2012-2013, op.cit.

662 Ibid.

663 Ibid.

664 Ibid.

665 Ibid.

### 7.3.5 Child Labour

According to the International Labour Organisation and Bangladesh Bureau of Statistics, some 1.6 million working children (ages 5-17) live in Bangladesh.<sup>666</sup> Although the number of working children has decreased in recent years, social norms and economic realities mean that child labour continues to be widely accepted and common in the country, with millions of children denied an education and vulnerable to violence and abuse. Employers often prefer to employ children – in domestic work, waste picking, construction, workshops, garment factories, hotels and restaurants, among many others – because they are cheaper and considered more compliant than adults.<sup>667</sup> Child labour in the garment industry including in the informal sector that has grown with and around the garment sector, remains a particular concern.<sup>668</sup>

Determining the number of “real child workers” also is critical.<sup>669</sup> Almost equal proportions of real child workers – two-fifths each – are engaged in agriculture and the service sector, with the industrial sector engaging one-fifth of workers. In agriculture, the proportion of working boys is much higher than that of girls (45 vs. 15.6 per cent), whereas the proportions of girl child workers are higher than that of boy child workers in both the industry (29.1 vs. 18.2 per cent) and service sectors (55.3 vs. 36.8 per cent).

While about 1 in 16 young adolescents aged 10-14 years is involved in work nationally, this proportion is as high as 1 in 6 in Dhaka, more than three times the national average. Evidence shows that nearly half of children (43.8 per cent) are involved in work in one ward in Dhaka City Corporation. The higher involvement of children in the workforce in Dhaka is mainly due to the vast number of young girls engaged in work. Indicating the high degree of disparities found between geographic locations, the proportion of real child workers ranges from 3 to 30 per cent for boys, and from 0.1 per cent to 27 per cent for girls – a factor of 270.<sup>670</sup>

### 7.3.6 Sexual Abuse of Children

Child sexual abuse is found in all classes of society in Bangladesh, as in other countries. Children are at risk of sexual abuse or harassment in their own homes, from relatives and family “friends,” or at school, in the community and in the workplace. While disadvantaged children and children with disabilities are more vulnerable to abuse, it is not limited to them. In the vast majority of cases, perpetrators of child sexual abuse are men: sons of influential families, factory supervisors, boys on the street and “uncles” or others connected to families. Perpetrators are mostly younger than age 30.<sup>671</sup> One report presented at a 2011 seminar on sexual abuse among schoolchildren in Bangladesh found that about 16 per cent of girl students and 7 per cent of boy students were victims of sexual abuse.<sup>672</sup>

The many dimensions of this complex issue have been little explored in Bangladesh, but require urgent attention. For example, the regular merging of child sexual abuse, commercial sexual exploitation and trafficking into one development “bundle” tends to combine different

666 *Report on National Child Labour Survey 2013*

667 Child Equity Atlas, op.cit.

668 In terms of child labour in the formalised garment sector, UNICEF has recently reported that children work at all stages of the supply chain in the fashion industry (<http://labs.theguardian.com/unicef-child-labour/>) while a 2013 report by the United States Department of Labor’s Bureau of International Labor Affairs identified garments and textiles as one of the sectors of the Bangladesh economy where child labour is present. Accessed at <http://www.dol.gov/ilab/reports/child-labor/findings/2013TDA/bangladesh.pdf>. A recent survey for the United States Department of Labor’s Office of Child Labor, Forced Labor and Human Trafficking also found that about one-third of the workers in the informal garment production sites observed were children under 18 years of age. (<http://www.dol.gov/ilab/reports/pdf/2013GarmentBangladesh.pdf>.)

669 Child Equity Atlas, op.cit. Real child worker refers to children aged 10-14 who are employed for the production of market and non-market goods not for household use or who are unpaid household services, and who are not in school.

670 Child Equity Atlas, op.cit.

671 Sexual Abuse Report, op.cit.

672 Alternative Report on Child Rights, op.cit.

situations that may be linked for some children, but not for others; moreover, sexual abuse concerns a population far larger than does commercial sexual exploitation (see sub-section below). Organisations operating within the paradigm of sexually abused children have been ill-equipped to reach out to adolescents working in prostitution who deny being children and refuse to be called victims, despite being younger than age 18.<sup>673</sup> Research also shows that sexual abuse leads to prostitution only in particular circumstances. The relationship between prostitution and trafficking also requires careful research: Trafficking does not always involve prostitution, and prostitution does not always entail trafficking.<sup>674</sup>

Child sexual abuse also has been found to be rooted in the overall social dynamic, not simply related to sexual behavior.<sup>675</sup> Girls are particularly vulnerable to sexual abuse by non-family members when they have no male guardian, when they are poor, when a scandal has tarnished the family reputation, or when the family are “outsiders” (children of sex workers) or belong to a minority group (Dalits, Gypsies).<sup>676</sup>

Middle-class families in particular tend not to seek justice for the sexual abuse of their children, often preferring to keep silent to limit the scandal.<sup>677</sup> Of 68 cases of sexual abuse investigated in one study, the law was activated only twice. Moreover, some of the means of addressing arbitration at community level (*shalish*) are completely contrary to the realisation of human rights, such as marrying the victim to her rapist – a common resolution proposed and implemented at *shalish*.<sup>678</sup>

All this underlines the fact that what society considers legitimate differs markedly from the law. Girls who suffer rape – often aged 13-18 years – and girls who consent to non-marital sexual relationships are similarly considered *noshto*, or permanently “stained.” Critically, rape taken to mean loss of “purity” and “honour” applies only to girls, and often is directly linked with child marriage, interruption of studies and limited participation in public life (see also Sections 2.4.3 and 2.4.5). Rape also is not recognised within marriage; there is no loss of “honour” when a husband rapes his wife.<sup>679</sup>

Linked to this sense of defilement and losing “honour,” it is considered impossible to rape a boy, yet such deeply ingrained notions of gender need to be addressed. While girls know from an early age that sexual abuse means to be made *noshto*, for boys the abusive act is considered shameful but socially irrelevant. Many boys who are child labourers report being abused by their employers with impunity.<sup>680</sup>

Many in Bangladesh believe that “lesser” forms of sexual abuse are not taken seriously by courts, law enforcement agencies, parents or caregivers.<sup>681</sup> Although the Ministry of Education has taken a “zero tolerance” approach to stop sexual abuse toward girls while in school or on the way to and from school (“eve teasing”), girls continue to be regularly abused.<sup>682</sup> Victims may even stop going to school if the abuse is severe. Lastly, pornography also is increasing as a tool of sexual abuse in social media. Out of 165 incidents reported in national daily newspapers, five involved girls who were victims of illicit videos being uploaded on the Internet.<sup>683</sup>

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673 Sexual Abuse Report, op.cit.

674 Ibid.

675 Ibid.

676 Alternative Report on Child Rights, op.cit.

677 CRC State Party Report, op.cit.

678 Sexual Abuse Report, op.cit.

679 Ibid.

680 Ibid.

681 Ibid.

682 Alternative Report on Child Rights, op.cit.

683 Ibid.

### 7.3.7 Sexual Exploitation of Children

The commercial sexual exploitation of children refers to girls and boys younger than 18 who engage in sex work, are exploited in the production of pornographic material, or participate in any other commercial enterprise of a sexual character.

Yet although prostitution below age 18 is illegal, young persons below that age have long engaged in it, particularly on the streets, and are vulnerable to arrest, beating, robbery, and HIV infection (see also Section 5.3). In brothels, many children – often children of women who also work there – must live as bonded sex workers. However, given the absence or manipulation of birth registration, it can be difficult to determine whether an adolescent in sex work is older or younger than 18.<sup>684</sup>

The great majority of girls and boys who are sexually abused (see sub-section above) do not engage in prostitution and never considered doing so. At the same time, 43 per cent of girls found engaging in prostitution had been sexually abused before joining the trade.<sup>685</sup>

If one excludes *hijra*, who project a strong image of their identity as a third gender and are highly visible, boys who take money for sex may not be readily identified as prostitutes. In field work undertaken in Chittagong, it was found that boys who earned from sexual services did not fix a price with their client beforehand and interpreted what they received as a gift for a favour rather than a fee for service.<sup>686</sup>

### 7.3.8 Trafficking of Children and Women

Although mainly a source country for human trafficking, particularly to neighbouring countries and to the Middle East, Bangladesh in recent years has also become a country of both transit and destination. The issue of human trafficking is integrally linked to insecurity of livelihoods as well as to continuing disparities and discrimination against marginalised communities generally, and against women in particular.

Many trafficked persons are lured and deceived by false promises of “good jobs” or marriage, while others are bought, abducted, kidnapped, coerced, threatened or used as debt bondage. Some of these women and children are trafficked with the tacit consent of their impoverished families.<sup>687</sup> Alongside intra-country and cross-border trafficking in women and children, trafficking of men for the purpose of labour exploitation also has been on the rise.

As of August 2012, 719 cases of trafficking in children and women were under trial.<sup>688</sup> Even if a case is brought, however, it is very difficult to obtain a conviction: Among 45 cases settled that year, only 8 ended in convictions; a total of 11 persons were convicted, of whom 10 received life imprisonment. A total of 209 new cases involving charges of trafficking also were lodged the same year.<sup>689</sup>

Various factors lead to the vulnerability of women and children to trafficking, such as poverty, unemployment, illiteracy, lack of awareness, gender discrimination, violence against women, natural disasters and a need for strengthened implementation of existing laws.<sup>690</sup> In border areas, many “enclaves” of land exist which belong to a nation other than that which surrounds them; frequently these areas are not controlled by law enforcement

684 Sexual Abuse Report, op.cit.

685 Ibid.

686 Ibid.

687 Ministry of Home Affairs. *Combating Human Trafficking: Bangladesh Country Report 2012*. Dhaka, 2012 (hereafter Trafficking Report).

688 CRC State Party Report, op.cit.

689 Trafficking Report, op.cit.

690 Ibid.



agencies. Research by the Bangladesh National Women Lawyers Association (BNWLA) has shown that these enclaves have been used as recruitment and collection sites by traffickers. Altogether, there are believed to be about 111 Indian enclaves in Bangladesh and 51 enclaves of Bangladesh in India.<sup>691</sup>

In addition, children may be kidnapped for use as sex workers within or outside the country; out of 4,000 sex workers in one identified brothel in Bangladesh, 500 were children, most of whom had been trafficked into the brothel by brokers. Meanwhile, 86 girl children were reported kidnapped from different areas of the country during January-June 2012; it has been assumed that most of these kidnapped children have been trafficked to neighbouring countries and the Middle East for commercial sexual exploitation.<sup>692</sup>

### 7.3.9 Protection Issues for Refugee and Ethnic Minority Populations

Refugee children, particularly Rohingya children,<sup>693</sup> as well as ethnic minority children in hard-to-reach areas such as CHT (see also Section 2.5.3), face acute protection challenges. For example, while about 32,000 Rohingyas live as registered refugees in southeastern Bangladesh, hundreds of thousands more exist as illegal migrants, frequently in unofficial camps, bereft of essential protection and other social services and vulnerable to ill health, exploitation and abuse. The Government of Bangladesh considers the Rohingyas largely to be undocumented Myanmar nationals; in 2013 the Cabinet, in a meeting chaired by the Prime Minister, approved a “National Strategic Paper on Refugees from Myanmar in Bangladesh and Myanmar Citizens Who Have Breached Bangladesh’s Border,” under which new measures to stop Rohingyas’ movement into the country are being implemented.<sup>694</sup>

In Cox’s Bazar district, where most of the Rohingya population lives, children and adolescents aged 5-19 represent around 40 per cent of the total population; in Teknaf and Ukhia sub-districts, around 191,596 adolescents and children have been identified.<sup>695</sup> Because of the protracted nature of the humanitarian issue, almost 60 per cent of documented Rohingyas alone have been born in Bangladesh. At the same time, already-limited humanitarian aid has face considerable further restrictions since 2012.

Rohingyas’ primary host communities likewise are among the poorest areas in Bangladesh, with 16.24 percent of people in Cox’s Bazar district considered extreme poor. Moreover, the main sub-districts of Rohingya settlement, Ukhia and Teknaf, are considered very hard-to-reach and extreme hard-to-reach respectively; only 9.5 percent of roads are paved.<sup>696</sup> All this is complicated by these communities’ vulnerability to natural disaster in the form of cyclones, earthquakes and deadly flash flooding, including the latest humanitarian emergency in late June 2015, when severe flooding killed some two dozen people, injured more than 20,000 and affected more than 1.81 million across three districts, including 1.22 million in Cox’s Bazar – 60 to 90 percent of the district population.<sup>697</sup>

691 Centre for Women and Children Studies. *Not for Sale: Trafficking in Bangladesh*. Dhaka, 2012. Trafficking-prone districts and *upazilas* have been identified as Dinajpur, Lalmonirhat, Nilphamari, Panchagarh, Rajshahi, Nawabganj and Joypurhat, in the northern region; Chuadanga, Meherpur, Kustia and Jhainadaha, in the northwest; Jessore and Satkhira, in the south; Cox’s Bazar and Chittagong, in the southeast; and Brahmanbaria and Comilla, in the east. Most of these are considered to be linked to trafficking networks in West Bengal and Assam, Tripura or Myanmar.

692 Alternative Report on Child Rights, op.cit.

693 The Rohingya ethnic and religious minority forms one of the world’s largest stateless populations and is at the centre of a chronic and growing humanitarian crisis across Southeast Asia. Up to 500,000 Rohingyas are now believed to be in Bangladesh since being stripped of citizenship in Myanmar, where ethnic tensions and reported violent campaigns of persecution for the past three decades have been acute.

694 Accessed at <http://bdnews24.com/bangladesh/2013/09/09/bangladesh-to-headcount-rohingyas>.

695 United Nations in Bangladesh. *Bangladesh CERF Underfunded Emergencies Prioritisation Strategy*. Dhaka, 31 July 2015.

696 *Bangladesh HCTT Joint Needs Assessment: Flash Floods in Cox’s Bazar, Bandarban and Chittagong Districts, June-July 2015*. 20 July 2015.

697 *Bangladesh HCTT Joint Needs Assessment Flash Floods and Landslides: Chittagong, Bandarban, Cox’s Bazar*. PowerPoint presentation, July 2015.

Despite official restrictions on their freedom of movement and the ability to pursue education and livelihood opportunities, Rohingyas are often publicly perceived as a burden on scarce resources such as water and firewood and a threat to local employment through the provision of cheap labour. In turn, this has given rise to continuous friction between Rohingyas and local communities and led to violence against refugees, particularly women and girls. Little security exists for the hundreds of thousands of undocumented refugees in particular, with no access to the justice system.

Sexual violence, domestic violence, and child and forced marriages are all endemic in both the host and Rohingya refugee communities, with stressful living conditions and the lack of access to the police or justice system putting refugee women and girls at particular increased risk of abuse. The most recent Joint Assessment Mission, in December 2012, found the principal protection risks in official refugee camps to include wife beating and wife abandonment; rape, and a lack of safe shelters for victims of rape; and early/non-consensual marriage.<sup>698</sup> The Mission also said that these major gaps appeared not to have closed in recent years, and in fact may even have widened. Women are often reluctant to report sexual violence and may need permission from their husband and local leaders to seek health care, which also severely limits the ability to provide much-needed support and raise awareness.

Moreover, the situation is believed to be equally dire, if not worse, among undocumented Rohingyas, who have no legal rights and often confront a climate of fear and impunity. In recent years, reports of sexual violence against unregistered refugees have increased, yet services remain at a minimum.<sup>699</sup> Indeed, violence has been reported by United Nations Agencies as being regarded as “normal” in Rohingya-populated areas and used as a means of social control by community leaders, security personnel, teachers and parents.<sup>700</sup> The 2012 Joint Assessment Mission reported that many women in refugee camps, for example, do not tend to leave their homes, meaning that female-headed, and especially all-female, households are in a particularly difficult situation with regard to accessing services and assistance.<sup>701</sup>

Many years of living in limbo and without basic services is pushing thousands of Rohingyas to risk everything in search of a better life and, increasingly, they are being joined by poor Bangladeshi migrants, often from Cox’s Bazar. In the first quarter of 2015 alone, a record 25,000 Rohingyas and poor Bangladeshis departed irregularly by sea from the Bay of Bengal, more than double the number recorded a year earlier. An estimated 300 died at sea during that period.<sup>702</sup> All have been attempting perilous boat journeys to Thailand and onward to Malaysia or Indonesia, often organised by people smugglers who subject the victims and their families to bribery, torture, rape, and ransom demands.

However, the discovery of mass graves believed to contain the bodies of Rohingyas on the Thai-Malaysian frontier in May 2015 instigated a Thai crackdown on smuggling; it also left hundreds or even thousands of Rohingyas and Bangladeshis stranded at sea.<sup>703</sup> In Bangladesh itself, meanwhile, the Government in May 2015 announced plans to relocate

698 Government of Bangladesh, UNHCR and WFP. *Joint Assessment Mission: Myanmar Refugees in Cox’s Bazar District, Bangladesh*. December 2012 (hereafter JAM).

699 Refugees International. *Bangladesh : The Silent Crisis*. April 2011 (hereafter Silent Crisis), accessed at <http://refugeesinternational.org/policy/field-report/bangladesh-silent-crisis>.

700 UNHCR. *States of Denial: A Review of UNHCR’s Response to the Protracted Situation of Stateless Rohingya Refugees in Bangladesh*. December 2011.

701 JAM, op.cit.

702 Estimates by UNHCR.

703 Agence France Presse, “Southeast Asia’s Traffickers Prey on Rohingyas’ Misery.” Koh Lipe, Thailand, 16 May 2015, accessed at <http://www.hindustantimes.com/chunk-ht-ui-worldsectionpage-topstories/of-smugglers-and-kingpins-southeast-asia-s-big-money-trade-in-humans/article1-1347734.aspx>. On 24 July 2015, Thailand indicted 72 people, including a Thai Army general, other military officials, senior police officers, local officials and local politicians, in connection with a multinational human trafficking syndicate; other suspects, including Bangladeshis, remain at large.

the tens of thousands of registered Rohingyas to the remote southern island of Hatiya<sup>704</sup> (see also Section 2.5.3). The success of this move, according to UNHCR, would depend on the availability of basic social services, including health and protection services and livelihood opportunities at the new location and on relocation being voluntary for the refugees. At the same time, this does not solve the challenges faced by the estimated 200,000 unregistered Rohingya refugees who do not live in camps and are not entitled to food or other aid.<sup>705</sup>

### 7.3.10 Children in Contact With the Law

As noted in Section 7.1 and in Chapter 3, the Children Act 2013 has been instrumental in offering a framework for comprehensive reform of the child justice system. Even so, arrest, detention and sentencing for children in contact with the law have often been arbitrary and, at times, even illegal, in part because of a lack of understanding of children's rights. Physical abuse, force and torture frequently are applied during arrest and interrogation.<sup>706</sup> As of May 2012, 53 children younger than 18, including five girls, were in various prisons in the country; a total of 447 children (42 girls) were in three *Kishore Unnayan Kendra* facilities (previously Juvenile Correction Centres). The lack of justice procedures for child victims with disabilities, along with limited sensitivities of staff in the justice system, remain especially critical.<sup>707</sup>

One of the most difficult challenges facing children in contact with the law is marginalisation from their communities, who commonly see them as dangerous mischief-makers and thieves.<sup>708</sup> Cultural programmes and public events in the community are being promoted on a pilot basis to contribute to community sensitisation efforts. Likewise, Community Based Child Protection Committees and community volunteers, including children themselves, are serving as change agents to promote family conferencing and a reintegration with families whenever this is a secure and viable option. At least 25 per cent of eligible cases in pilot areas are expected to be dealt with through alternative case mechanisms.

### 7.3.11 Children With Disabilities

Most of the services being developed in support of a comprehensive child protection system in Bangladesh cannot yet address the various barriers faced by children with disabilities (see also Section 2.5.1). Children with disabilities in Bangladesh are primarily cared for at home by their families. In some cases, the parents are strong advocates for realisation of the children's rights and have managed to improve their access to education and health care. However, for a large number of children with disabilities, treatment at home is not equitable or supportive, since very poor families often see the child as a burden. With limited knowledge and support, families also may keep children with disabilities sequestered at home, in some cases to avoid shame, and many children are neglected or exploited.<sup>709</sup>

704 Agence France Presse, "Bangladesh Plans to Move Thousands of Rohingyas to Island." Dhaka, 27 May 2015, accessed at <http://news.yahoo.com/bangladesh-plans-move-thousands-rohingya-island-113719453.html>.

705 The Guardian, "Bangladesh plans to move Rohingya refugees to island in the south". London, 28 May 2015, accessed at <http://www.theguardian.com/world/2015/may/28/bangladesh-plans-to-move-rohingya-refugees-to-island-in-the-south>

706 UNICEF Bangladesh. "Justice for Children Factsheet." Dhaka, January 2015.

707 Disability Situation Analysis, op.cit.

708 "Justice for Children Factsheet," op.cit.

709 Disability Situation Analysis, op.cit.

Social protection does not yet reach a large number of these families, and procedures to access such services are often not family-friendly or disability-friendly. MoSW reported in 2012 that 1,720 children with disabilities were living in institutions and 280 students with disabilities were residing in residential schools. Institutional care in many cases is inadequate and violates many rights of the child.<sup>710</sup> Information on exposure to exploitation, violence and abuse of children with disabilities remains limited; however, small-scale assessments conducted by NGOs reported a high incidence of abuse and violence, especially targeted at girls. Equally violating is the emotional abuse faced daily by children with disabilities in their homes, schools and communities due to pervasive negative attitudes about disability.

### 7.3.12 Children on the Streets and Children Without Parental Care

The Committee on the Rights of the Child has expressed concern over the rising number of children living or working on the streets in urban centres, particularly Dhaka. It described these children as prime targets of organised child trafficking rings and warned that they “are susceptible to abuse and are often charged with the crime of vagrancy and confined in vagrant homes and shelters that are not suitable for children.”<sup>711</sup>

An estimated 1.3 million children lived on the streets in 2012, with about 250,000 involved in begging in Dhaka; many also are involved with violence and theft, and/or use drugs.<sup>712</sup> These children on the streets often are exploited by brokers or middlemen; one case study has found that brokers take most of whatever the children earn every day. An alarmingly high proportion of girls on the street, nearly 1 in 2 (46 per cent), are reported to be the victims of sexual abuse or physical torture.

Meanwhile, orphaned children or those living with only one parent are likewise very vulnerable because of the lack of full parental care. The prevailing approach to responding to the care and protection of orphans, both by the Government and NGOs, has focused primarily on the provision of institutional care. Programmes aimed at preventing children from being separated from their remaining family members are very limited, and alternative family-based care programmes are generally lacking. While 85.7 per cent of children aged 0-17 live with both parents, 3.8 per cent live with neither biological parent (girls more than boys), 8.8 per cent live only with their mother, and 1.2 per cent live only with their father. About 4.3 per cent of children have suffered the death of one or both parents.<sup>713</sup>

In addition, the MICS 2012-2013 measured children “left behind,” i.e., for whom one or both parents have migrated abroad. The total of “left behind” children is about 4.8 per cent, with mostly the father living abroad. However, there exist notable differences between groups of children, with the percentage of at least one parent abroad being much higher in Chittagong Division (9.9 per cent) and, interestingly, among children in the richest households (12 per cent).

710 Ibid.

711 Committee on the Rights of the Child. *Concluding Observations of the Committee on the Rights of the Child: Bangladesh*. New York, June 2009.

712 Alternative Report on Child Rights, op.cit.

713 MICS 2012-2013, op.cit.

## 7.4 ROOT AND UNDERLYING CAUSES OF KEY PROTECTION CHALLENGES

Based on the above analysis, as well as a UNICEF capacity gap and role pattern analysis (see also Annex 7), a number of root causes for child protection-related challenges in Bangladesh, at different levels of duty bearers, have been identified:

- Social norms and traditional/cultural beliefs regarding the perception of who is a “child,” which differs from the one implicit in the CRC
- Social norms and traditional/cultural beliefs resulting in low status of girls and women
- Social norms and traditional/cultural beliefs resulting in denial of sexual and other abuse of boys
- Social norms and traditional/cultural beliefs accepting corporal punishment as an “educational” measure
- Acute institutional capacity issues, including in monitoring and accountability, and gaps in human resources
- Need for strengthened commitment/political will to expand the protection continuum of care and its services
- Wide social disparities and poverty
- Overall lack of awareness of importance of child protection issues; for example, parents do not see the importance and benefit of registering the birth of their children until school enrolment age, or adhere to traditional delays in naming of a child
- Shortcomings in enforcement of legal/policy frameworks

All this results in a variety of underlying challenges, including:

- Emphasis on “purity” and “honour” for girls
- Stigmatisation of victims of sexual abuse, with lack of available support and inequitable power forces in society
- Slow movement from responsive to right-oriented protection system
- Need for enhanced coordination among child protection stakeholders
- Need for extension of and strengthened child-sensitive social protection, including in remote and hard-to-reach areas and populations (urban slums, CHT, refugee communities)
- Children, particularly adolescent girls, often are unaware of their legal rights or are made to feel they cannot exercise those rights
- Pressure to change the date of birth of a child either for the right to sit for an educational examination, or to register an child marriage
- Need for strengthened targeting of social protection programmes



## 7.5 RECOMMENDATIONS TO IMPROVE CHILDREN'S AND WOMEN'S PROTECTION STATUS

All children, adolescents and women have the right to be protected from violence, abuse and exploitation. While the direct impact of a society's failure to adequately protect its children is difficult to quantify and the impact on poverty is not directly documented, it is recognised that abuse, violence and exploitation of children are fundamental social problems that have implications not only for the well-being and rights of children, but also for the long-term well-being and stability of society as a whole. Creating a truly protective system is a highly complex undertaking. With that in mind, recommendations include:

Policy/Strategy	<p>Support continuation of legal reform with regard to protection issues</p> <p>Support development of a Plan of Action to end child marriage by 2041</p>
Institutions/ Governance	<p>Facilitate strengthened coordination between health and birth registration sectors</p> <p>Coordinate, plan, develop capacity and release budget to help enforce the 2013 Children Act, ensuring a continuum of care, including availability of quality services, nationwide</p>
Programme, Including Gender/Adolescents/ Child Marriage/Urban Slums	<p>Provide children and adolescents with skills to cope with/ manage risks and challenges and to seek appropriate support</p> <p>Educate families, caregivers and parents on their child's development and provide parenting skills</p> <p>Accelerate and extend implementation of C4D activities to strengthen social mobilisation and community engagement for social and behavioural change, abandonment of harmful social norms/practices, and adherence to the CRC</p> <p>Work with men and boys to reduce violence</p> <p>Promote greater protection for children with disabilities, especially girls; specifically invest in the education system to implement measures to eliminate physical punishment and inclusive education for children with disabilities</p>
M&E/Data/Knowledge Management/ Innovation	<p>Support increased accountability of duty bearers through a strengthened monitoring system</p>



## Chapter 8

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# Conclusion: The Way Forward

Despite numerous challenges, Bangladesh has achieved major improvements in the lives of children, adolescents and women in recent decades. Moreover, the country has managed to achieve these successes in a relatively short time, and with comparatively small budgets in the social sector. Bangladesh's girls and boys, adolescents and women thus are generally better off today than their peers from a few decades ago. While considerable challenges remain, these are being increasingly recognised and addressed by the Government, communities, parents, families, the international community, and children themselves. Bangladesh must be encouraged to foster an ever-stronger commitment to development of its children. In so doing, the country can move a long way toward realising its ambitious hopes and vision.

Even so, from the analysis above it is clear that many of the development challenges that continue to face Bangladesh arise from the same or similar root causes, and that constraints to realisation of the full spectrum of rights among all of the country's children, adolescents and women remain profound.

Key root causes of major disparities include, among others, (1) an acute need for systems/institutional strengthening, including at sub-national levels, to address insufficient capacities for equity-based planning, implementation, coordination and monitoring; (2) a strong need for a culturally sensitive transformation in social and behavioural development, including social norms to eliminate harmful practices, and to ensure respect for the rights of all women, adolescents and children; (3) the persistence of widespread poverty despite national economic progress, which continues to influence the life choices of many families; (4) a need to direct more substantive attention to quality services in disadvantaged areas lagging in human development, including urban slums and hard-to-reach areas; (5) inadequate knowledge and awareness, particularly at family level, on good development practices and their benefits; and (6) Bangladesh's continuing heightened vulnerability to disaster and ensuing emergencies.

At the same time, most of these challenges are complex, warranting comprehensive policies and robust implementation over a sustained period of time. This suggests that an integrated approach to Bangladesh's development needs among children and women would best serve the country in many cases. Priority will need to be given to the six emerging themes highlighted across all sectors, namely, systems strengthening; promotion of local-level planning; mainstreaming gender; enhancing attention to adolescents; ending child marriage; and special attention to rapidly growing urban slums. In turn, these themes are drawn not only from this analysis but also are aligned with the Government's overarching Vision 2021 as well as the post-2015 global development agenda.

In all, these priority areas are intended to capture key development issues as well as broad and important structural causes – socio-cultural, economic, institutional and those related to governance, and environmental – that form the basis of deeper themes of vulnerability. At the same time, it is also important to note that it is not that the structure, systems or legal provisions of Bangladesh are not changing; they are, sometimes even quite dramatically. What is at issue, however, is the very embeddedness of the analysed structural causes in everyday life, which still constricts social, economic, cultural and governance opportunities for significant numbers of children, adolescents and women in the country.

To address these broad areas, it will again be necessary to highlight the importance of context-responsive strategies that are tailored specifically to local realities as well as to disparities among and within Bangladesh's regions, socioeconomic groups, and others. Support to programme sectors to strengthen Communication for Development (C4D) components can particularly assist in raising awareness, development of positive attitudes, behaviours and social norms among selected participant groups for sustainable development. In so doing, all this can help to ensure that the well-being of all children, adolescents and women in Bangladesh, particularly those from disadvantaged and vulnerable groups, is enhanced to the maximum.

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## ANNEX 1: LIST OF PERSONS INTERVIEWED

1. Dr. Mansoor Ahmed, Professor Emeritus, Institute of Educational Development BRAC University
2. Justice Md. Imman Ali, Justice of the Supreme Court
3. S.A. Abdullah Al Mamun, Programme Specialist (Urban), Field Operations Section, UNICEF Bangladesh
4. Roshni Basu, Gender and Development Specialist, UNICEF Bangladesh
5. Edouard Beigbeder, Representative, UNICEF Bangladesh
6. Amy Delneuville, Child Protection Specialist, UNICEF Bangladesh
7. Omar Farooq, Head of Zone Office, Mymensingh, UNICEF Bangladesh
8. Government, NGO/civil society service providers and service recipients from unions under Islampur *Upazila*, Jamalpur
9. Government, NGO/civil society service providers and service recipients from Sahbajpur Union, Jamalpur Sadar *Upazila*, Jamalpur
10. Md. Shamiul Hasan, Project Coordinator, Education Project for the Children Living in the Slums, Association for Realisation of Basic Needs, ARBAN
11. Zahid Hussain, Lead Economist, Macroeconomic & Fiscal Management, World Bank Office, Bangladesh
12. Alexandra Illmer, Monitoring and Evaluation Specialist, UNICEF Bangladesh
13. Syeda Shima Islam, Chief, Communications, Advocacy and Partnerships, UNICEF Bangladesh
14. Md. Shahabuddin Khan, Deputy Commissioner, Jamalpur District
15. Hira Khanam, Programme Officer-P&M, Zone Office, Mymensingh, UNICEF Bangladesh
16. Shudhir Kumar, Superintending Engineer, Groundwater Circle, Department of Public Health Engineering
17. Lianne Kuppens, Chief, Health, UNICEF Bangladesh
18. Dr. Imtiaz Mahmud, Deputy Chief of Planning, Ministry of Primary and Mass Education
19. Anjana Mangalagiri, Chief, Education, UNICEF Bangladesh
20. Louise Mvono, Deputy Representative, UNICEF Bangladesh
21. Rose-Anne Papavero, Chief, Child Protection, UNICEF Bangladesh
22. Md. Masumur Rahaman, *Upazila Nirbahi* Officer (UNO), Islampur, Jamalpur
23. Shukhrat Rakhimjanov, Health Specialist, UNICEF Bangladesh
24. Andrew M. Sammy, Nutrition Specialist, UNICEF Bangladesh
25. Hrachya Sargsyan, Chief, Water, Sanitation and Hygiene (WASH), UNICEF Bangladesh
26. Dr. M. Ziya Uddin, HIV/AIDS Specialist, UNICEF Bangladesh
27. Nance Webber, Chief, Communication for Development (C4D), UNICEF Bangladesh

**ANNEX 2: CAPACITY AND ROLE PATTERN ANALYSIS MATRIX FOR UNICEF BANGLADESH SITUATION ANALYSIS – NUTRITION**

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Immediate Caregiver/Family/ Household</b>  (1) U5 Children (2) Pregnant and lactating women (3) Adolescent girl	<ul style="list-style-type: none"> <li>Mother, Caregivers/ family members to bring under five children to community level outreach centre and facility for nutrition intervention including counselling, GMP, nutrition screening etc.</li> <li>Family members to support/ accompany Pregnant, lactating women and adolescent girls for nutrition intervention including nutrition education and counselling and others</li> <li>Support or participate in awareness raising through BCC intervention (including promotion of growth monitoring, breast feeding and complementary feeding, impact of poor nutrition among children, adolescent, pregnant and lactating women).</li> </ul>	Yes but not fully <ul style="list-style-type: none"> <li>Limited utilization of services like SAM management, GMP by facility delivery because of HH food insecurity, inadequate maternal education and poor service seeking behaviours</li> <li>Challenges related to coverage of national programs are lower in known hard-to-reach areas, including the CHT, Southern districts and urban slum areas, which face significant bottlenecks in geographic accessibility</li> <li>Limited knowledge and practice related to effective coverage of nutrition specific interventions</li> <li>Large gaps between availability and utilization, as well as utilization and effective coverage that influences behavior (e.g. knowledge gaps, taboos).</li> <li>Availability of trained service providers for Nutrition is limited.</li> <li>Low status of women and adolescent that contributes to Child marriage and inequitable household access to food leading to an on-going intergenerational cycle of undernutrition.</li> </ul>	Yes, partially <ul style="list-style-type: none"> <li>Many women and adolescent have no authority take decision for visiting facilities for nutrition services.</li> <li>Family members are not always supportive.</li> </ul>	Yes, partially <ul style="list-style-type: none"> <li>Inadequate knowledge and practices for changing behaviour</li> </ul>

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> <b>Who</b> is supposed to do <b>what</b> to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Community</b> (please specify) <ol style="list-style-type: none"> <li>Government/ NGO health service providers :GoB /NGO frontline workers</li> <li>Community support groups: Community Clinic Support Group and Community Group</li> </ol>	<ol style="list-style-type: none"> <li>Facility based nutrition intervention</li> <li>Community based approach</li> </ol>	Yes, they do accept the responsibility but the job description and role function regarding nutrition is not clearly understood by them. <ul style="list-style-type: none"> <li>Inadequate attention is paid for nutrition BCC activity and counselling because of inadequate capacity and skills for nutrition intervention.</li> <li>Insufficient supervision and monitoring along with site level mentoring is absent for helping frontline workers to better perform job. And relatively poor accountability at all level.</li> </ul>	Yes, partially as they are not adequately capacitated for performing their job function <ul style="list-style-type: none"> <li>National and local level stewardship and coordinated mechanism among DG- Health, IPHN and DG- FP to support field implementation</li> </ul>	<ol style="list-style-type: none"> <li>Yes, partially.</li> <li>Inadequate knowledge and skills among GOB health service providers and community support groups for implementation of full sets of direct nutrition intervention.</li> <li>No provision for on the job training under the monitoring mechanism.</li> <li>Limited knowledge on reporting, analysis and interpretation.                             <ul style="list-style-type: none"> <li>Poor screening and referral SAM, MAM from community level.</li> </ul> </li> </ol>
<b>Sub-National Level:</b> <ol style="list-style-type: none"> <li><b>Local Government</b>                              (please specify)                             <ol style="list-style-type: none"> <li>Public representatives                                     <ul style="list-style-type: none"> <li>Upazila Parishad</li> <li>Union Parishad chairman, members</li> </ul> </li> </ol> </li> </ol>	Ensure supporting environment / advocacy/ monitoring	Yet not established a uniform system to institutionalize and no local accountability. It depends in individual interest and motivation.		<ol style="list-style-type: none"> <li>Public representatives do not have adequate awareness about their job function and role. There is no such structured system in place.</li> </ol>

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<p><b>b. Local Service Providers</b> (please specify)</p> <p>At division, district and upazila level:</p> <ul style="list-style-type: none"> <li>• First line and second line supervisors, Managers</li> <li>• Facility service providers (primary, secondary and tertiary service facilities)</li> </ul>	<p>Yes, partially Local GoB authority/managers need to focus on establishing a strong mechanism for</p> <ul style="list-style-type: none"> <li>• District and sub district level planning, implementation and monitoring the progress and corrective action</li> <li>• Coordination at district and below among MOHFW</li> <li>• Coordination with other sectors (GOB and NGO program)</li> <li>• Program and operation management (HR, supplies)</li> <li>• Advocacy and awareness</li> </ul>	<p>Yes, the duty bearers have the authority to implement and monitor the national program according to the operational plan of NNS/IPHN, MOHFW for mainstreaming nutrition.</p>	<p>Yes, with a limited authority for decentralized planning and budget allocation for implementation of national nutrition services.</p>	<p>Yes, with some limitations to overcome.</p> <p>6. Many job position remains vacant.</p> <p>7. Limited knowledge and skill to SAM, MAM screening and management and other nutrition specific interventions</p> <ul style="list-style-type: none"> <li>• Limited resources particularly based on HR and supply gap.</li> <li>• Knowledge and skill on using information for decisions, planning, follow up and corrective actions is inadequate.</li> </ul>

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>National Government</b> (please specify) <ul style="list-style-type: none"> <li>• MoH&amp;FW</li> <li>• DGHS and DGFP</li> <li>• Line Director, NNS/IPHN and within DGHS and DGFP</li> </ul>	<ul style="list-style-type: none"> <li>• Policy and strategy formulation</li> <li>• Planning and budgeting</li> <li>• Capacity building</li> <li>• coordination with donors/partners</li> <li>• Logistic support</li> <li>• Monitoring and evaluation</li> <li>• Advocacy</li> <li>• Governance/ Accountability</li> </ul>	yes	yes	Yes, <ul style="list-style-type: none"> <li>• Nutrition is a low priority in the political economy and public health budgeting.</li> <li>• Weak coordination between sectors which is fragmented and heavily centralized. Coordination and harmonization between Line Directors is a challenge</li> <li>• Limited resources and capacity for supportive supervision/ monitoring.</li> <li>• Variable program design and coverage by different implementing stakeholders.</li> <li>• Inadequate and unskilled human resources quality nutrition intervention with supportive supervision</li> <li>• No coordination between local government budget and NNS budget planning at local level.</li> <li>• Inadequate multi-sectoral coordination for nutrition sensitive interventions</li> <li>• Inadequate investment on addressing demand side behaviors through SBCC and strengthening community outreach for nutrition in Health and relevant sectors.</li> <li>• Responsive plan with better understanding social status of women and adolescent girls, and child marriage issues.</li> <li>• Coordinated effort with WASH sector on changing hygiene and sanitary behaviors for impact on nutrition</li> <li>• Weak implementation of laws in relation to nutrition.</li> <li>• Insufficient data and program to address low birth weight.</li> </ul>



<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> <b>Who</b> is supposed to do <b>what</b> to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>International Partners</b> (please specify)  Donors/ DPs in interest for Nutrition program  International NGOs  Private Sector  UN agencies	<ul style="list-style-type: none"> <li>Coordination among DPs, UN agencies for addressing national needs and priority and support to implement national operational plan and test innovation for national replication</li> <li>A systematic coordination and review for better understanding DP's Interest to match with national program priority.</li> </ul>	Yes	yes	Yes, partially  Evidence/ need based allocation and prioritization is a challenge.

### ANNEX 3: CAPACITY AND ROLE PATTERN ANALYSIS MATRIX FOR UNICEF BANGLADESH SITUATION ANALYSIS – HEALTH

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Immediate Caregiver/Family/ Household</b>	1. Caregivers/ family members to bring <ul style="list-style-type: none"> <li>• child to vaccination centre and health facilities</li> </ul> 2. family members to bring pregnant women for TT vaccination, ANC, delivery care, PNC                     3. Support awareness raising on- <ul style="list-style-type: none"> <li>• Danger signs for newborn and pregnant women</li> </ul>	1. Yes 2. Limited compliance for delivery by SBA, ANC, PNC/ ENC, Facility delivery <b>Reason:</b> HTR area – challenge to access the services, quality of care, benefit of ANC/PNC/ENC not well understood by users/ family 3. Limited knowledge and practice: <b>Reason:</b> Poor counselling and relative illiteracy to understand the messages of BCC materials	1. Yes 2. and 3: Not fully Many women have no authority take decision for ANC/PNC, safe birth planning. Family members, with decision making capacity, are not supportive to avail services (gender issue). Behavioural practice depends on SES and literacy level	1. Yes 2. Inadequate knowledge and awareness on good practices and it's benefits. No continuity of good practices Limited social protection to avail quality health services (Out of pocket expenditure is high)
<b>Community</b> (please specify) <ol style="list-style-type: none"> <li>1. Government/ NGO health service providers</li> <li>2. Community support groups:                             <ul style="list-style-type: none"> <li>• Religious leaders</li> <li>• Women representatives</li> </ul> </li> </ol>	1. Preventive and curative service delivery 2. Community awareness and practices	1. Yes, they do accept the responsibility officially. However physical presence at local level is a challenge because of relatively poor accountability (lack of supervision/ monitoring) mechanism.	1. Yes 2. Yes	1. Yes, GOB/NGO health service providers have the knowledge and skills for immunization. But inadequate skill for newborn care because they are not utilizing the knowledge regularly. Limited resources (HR, finance) to apply their role. 2. Limited knowledge and skill to practice it.

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Sub-National Level:</b> <b>a. Local Government</b> (please specify) <ol style="list-style-type: none"> <li>Public representatives                             <ul style="list-style-type: none"> <li>Upazila Parishad</li> <li>Union Parishad chairman, members</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>Ensure supporting environment / advocacy/ monitoring</li> </ol>	<ol style="list-style-type: none"> <li>The responsibility depends on the individual motivation, not in general representation of all public representatives. Yet to be institutionalised it.</li> </ol>	<ol style="list-style-type: none"> <li>Yes</li> </ol>	<ol style="list-style-type: none"> <li>Public representatives do not have required knowledge and skill to practice it.</li> <li>No coordination between local government health budget and MoH&amp;FW health budget planning at local level.</li> </ol>
<b>2. Local Service Providers</b> (please specify) <p>At division, district and upazila level:</p> <ul style="list-style-type: none"> <li>Health Managers</li> <li>Clinical service providers</li> </ul>	<ul style="list-style-type: none"> <li>District and sub district level planning, implement and monitor the progress/ performance</li> <li>Program and operation management (HR, supplies and district budget plan)</li> <li>Advocacy and awareness, coordination with other sectors (GOB and NGO program)</li> </ul>	Yes, the duty bearers have the authority to implement and monitor national program.	Yes for implementation of national program. However, limited authority for decentralized planning and budget allocation.	Limited resources particularly the HR gap. Knowledge and skill on using information for planning and corrective actions is inadequate.

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> <b>Who</b> is supposed to do <b>what</b> to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>National Government</b> (please specify) <ul style="list-style-type: none"> <li>• MoH&amp;FW</li> <li>• DGHS and DGFP</li> <li>• Line Directors within DGHS and DGFP</li> </ul>	<ul style="list-style-type: none"> <li>• Policy and strategy formulation</li> <li>• Planning and budgeting</li> <li>• Capacity building</li> <li>• Logistic support</li> <li>• Monitoring and evaluation</li> <li>• Advocacy and coordination with donors/ partners</li> <li>• Governance/ Accountability</li> </ul>	Yes	Yes	Required resources are available, however the challenge is efficient and equitable allocation/ utilization of resources (HR, supplies, and finance). Application of knowledge for evidence based and with efficient budget planning is a challenge. Coordination and harmonization between DGFP and DGHS, and between Line Directors is a challenge. Governance and leadership
<b>International Partners</b> (please specify) Donors/ DPs in interest for Health program International NGOs Private Sector UN agencies	Priority on donor interest/ objective rather on country's actual need. Not fully coordinated among DPs. Sometimes it is in competitive nature rather coordinated efforts for complementarity.	Not fully.	Yes	Efficient evidence/ need based allocation and prioritization is a challenge. Organizational objectives gets priority.

**ANNEX 4: CAPACITY AND ROLE PATTERN ANALYSIS MATRIX FOR UNICEF BANGLADESH SITUATION ANALYSIS – WASH**

<p><b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)</p>	<p><b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?</p>	<p><b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?</p>	<p><b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?</p>	<p><b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?</p>
<p><b>Immediate Caregiver/Family/ Household</b> (1) <b>Mother</b> (2) <b>U5 Child Caregiver</b> (3) <b>Adolescence girl</b> (4) <b>Household Head</b></p>	<p><b>WATER</b> (1)(2) Water collection, Household water storage  (4) Ensure water source for household, Ensure water quality (WQ)</p> <p><b>SANITATION</b> (1)(2) Latrine cleanliness, ensure water at latrine, hand washing soap/ash for hand washing after latrine use, child faces disposal  (4) Construction of latrine, household Solid waste management,</p> <p><b>HYGIENE PRACTICE</b> (1)(2) ensure child hygiene, educate child on personal hygiene, ensure household hygienic environment (1)(2)(3)(4) practice personal hygiene  (4) ensure hand washing and personal hygiene material available (1)(2)(3) practice menstrual hygiene</p>	<p><b>WATER</b> Duty bearer don't accept the responsibilities of water quality  <b>Reason :</b> (1) Lack of low cost water quality testing facilities  (2) Lack of knowledge about WQ impact on health and nutrition  (3) Depend on Government initiatives  <b>SANITATION:</b> (1) Treat Sanitation as a secondary needs of life  (2) Lack of technology and system for solid waste management  <b>HYGIENE PRACTICE</b> (1) Lack of understanding of Value for money for hygiene practice</p>	<p>Yes all duty bearer have the authority to carry out the role except urban slum dweller. Urban slum dweller don't have the authority to install water options. Only City corporation WASA have that authority</p>	<p>Duty bearer have knowledge about safe water but they have insufficient skill on water source repairing and water quality testing. Duty bearer don't have alternative and low cost technology options for lowering water table area, salinity prone area, high arsenic contaminated area. Duty bearer have knowledge on latrine use but don't have sufficient knowledge on improved/unimproved latrine. Duty bearer don't have alternative sanitation technology at haorr and disaster prone area. Duty bearer have sufficient knowledge on hygiene practice but don't have sufficient low cost household level hand washing technologies.</p>



<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Community</b> (please specify) (1) Water user group (2) Community latrine user group (3) WATSAN Committee (4) School Management Committee (5) Community Health promotor	Duty bearer (1) and (3) is responsible for water points/supply operation and maintenance, water quality issue and water accessibility. Duty bearer (2) and (3) is responsible for community latrine operation and maintenance, cleanliness, solid waste management Duty bearer (4) is responsible for school water and sanitation facilities Duty bearer (5) is responsible for community level health and hygiene related issues	Yes all duty bearer accept their responsibilities. Only duty bearer (5) is more focus on health issue and less focus on hygiene promotion.	Yes all duty bearer have to authority to carry their role	All duty bearer have knowledge but have partial skill on water quality issue, latrine structure and necessary fund and mechanism for operation and maintenance
<b>Sub-National Level:</b> <b>a. Local Government</b> (please specify) (1) Local Government Institute (Union Parisad) (2) Department of Public Health Engineering (DPHE) (3) Department of Primary Education (4) Department of Secondary Education (5) Department of Health (6) Hill Development Board (HDC) (7) Municipality	Duty bearer (1) is responsible to allocate 20% ADP <sup>1</sup> for sanitation at union <sup>2</sup> level, advocate for WATSAN facilities, responsible for open defecation free community Duty bearer (2) is responsible for water and sanitation technology implementation, water quality screening Duty bearer (3)(4) is responsible for WASH in School Duty bearer (5) is responsible for personal hygiene Duty Bearer (6) is a special type of duty bearer. Who are focus for Chittagong Hill track development Duty Bearer (7) is the authority for small town	All duty bearers are accept their responsibilities	All duty bearer have the authority to implement activities but have insufficient authority for planning and leverage financial resource	All duty bearer have knowledge, skill but have insufficient human resource, technical solution, lack of operation and monitoring funding. Also, inter organizational coordination is a major issue.

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>b. Local Service Providers</b> (please specify)  (8) WATSAN entrepreneur (9) Plumber (10) NGO	Duty bearer (1) ensure water and sanitation products available at local market Duty bearer (2) ensure construct Water and Sanitation facilities at local area Duty Bearer (3) ensure water, sanitation, hygiene related enabling environment at local management	All duty bearer accept the water, sanitation and hygiene product installation, supply and after sale service but no one accept the responsibilities of water quality issue, solid waste management.	Yes, all duty bearer have the authority to carry forward their roles	Duty bearer have the knowledge and skill. But there are shortage of low cost WATSAN technology, limited R&D initiative for alternative technology for lowering water table, deal with water quality issues, gender sensitive and disable focus sanitation products, hygiene products and climate resilience technologies.
<b>National Government</b> (please specify)  (1) 5 Ministry (Local Government, Education, Health, Disaster and Water resource ) (2) Government Line Agencies (DPHE, DPE, DHSE, DG-Health, PSU, WASA)	Duty bearer (1) approve and endorse WATASN related rules, regulation and policies. Inter Ministry coordination. Approve Government projects and Budget. Duty Bearers (2) are responsible for implement national projects, field mobilization, financial authority, sector coordination, section rules, regulation, and policy development. Took Sector R&D initiative and develop O&M mechanism. Duty Bearers (2) ensure sector information management, dissemination and support sector for planning. Also they are responsible for ensure water quality	All duty bearer accept the responsibilities	All duty bearer have to authority to deal their work	All duty bearer have knowledge, skill but they have funding gap for sector research and development, operation and maintenance funding mechanism. Also have insufficient initiative to disseminate sector rules, regulation and policy to local level. There are lot of ambiguity on duty bearer roles after service delivery. Duty bearers are unable to ensure separate WASH budget line at National Budget.

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>International Partners</b> (please specify) (1) UN Agency (2) Bi-lateral Agency	Duty bearer (1) is responsible for government and sector's technical capacity development Duty bearer (2) is responsible to fill sector funding gap as needed	Both duty bearer accept their responsibilities	Both duty bearer have the authority to carry out their role	Duty bearers have the knowledge, skill and material. Missing is sector funding on water quality monitoring, extensive research, information knowledge management.

**ANNEX 5: CAPACITY AND ROLE PATTERN ANALYSIS MATRIX FOR UNICEF BANGLADESH SITUATION ANALYSIS – HIV AND AIDS**

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Immediate Caregiver/Family/ Household</b>	<ul style="list-style-type: none"> <li>Parents seeking info and services for HIV and AIDS</li> <li>Parents providing information on HIV and AIDS prevention</li> <li>Parents facilitating service access and utilization by children and adolescent</li> <li>Parents ensured that they on ART regularly</li> <li>Parents ensuring ART for infected children</li> </ul>	<ul style="list-style-type: none"> <li>If easily accessible, ready to accept</li> <li>Due to social taboo, feel shy to communicate on the issues of sexuality and drug use.</li> <li>Parents are not aware that they need to facilitate services for children and adolescent</li> <li>Not aware the impact of irregularity of ART</li> <li>Parents motivated to ensured.</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Yes</li> <li>Yes</li> <li>Yes</li> <li>Parents motivated to ensure.</li> </ul>	<ul style="list-style-type: none"> <li>Not enough information available.</li> <li>Parents do have the skill to communicate with children and adolescent on sensitive issues like sexuality, drug use etc.</li> <li>Service information not available, also social norm hinders promotion of HIV and SRH health</li> <li>Not enough info on ART retention and inadequate follow up by care workers</li> <li>Parents ensuring ART for infected children</li> </ul>
<b>Community</b> (local neighbourhood, member of sub population / network)	<ul style="list-style-type: none"> <li>Proactively receive info on HIV and AIDS</li> <li>Dissemination of HIV and AIDS info</li> <li>Creating enabling environment</li> <li>Facilitating local service centres to provide HIV and AIDS services</li> <li>Cost sharing with service providers</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Sometimes, not very proactively</li> <li>Partly, social norm and taboos influence them against working for enabling environment</li> <li>Partly</li> <li>Ready for cost sharing in specific areas</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Yes</li> <li>Yes</li> <li>Yes</li> <li>Yes</li> </ul>	<ul style="list-style-type: none"> <li>Info and materials not available adequately</li> <li>Specific activity not present to engage them</li> <li>Knowledge and skill, resources are not available</li> <li>Social mobilization activities are not present</li> <li>Structured cost structure absent</li> </ul>

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> <b>Who</b> is supposed to do <b>what</b> to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Sub-National Level:</b> <b>a. Local Government</b> (please specify)	<ul style="list-style-type: none"> <li>Elected local representative provide leadership to guide HIV and AIDS activities</li> <li>Provide local resource; space, structure, fund allocation to HIV and AIDS service providers</li> <li>Provide leadership in creating enabling</li> </ul>	<ul style="list-style-type: none"> <li>Not adequately trained on HIV and AIDS activities</li> <li>Not motivated to use scare resource for HIV and AIDS</li> <li>Understanding of role not clear</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> <li>Yes</li> <li>Yes</li> </ul>	<ul style="list-style-type: none"> <li>Not adequately trained on their role on HIV and AIDS activities</li> <li>Local allocated resources not available</li> <li>Not adequately trained on their role</li> </ul>
<b>b. Local Service Providers</b> (please specify)	<ul style="list-style-type: none"> <li>Uninterrupted NGO and local Govt. agencies provide services in an friendly environment</li> <li>Regular follow up to maintain adequate coverage</li> <li>Ensure quality of the services</li> </ul>	<ul style="list-style-type: none"> <li>Basic capacities are present</li> <li>Need updating of knowledge and skills</li> </ul>	<ul style="list-style-type: none"> <li>Required authorities are present</li> </ul>	<ul style="list-style-type: none"> <li>Frequent interruption of funding</li> <li>Due to inadequate resource materials are not updated</li> </ul>
<b>National Government</b> (please specify)	<ul style="list-style-type: none"> <li>Provide leadership, coordination and arrange funding</li> <li>Ensure adequate monitoring and quality</li> <li>Organize policy and capacity building initiatives</li> </ul>	<ul style="list-style-type: none"> <li>National HIV/AIDS wings works as adhoc basis</li> <li>Organization is not adequately staffed and capacity is not enough.</li> <li>Funding not regular</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> </ul>	<ul style="list-style-type: none"> <li>Not adequate capacity of programme management, coordination and leadership</li> <li>Staff not adequate</li> <li>Funding irregular</li> </ul>
<b>International Partners</b> (please specify)	<ul style="list-style-type: none"> <li>Provide technical leadership, organize transfer of technology</li> <li>Advocacy on key programme issues</li> <li>Coordination among the international agencies</li> <li>Organize financial support on key and emerging areas</li> </ul>	<ul style="list-style-type: none"> <li>Reduced priority on HIV and AIDS</li> <li>Enough funding not available</li> <li>Coordination not regular</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> </ul>	<ul style="list-style-type: none"> <li>Knowledge and Skills available</li> <li>Funding situation poor</li> <li>Adequate manpower not available</li> </ul>



## ANNEX 6: CAPACITY AND ROLE PATTERN ANALYSIS MATRIX FOR UNICEF BANGLADESH SITUATION ANALYSIS – EDUCATION

<p><b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)</p>	<p><b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?</p>	<p><b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?</p>	<p><b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?</p>	<p><b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?</p>
<p><b>Immediate Household</b></p> <p><b>a) ECD</b></p> <ul style="list-style-type: none"> <li>Inadequate understanding of the child rearing and child development, especially the importance of early stimulation and learning</li> </ul> <p><b>b) NFE/SCF</b></p> <p>Dropout from school and the issue of opportunity cost of education</p> <p><b>c) Primary Education</b></p> <ul style="list-style-type: none"> <li>Social norms and practices (e.g. child marriage, child labour and others)</li> <li>Inadequate information on the importance and value of education</li> <li>Lack of resources to support the education of their children</li> </ul> <p><b>d) Secondary education:</b></p> <ul style="list-style-type: none"> <li>Social norms and practices (e.g.: child marriage, child labour etc.)</li> <li>Inadequate information on the importance and value of education</li> <li>Unequal distribution of family expenses: Preference for boys' education because girls will be married off</li> <li>Engaging girls in family chores/ taking care of siblings etc.</li> <li>Engaging boys in crop fields/ income-generating activities</li> <li>Separate toilets for girls and boys</li> </ul>	<ul style="list-style-type: none"> <li>Responsive feeding by parents especially by the mothers</li> <li>Spending quality time with the children</li> <li>Preparing the children for schools</li> <li>Sending the children to nearest preschools</li> <li>Parents needs to keep their children in schools until they complete basic education/ primary education</li> <li>Children need to be followed up in their learning difficulties</li> <li>Government: to conduct social mobilization and communication for development to address social norms and practices including issues on gender, child labour and children with disability</li> <li>Government and other stakeholders to orient parents/families/households on importance of education</li> <li>Parents to enrol all their children in school</li> <li>Government: to conduct social mobilization and communication for development to address social norms and practices including issues on gender, child marriage, child labour, value of education etc.</li> <li>Government and other stakeholders to orient parents/families/households on importance of education</li> <li>Massive awareness programmes for adolescents through leadership training to build respect for each other and prepare to be engaged in productive activities</li> <li>Creating scope in the areas of sports, creative and extra-curricular activities, engage adolescents in social media through ICT training etc.</li> <li>Establish wash blocks for girls and boys</li> </ul>	<ul style="list-style-type: none"> <li>As the first DB is the family, parents/caregivers have to perform these duties but due to ignorance and cultural beliefs they always do not perform these</li> <li>Poorest families cannot afford sending the children who are grown up (8-14) especially for livelihood reasons.</li> <li>Children need to pool resource for their family income. Private expenditure of education is also high for them to afford.</li> <li>Yes, although there are some limitations on the part of the government to address sensitive issues around social norms and practices</li> <li>Parents/families/ households accept the responsibility, but may require support to carry out their responsibilities due to lack of knowledge/ awareness of the importance of education, the impact of negative social norms and practices, and also due to poverty/economic costs associated with schooling</li> <li>The GOB itself is promoting to reduce legal age for girls from 18 years to 16 years. This has created a tension amongst all the stakeholders;</li> <li>Parents/families/ households accept the responsibility, but may require support to carry out their responsibilities due to lack of knowledge/ awareness of the importance of education, the impact of negative social norms and practices, and also due to poverty/economic costs associated with schooling</li> <li>Same as above for ICT support, GOB is providing ICT support to all secondary schools through a national prioritized programme; schools has to demand for it</li> </ul>	<ul style="list-style-type: none"> <li>Yes, the parents as the first caregivers have the authority but in most of the cases, are dependent on the State subsidy</li> <li>Yes, the government needs the political will and determination</li> <li>Parents/families/ households have the authority to carry out the role regarding their children's education.</li> <li>Government can come in to encourage and support them</li> <li>GOB need to follow UN mandate as a signatory and show strong political will and determination</li> <li>Parents/families/ households have the authority to carry out the role regarding their children's education. GOB is encouraging and supporting them but it need more emphasis at national level;</li> <li>GOB is launching different programmes to encourage sports and school has the authority to motivate students to take these opportunities GOB is providing fund for wash blocks, schools have the authority to claim the fund and fix the wash blocks;</li> <li>Same as above for ICT support, GOB is providing ICT support to all secondary schools through a national prioritized programme; schools has to demand for it</li> </ul>	<ul style="list-style-type: none"> <li>Not always, especially the importance of early learning and stimulation, giving time to the children and helping the child to grow in a holistic way.</li> <li>Inadequate knowledge and information on the importance of the completion of Primary education Cycle limits their understanding. However, resource constraints are the main barriers especially the high cost of education materials.</li> <li>Not adequate, the government therefore may require capacity development in its efforts to provide education to all children.</li> <li>Inadequate knowledge, skills, and material resources, therefore parent/ families/ households need support to develop their capacity in order to carry out their role.</li> <li>Not adequate, the government therefore may require capacity development in its efforts to provide education to all children.</li> <li>Inadequate knowledge, skills, and material resources, therefore parent/ families/ households need support to develop their capacity in order to carry out their role.</li> </ul>

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<p><b>Community</b> (please specify)</p> <p><b>b) ECD</b></p> <p>c) Lack of understanding of the ECD imposed learning structure and values on the young children (religious education at this early age)</p> <p><b>e) NFE/SCE</b></p> <p>Community Learning System</p> <p><b>c) Primary Education</b></p> <p>d) Lack of knowledge and resources among communities to support the education of their children</p> <p><b>d) Secondary Education:</b></p> <ul style="list-style-type: none"> <li>Lack of knowledge and resources among communities to support the education of their children</li> <li>Gender based violence inside the school and on the way to school, especially for girls</li> </ul>	<ul style="list-style-type: none"> <li>Community structures, the social structure should pay attention to the development of the young children through organized play groups, fun and learning</li> <li>Community system to act in making the balance between children needs and response with the imposed pattern of early education</li> <li>Community should have a system for NFE/SCE provision for the never enrolled or dropout children</li> <li>Support mechanism to the school dropouts</li> <li>Communities to initiate social protection mechanisms that support the education of all children</li> <li>Communities to be actively engaged in school management including mobilizing parents to enrol all school-age children</li> <li>Communities to be actively engaged in school management including mobilizing parents to enrol all school-age children</li> <li>Communities to initiate social protection mechanisms that support the education of all children</li> <li>Each school to form a committee comprising members from SMC, HTs and parents to safe guard the students and work jointly to initiate protection mechanism for all students;</li> <li>School authority and parents/community people work jointly to find ways for common transportation to provide security for girls and boys as appropriate;</li> </ul>	<ul style="list-style-type: none"> <li>Community leaders (social, religious) do not accept the role because of lack in understanding of the child development</li> <li>Community emphasize on the importance of social norms, values and religious education (Maktab education/ temple education) instead of early learning or school preparedness for the children</li> <li>The DBs accept this role but from the sense of religious obligation (establishment of orphanage for example)</li> <li>Organizing the alternative learning system for the school dropouts by the communities except any NGO or government run project is rare</li> <li>Yes, but communities may require knowledge to guide them</li> <li>Yes, but communities may require support knowledge to guide them</li> <li>All the stakeholders (GO-NGO) collaboration is required to develop guidelines for the community people, parents and school authority to work together in these areas</li> </ul>	<ul style="list-style-type: none"> <li>Yes, the community can organize the early learning in collaboration with the other DBs such as Local Government</li> <li>Community can transform the religious education with early literacy and numeracy in the current structure</li> <li>The community can initiate, run with local resources but the entire system to run they need government assistance (the local government, education department, private sector)</li> <li>Communities have authority and can mobilize people to set up mechanisms.</li> <li>Communities have authority and can mobilize school and people to set up mechanisms with the leadership of school authority</li> </ul>	<ul style="list-style-type: none"> <li>Community can mobilize resource but lacks the materials such as age appropriate learning materials, trained caregivers/teachers/supervisors</li> <li>Communities have the knowledge of learning centre organization, local resource mobilization but lack the efficiency in management, educational materials, supervision, training and monitoring resources.</li> <li>Inadequate capacity: communities require capacity building and development to fulfil their role. They need knowledge, skills, and material resources for their active involvement in the enrolment all children including those with disabilities, and setting up community support mechanisms for disadvantaged children</li> <li>All the stakeholders (GO-NGO) need to collaborate to develop guidelines for the community people, parents and school authority to work together to take care of gender-based violence</li> <li>They need knowledge, skills, and material resources for their active involvement</li> </ul>

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>Sub-National Level:</b> <b>h. Local Government</b> (please specify) a) ECD Lack of coordination	<ul style="list-style-type: none"> <li>Local BSA and DPE to coordinate all ECD related activities at the field level</li> <li>Facilitating the children's access to ECD service</li> </ul>	<ul style="list-style-type: none"> <li>As per government policy and provisions, these are obligatory role of the local government system</li> </ul>	<ul style="list-style-type: none"> <li>Yes they have as per policy (ECD policy, PPE provision)</li> </ul>	<ul style="list-style-type: none"> <li>Lack knowledge and skills</li> <li>Lack trained HR and adequate financial resource</li> <li>Clear political stand is missing</li> </ul>
b) NFE/SCE Lack of proactive initiative for NFE	<ul style="list-style-type: none"> <li>As per LG government act and provisions, the Union Parishads, municipalities, pourashavas and city corporations have the responsibility to educate the children</li> </ul>	<ul style="list-style-type: none"> <li>Though the LG have to accept but different limitations are there. It depends on the leadership at that level and varies case to case.</li> </ul>	<ul style="list-style-type: none"> <li>Yes, there is authority (standing committee on education) but due to unclear decentralization structure and delegation of authority, it cannot be performed in true sense</li> <li>Yes they have authority through devolution of power</li> </ul>	<ul style="list-style-type: none"> <li>Lacks knowledge and skills</li> <li>Lack of trained HR and Financial resources</li> </ul>
<b>a) Primary Education</b> <ul style="list-style-type: none"> <li>Mechanisms for effective planning and monitoring of provision of education services</li> <li>Coordination of provision of education services</li> </ul>	<ul style="list-style-type: none"> <li>Central level to facilitate capacity for effective planning and provision of education services and monitoring at local government level: Divisional and Upazilla.</li> <li>Central level to facilitate coordination of provision of education services at local level and local government level to strengthen coordination</li> </ul>	<ul style="list-style-type: none"> <li>Yes, however, local government level may need support to carry out their role</li> <li>Yes, with support from central level</li> </ul>	<ul style="list-style-type: none"> <li>Yes, in a decentralized system</li> <li>They have authority through delegation of power</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate capacity: they need more knowledge, skills, organizational – making local structures function effectively including local EMIS, and material resources to carry out their role.</li> <li>Not adequate – may need capacity to achieve effective coordination mechanism.</li> </ul>
<b>d) Secondary education:</b> <ul style="list-style-type: none"> <li>Lack of mechanisms for effective planning and monitoring of provision of education services</li> <li>Lack of coordination of provision of education services</li> </ul>	<ul style="list-style-type: none"> <li>Central level to facilitate capacity for effective planning and provision of education services and monitoring at local government level: Divisional and Upazilla.</li> <li>Central level to facilitate coordination of provision of education services at local level and local government level to strengthen coordination</li> </ul>	<ul style="list-style-type: none"> <li>Yes, however, upazilla education officers may need support to carry out their role from Central body</li> <li>Yes, with support from central level</li> </ul>	<ul style="list-style-type: none"> <li>They have authority in a decentralized system</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate capacity: they need more knowledge, skills, organizational – making local structures function effectively including school and upazilla level EMIS, and material resources to carry out their role.</li> <li>Not adequate –there is a need to enhance capacity at sub-national /local level to achieve effective coordination mechanism.</li> </ul>

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<b>i. Local Service Providers</b> (please specify) ECD & NFE Coordination and convergence	<ul style="list-style-type: none"> <li>The government, CSOs and the private sector agencies are mandated to provide services to the young children for ECD and NFE services to the unenrolled or dropped out children and they try to do within their limited capacity. However, coordination among the actors, coverage based on a baseline and geographic plan and monitoring of implementation remains un-coordinated.</li> </ul>	<ul style="list-style-type: none"> <li>Yes, all have accepted to perform their role as per approved policy (Education Policy 2010, NFE policy 2006 and NFE Act 2014)</li> </ul>	<ul style="list-style-type: none"> <li>Yes, they have within scope and specified by the policy and provisions (the GO-NGO collaboration guidelines for example for PPE)</li> </ul>	<ul style="list-style-type: none"> <li>The service providers have experience and knowledge but they need resource sharing from the government.</li> </ul>
<b>c) Primary Education</b> <ul style="list-style-type: none"> <li>Linking planning at Upazila and school level</li> </ul>	<ul style="list-style-type: none"> <li>Upazila Education office to facilitate linkage between upazila primary education plans (UPEP) and school level improvement plans (SLIP).</li> </ul>	<ul style="list-style-type: none"> <li>Yes within their mandate</li> </ul>	<ul style="list-style-type: none"> <li>Yes they have the authority</li> </ul>	<ul style="list-style-type: none"> <li>Yes, but not adequate – capacity development is required.</li> </ul>
<ul style="list-style-type: none"> <li>Coordination of provision of education services by private providers at Upazila level.</li> </ul>	<ul style="list-style-type: none"> <li>Upazila Education Officers to be involved in coordination and maintaining of local database on education providers within the Upazila</li> </ul>	<ul style="list-style-type: none"> <li>Yes – may require support and encouragement to achieve this role.</li> </ul>	<ul style="list-style-type: none"> <li>Yes, to some extent they do, but may require support of central level government</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate capacity – require developing their capacity</li> </ul>
<b>d) Secondary Education:</b> <ul style="list-style-type: none"> <li>Coordination of planning at Upazila and school level</li> </ul>	<ul style="list-style-type: none"> <li>Upazila Secondary Education Officers are already involved in coordination and maintaining of local database on secondary education providers within the Upazila but need to reinforce this</li> </ul>	<ul style="list-style-type: none"> <li>Yes within their mandate but maybe there is a need to reiterate the issues at sub-national level</li> </ul>	<ul style="list-style-type: none"> <li>Yes, they have the authority</li> </ul>	<ul style="list-style-type: none"> <li>Yes, but not adequate – capacity development is required.</li> </ul>
<ul style="list-style-type: none"> <li>Coordination of provision of education services by private sector providers at Upazila level.</li> </ul>		<ul style="list-style-type: none"> <li>Yes – they require support and reinforcement from central body to achieve this role.</li> </ul>	<ul style="list-style-type: none"> <li>Yes, to some extent they do, but may require support of central level government</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate capacity – require developing their capacity</li> </ul>

<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<p><b>National Government</b> (please specify)</p> <p><b>a) ECD</b></p> <ul style="list-style-type: none"> <li>Strategic planning and promotion</li> <li>Resource for promotion of ECD</li> <li>Human resource development</li> <li>National coordination mechanism</li> </ul> <p><b>b) NFE/SCE</b></p> <ul style="list-style-type: none"> <li>National strategic direction and ownership</li> <li>Coordination among NFE providers</li> <li>Equivalency framework between formal and non-formal education</li> <li>Institutional deficiency for technical/vocational education in the informal sector</li> </ul> <p><b>c) Primary Education</b></p> <ul style="list-style-type: none"> <li>Management and monitoring structures</li> <li>Technical assistance (TA) strategies for ensuring institutional capacity development</li> <li>Coordination mechanism</li> <li>Bottlenecks in coverage and service delivery</li> <li>Assessment of children's competencies / learning achievement</li> </ul> <p><b>d) Secondary Education:</b></p> <ul style="list-style-type: none"> <li>Converge amongst different streams of secondary education (mainstream, vocational and madrasa);</li> <li>Sector wide Approach (SWAp) and extend primary level following NEP ;</li> <li>Management and monitoring structures</li> </ul>	<ul style="list-style-type: none"> <li>The Mo/WCA, the MoPME, MoH&amp;FW, MoSW and others (16 ministries) are to perform their duties as per ECD policy 2013.</li> <li>The MoPME guided by the Bureau of Non-Formal Education (BNFE) was supposed to perform these responsibility in general</li> <li>Under a changed provision, DPE has to ensure SCE for 8-14 years of children under PEDP3</li> <li>National Skills Development Council(NSDC) to guide the skills development for skills development</li> <li>Government to develop an effective management and monitoring structures that support effective implementation of key interventions</li> <li>Government and development partners to put in places TA strategies that institutional capacity within the government</li> <li>Government to strengthen coordination mechanism in the provision of education services including training programmes</li> <li>Government, UNICEF and other DPs to engage collectively at national and sub-national levels for addressing bottlenecks in coverage and service delivery</li> <li>Government to ensure teachers' capacity in continuous assessment of children's competencies/learning achievement</li> <li>Government, DPs and UNICEF to engage collectively at national and sub-national levels to converge and provide service delivery through Secondary Education SWAp following National Education Policy (NEP) 2010</li> <li>Government to develop an effective management and monitoring structures that support effective implementation of key interventions</li> </ul>	<ul style="list-style-type: none"> <li>Yes, the ECD policy has clearly spelt out the nature and scope of the roles of concerned ministries and line departments for ECD but these are yet to take proper shape because of the absence of a) national plan of Action, b) directives form the highest level of the government, c) consensus in the government about resource allocation (priority) and d) inter-ministerial coordination</li> <li>Yes, they accept as per policy and acts (education policy, NFE policy, NSDP) but the roles are not that visible because of the weak institutional structure and lack of decision making</li> <li>Yes, but may need encouragement to take up the responsibility</li> <li>Yes, but an area that require institutional change</li> <li>Yes, this requires increased political will</li> <li>Yes, but government may require a lot of encouragement and support</li> <li>Yes, through adjustments to teacher training programmes</li> </ul> <p>Yes, but may these require:</p> <ol style="list-style-type: none"> <li>reinforcement from GOB to take up the responsibility;</li> <li>increased political commitment to bring in institutional changes;</li> <li>Continuous dialogue, discussion and planning etc. to be carried out amongst GOB, UN, DPs for collective actions;</li> </ol>	<p>Yes, as per approved ECD policy the authority is there</p> <p>Yes, there is authority but lack of decisions delays things. BNFE could not prove itself as competent authority and agency to oversee NFE/SCE implementation with it's guidance rather it wanted to implement by itself</p> <p>Yes, the government has the authority even to initiate changes within the existing structures</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes, the government has the authority even to initiate changes within the existing structures and increased political commitment and continuous dialogue, discussion and planning etc. to be carried out amongst GOB, UN, DPs for collective actions;</p>	<p>Lack adequate knowledge and skills, human resource and financial resource as well</p> <p>The DBs are struggling at this point in time to select a workable model for NFE, b) adopt the appropriate methodologies especially for NFE. C) creating a responsible division at DPE to oversee SCE implementation and ascertain the number of OoSC (database)</p> <ul style="list-style-type: none"> <li>Not adequate capacity; government requires institutional capacity development and knowledge, skills, human and material resources</li> <li>Capacity is inadequate; government requires capacity to effectively plan for TA support in order to realize institutional capacity</li> <li>Inadequate capacity; government requires capacity for systems strengthening</li> <li>Yes, but both national and sub-national levels will require capacity to engage in the bottleneck analysis</li> <li>Government requires support to develop capacity of teachers and its institutions to assess and monitor</li> <li>Not adequate capacity; government requires institutional capacity development and knowledge, skills, human and material resources</li> <li>Yes, but both national and sub-national levels will require capacity to engage in the bottleneck analysis</li> </ul>



<b>Duty Bearers</b> (as defined in relation to the issue at hand and the local situation)	<b>Role Pattern Analysis</b> Who is supposed to do what to help address the issues?	<b>Capacity Analysis: Motivation</b> Does the duty bearer accept the responsibility? If not, why not?	<b>Capacity Analysis: Authority</b> Does the duty bearer have the authority to carry out the role? If not, who does?	<b>Capacity Analysis: Resources</b> Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
<b>International Partners</b> (please specify)	<ul style="list-style-type: none"> <li>Development Partners to follow the ECD issue with cross ministries as regular task as they are involved with development projects/programmes supported by them</li> <li>Advocacy with the line ministries to boost up the government programmes in support of ECD</li> </ul>	<ul style="list-style-type: none"> <li>Not all the international partners are in line with and committed for ECD activities in Bangladesh</li> </ul>	<ul style="list-style-type: none"> <li>International agencies have the authority to decide on the thematic development and resourcing</li> </ul>	
<b>a) ECD</b> Commitment for ECD	<ul style="list-style-type: none"> <li>International partners have shrunk the resource channelled for NFE during the last 5 years.</li> <li>Large programs are absent in the country these days</li> </ul>	<ul style="list-style-type: none"> <li>International partners committed in the international forums, aid agreements</li> </ul>	<p>Yes.</p>	<ul style="list-style-type: none"> <li>Adequate resource for NFE/SCE</li> </ul>
<b>b) NFE/SCE</b> Shrinking the resource envelope for NFE	<ul style="list-style-type: none"> <li>DPs and government to work towards further strengthening sector coordination and increase government accountability</li> <li>DPs to pursue strategies that strengthen the provision of TA support to ensure government officials benefits from transfer of technical knowledge and skills</li> </ul>	<ul style="list-style-type: none"> <li>Yes, this responsibility is covered in the Joint Financial Arrangement</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> </ul>	<ul style="list-style-type: none"> <li>Yes – the capacity to achieve this exists</li> </ul>
<b>c) Primary Education</b> <ul style="list-style-type: none"> <li>Sector coordination</li> <li>Strategies for promoting national technical leadership</li> </ul>	<ul style="list-style-type: none"> <li>Government, DPs and UNICEF to engage collectively to establish Secondary Education SWAp following National Education Policy (NEP) 2010</li> <li>Government to take lead by engaging DPs to work towards formulation of sector coordination and increase government accountability</li> </ul>	<ul style="list-style-type: none"> <li>Yes – DPs have committed to this responsibility through the TA mapping and guidelines document</li> </ul>	<ul style="list-style-type: none"> <li>Yes</li> </ul>	<ul style="list-style-type: none"> <li>Yes, there is capacity</li> </ul>
<b>d) Secondary Education:</b> <ul style="list-style-type: none"> <li>Too many partners focus on primary and less for secondary education</li> <li>Sector wide Approach for secondary education</li> <li>Increased coordination amongst different relevant ministries (MOE, MOPME, MOWCA, Ministry of Health, Sports, Social Welfare etc) ;</li> <li>Increased coordination amongst different implementing agencies (NCTB, DSHE, MOE, TVET etc)</li> </ul>	<p>Yes, dialogue has been initiated to establish SWAp but may these require:</p> <ol style="list-style-type: none"> <li>reinforcement from GOB to take up the responsibility;</li> <li>increased political commitment to bring in institutional changes;</li> <li>Continuous dialogue, discussion and planning etc. to be carried out amongst GOB, UN, DPs for collective actions;</li> </ol>	<p>Yes, the government has the authority even to initiate changes within the existing structures with increased political commitment and continuous dialogue, discussion and planning etc. to be carried out amongst GOB, UN, DPs for collective actions;</p>	<ul style="list-style-type: none"> <li>Not adequate capacity; government requires institutional capacity development and knowledge, skills, human and material resources</li> <li>Yes, but both national and sub-national levels will require capacity to engage in the bottleneck analysis</li> </ul>	

**ANNEX 7: CAPACITY AND ROLE PATTERN ANALYSIS MATRIX FOR UNICEF BANGLADESH SITUATION ANALYSIS – CHILD PROTECTION**

Duty Bearers (as defined in relation to the issue at hand and the local situation)	Role Pattern Analysis Who is supposed to do what to help address the issues?	Capacity Analysis: Motivation Does the duty bearer accept the responsibility? If not, why not?	Capacity Analysis: Authority Does the duty bearer have the authority to carry out the role? If not, who does?	Capacity Analysis: Resources Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
Immediate Caregiver/ Family/Household	Families are the duty-bearers with the most immediate responsibilities for ensuring children's right to protection.	<p>Deep-rooted norms and traditions of patriarchy and subordination of girls and women make it difficult for girls to claim their rights and for mothers to ensure their children's protection. Families feel social pressure to maintain the image of their daughters' "purity" to the extent that some of them reject their daughters when they become victims of trafficking and/or sexual exploitation.</p> <p>Corporal punishment is considered as an educational and disciplinary measure supporting learning. Physical, verbal, humiliating and threatening forms of discipline or punishment are adult behaviours that children most dislike. However, many forms of child abuse are accepted in society and even by the children themselves.</p> <p>In fact, sexual abuse is under-reported by parents due to shame and limited belief in the efficiency of the system. Finally, children and families are not encouraged to report cases of sexual abuse as they will experience stigma if they do so, while the child, especially if a girl, will be perceived impure and immoral rather than victim. Through the stigmatisation and rejection of the abused girl representing a community "sanction", we should recognise harmful social norm as the root cause of under-reporting.</p>		<p>A number of factors challenge family capacities to fulfil their duties related to protection. Many live in poverty and have to make choices on the basis of immediate survival needs. Families often lack the knowledge and awareness needed for positive behavioural change.</p>

Duty Bearers (as defined in relation to the issue at hand and the local situation)	Role Pattern Analysis Who is supposed to do what to help address the issues?	Capacity Analysis: Motivation Does the duty bearer accept the responsibility? If not, why not?	Capacity Analysis: Authority Does the duty bearer have the authority to carry out the role? If not, who does?	Capacity Analysis: Resources Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
Community (please specify)	Communities have duties to mobilize for child protection within the community and to demand accountability when these rights are violated.	Communities are hampered in carrying out their duties by lack of awareness, adherence to social and cultural norms that are harmful to children and limited organizational capacity.		Different models of community committees are established to facilitate projects implementation at the local level and benefit from related capacity building. There is no systematic foundational training for these committees on child rights and the role they can play in enhancing enabling environment and access to services.
Sub-National Level: a. Local Government (please specify)	Social workers, probation officers, administrators, judiciary, police and others at the local level have the duty to ensure the delivery of appropriate services to socially disadvantaged and at-risk people, including children. Committees at various local levels, in particular Child Development Board at District and Upazilla levels, are responsible for facilitating access to services, monitoring and evaluating service delivery.			Local government institutions are constrained by their own lack of knowledge regarding children's rights, limited capacity, large and growing caseloads, low levels of resources in particular human resources (too many vacant positions) and coordination difficulties. Concerns about abuses by the police and their lack of responsiveness have been repeatedly reported. Each police station is supposed to have a trained woman-/ child-friendly police officer; however, most of the time there is no woman officer. In addition, training to police officers in charge of child desk is organized outside the police academy training curriculum and when one of them is affected to a new police station, there is no more capacity for child-friendly process.

Duty Bearers (as defined in relation to the issue at hand and the local situation)	Role Pattern Analysis Who is supposed to do what to help address the issues?	Capacity Analysis: Motivation Does the duty bearer accept the responsibility? If not, why not?	Capacity Analysis: Authority Does the duty bearer have the authority to carry out the role? If not, who does?	Capacity Analysis: Resources Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?
0. Local Service Providers (please specify)	National and international NGOs play a substantial role in supporting all aspects of children's right to protection in Bangladesh. They advocate for women's and children's rights and provide services. They also support adolescent clubs throughout the country that provide adolescents (especially girls) with opportunities to socialize, play games and sports, read books, learn life skills and raise their social awareness.		The delineation of the roles of NGOs vis-à-vis the Government in the provision of services is sometimes not well understood, leading to distrust between the Government and NGO sector, which hampers their effectiveness. Another constraint facing NGOs is their financial dependence on donor funds (and therefore on the priorities of donors).	Lack of coordination is resulting in scattered resources and low quality of services. At the local level, NGOs are not always fully qualified and at local level there are no institutions providing regular capacity building to community/professionals on child protection. Adolescent cluster and sub-clusters at local level started to address the issue strengthening coordination and supporting a local pool of trainers.
National Government (please specify)	The Government holds the ultimate responsibility for ensuring the rights of all citizens. It has the duty to provide legislation consistent with its international obligations, including the Convention on the Rights of the Child, and for ensuring enforcement of related laws and policies. The 1974 Children Act has been repealed by the newly enacted Children Act which came into force in August 2013. The 2013 Children Act recognizes a child as any person under the age of 18 years. It offers safeguards for children who come into contact with the law and protection for vulnerable children, including children without parental care. An amendment to the 2004 Birth and Death Registration Act was also adopted in 2013 establishing the Office of the Registrar General as the permanent government structure to oversee birth and death registrations.		Enforcement of the 2013 Act is slow, extensive dissemination and attribution of an exceptional budget for the next 5 years to ensure proper planning as well as the implementation of the legal reform required for its full enforcement.	The risk is that Children Act 2013 implementation will remain limited due to: (1) lack of dissemination and understanding of concerned professionals, (2) slow development of the rules, (3) unprepared system, low political will and resistance to undertake the child protection system needs reform: logistics, training, and budget.

<p>Duty Bearers (as defined in relation to the issue at hand and the local situation)</p>	<p>Role Pattern Analysis Who is supposed to do what to help address the issues?</p>	<p>Capacity Analysis: Motivation Does the duty bearer accept the responsibility? If not, why not?</p>	<p>Capacity Analysis: Authority Does the duty bearer have the authority to carry out the role? If not, who does?</p>	<p>Capacity Analysis: Resources Does the duty bearer have the knowledge, skills and organisational, human and material resources to carry out the role? What's missing?</p>
<p>International Partners (please specify)</p>	<p>Development partners have a responsibility to ensure the effectiveness, local relevance, and sustainability of the projects and programmes they support. UNICEF supports all areas of child protection in Bangladesh in collaboration with other development partners.</p>			





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