Acknowledgements

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Special thanks to Dr. Karen Dunn, who undertook the desk review, conducted the consultations, and produced the final report.
A critical moment has arrived in the history of Bangladesh—a time of abundant opportunities to strengthen the fulfillment of human rights, including children’s rights. A democratically elected Government came to office this year with a pledge to address a wide range of child rights issues and a commitment to the Millennium Development Goals (MDGs) and the Convention on the Rights of the Child (CRC). The Government is now preparing a Five Year Plan consistent with a long-term vision of economic growth, poverty reduction, and a more inclusive and equitable society. At the same time, the Government and its development partners are formulating new instruments for international support to Bangladesh’s development process, including a Joint Cooperation Strategy and a new United Nations Development Assistance Framework.

UNICEF has prepared the Situation Assessment and Analysis of Children and Women in Bangladesh 2009 with the intention of helping Bangladesh to take advantage of the opportunities at hand. As envisioned in the CRC and statements of the Commission on the Rights of the Child, UNICEF provides technical assistance in Bangladesh upon the request of the Government. This report contributes to the evidence base upon which UNICEF can provide such assistance. It has a broader purpose as well. With this report, we aim to stimulate policy dialogue around issues of children’s rights and we hope to provide useful input for related strategies and programmes of the Government, civil society organizations, and international development partners.

The Situation Assessment and Analysis reviews Bangladesh’s progress toward fulfilling children’s rights to education, health and nutrition, protection, safe water and sanitation, and participation. The report identifies poverty, food insecurity and malnutrition, population growth and urbanization, the quality of governance, social and cultural norms and values, and natural disasters as the basic (structural) factors influencing the realization of children’s rights. It highlights the rights of children with disabilities and the importance of child injury prevention and care as emerging areas of concern and opportunity. The recommendations of the report underscore the importance of child-centered policy development, capacity building, communication for development, and cooperation between the Government and civil society. Further inquiry is suggested in areas where gaps in current knowledge have emerged, such as child sexual abuse, the quality and quantity of private and NGO health services, and the barriers to behavior change in childbirth, neonatal and postnatal care, and water, sanitation, and hygiene practices.

In Bangladesh, as everywhere in the world, adults frequently observe that children are the future. Their opportunities for survival and development, the care and protection they receive, and their capacity to make choices and express themselves influence their lifetime contributions to society and the legacy that they transmit to future generations. Childhood and adolescence are, however, very short. Every week counts for a child. Children have no time to spare. Adults rarely perceive that the future of children has to be built now! The pursuit of a secure, productive, and just society requires a full understanding and acknowledgement of the child rights situation and the causes underlying it so that appropriate actions can be taken soon that will lead to a society with equal opportunities for all children. UNICEF offers the Situation Assessment and Analysis as a contribution to this pursuit in Bangladesh.

Carel de Rooy
Representative
UNICEF Bangladesh
September 2009
A young girl collects polythene bags and other recyclable materials from the street.
The Situation Assessment and Analysis of Children and Women in Bangladesh provides an overview of the situation regarding children’s rights to education, health and nutrition, protection from abuse and exploitation, participation, and water, sanitation, and hygiene. It identifies the immediate, underlying, and basic (or structural) factors influencing the realization or violation of children’s rights and analyzes the roles and capacities of duty bearers—those with responsibility for ensuring that children realize their rights. The principal frame of reference is the Convention on the Rights of the Child (CRC), which the Government of Bangladesh ratified in 1990.

CHILDREN’S RIGHTS IN BANGLADESH: THE CONTEXT

The overall context for children’s rights has legal, political, social, cultural, economic, demographic, and environmental dimensions. The Government is developing laws and policies with a view toward consistency with the CRC and Bangladesh’s other human rights commitments. At present, however, many of the rights guaranteed in international conventions are not yet supported with legislation, and some laws and policies contradict them. When appropriate laws and policies are in place, they are often poorly implemented and enforced.

The last national Household Income and Expenditure Survey, in 2005, found that about 40 per cent of Bangladeshi households were poor and more than one-quarter were extremely poor. Poverty is even more prevalent among the country’s 63 million children. In 2007-2008, two major floods, a devastating cyclone, and a spike in food prices exacerbated poverty and food insecurity for many people. The coping strategies of the poor included reducing food intake and health expenditures, withdrawing children from school, and taking on debt—all of which are likely to have lasting impacts. The indicators for primary and secondary education, health, and access to water, sanitation, and hygiene are highly correlated with wealth. Poverty and food insecurity leave children vulnerable to exploitation and separation from their parents and contribute to personal stress and social/family tensions, which can lead to abuse. Most of the children who reside in institutions, live on the street, and engage in hazardous work are from poor families. While poverty is clearly a basic cause of rights violations, its role in causality is complicated. National policy statements recognize that poverty is also a consequence of rights violations.

Population growth and urbanization are also basic factors in the realization of children’s rights. Bangladesh is a densely populated country of about 148 million people. Despite success in reducing fertility since the 1970s, the fertility rate remains above the replacement rate. The population is likely to almost double over the next century and to become predominantly urban in about three decades. Urbanization strains the capacity of all service providers. The policy agenda has largely neglected the burgeoning urban slums and the urban poor. Education, parenting support, health care, water and sanitation, and child protection services are severely limited.
for the urban poor, and vulnerability to eviction underlies and compounds the difficulties slum dwellers face.

Bangladesh suffers from a range of governance problems that obstruct the realization of children’s rights. The Government’s structure is highly centralized, limiting local officials’ authority and flexibility to adapt services to local circumstances and demand. Achievements in the social sectors since the early 1990s have mainly expanded access. Relative to the deeper, institutional changes needed to improve service quality and equity, expanding access is administratively easier and brings more immediate political gains. A vibrant civil society and politically engaged population provide some accountability, but formal accountability institutions are generally ineffective. Low levels of public expenditures in the social sector reflect the country’s poverty, low rates of revenue collection, and weak implementation capacity. The new Government has promised a number of important reforms related to children’s and women’s rights.

Social and cultural norms and values influence the realization of children’s rights. In many communities, for example, the low social and economic status of women and girls contributes to social acceptance of child marriage, which is harmful to children and women. Norms of childhood contribute to social acceptance of child labor, sometimes even in hazardous types of work. The concept of family honor is often linked with the behavior and experiences of girls and women. As a result, girls and women who are victims of abuse—and even those who seem likely to have been victims—suffer greater social consequences than do their abusers. The low socioeconomic status of women is reflected in the health and educational services provided to mothers and children, their food intake, and their decision-making authority. Gender norms make it difficult for women to access water and sanitation facilities located away from their homes. Social taboos regarding the discussion of sex and drug use obstruct efforts to raise awareness of HIV/AIDS and expand access to testing, treatment, and care. A low level of respect for the rule of law—especially when it conflicts with other social norms—contributes to rights violations.

Bangladesh has always been disaster-prone, experiencing severe floods, cyclones, storm surges, droughts, and other natural disasters. Climate change could increase the frequency and intensity of disasters. The Government has developed substantial capacity in disaster management and risk reduction, but the country’s location, low elevation, poverty, population density, poor infrastructure, and high dependence on natural resources make it exceptionally vulnerable.

Children’s ability to exercise their right to participation is part of the context for the exercise of all their rights. In Bangladesh, children rarely have opportunities to express themselves, and when they do, adults tend not to take them seriously. Social norms regarding childhood and low awareness of the developmental stages of childhood and adolescence obstruct child participation. In the middle years of childhood, when children are developing the capacity for independent opinions and participation in decision-making, parents often tightly control children, expect them to work or study hard, and unilaterally make important decisions concerning their lives. A number of civil society organizations now encourage adults to share information with children and to develop new kinds of partnerships with them. The Government is seeking children’s views in the formulation of policies regarding child abuse and the commercial sexual exploitation and trafficking of children. The proportion of children who are able to raise their voices regarding public policy, however, is very small. Many parents resist children’s participation in such initiatives because they detract their attention from work or study and because speaking out, particularly for girls, is considered inappropriate.

Estimates of the prevalence of disability range from 2 per cent to 10 per cent of the population. Mortality is substantially higher among children with disabilities than among children overall, indicating that if more children with disabilities could survive their early years, the disability prevalence rate would be higher. Disability prevalence rises with age, but childhood is a critical stage for the onset

Executive Summary
The disability prevalence rates for different population groups reflect other inequalities in society. The main immediate causes of disability among children are maternal and child under-nutrition, disease, birth and congenital problems, and accidents. Most of these causes are preventable. Low access to adequate health and disability services is an important underlying cause of both disability and the vulnerability of people with disabilities. Many temporary ailments become permanent when appropriate health services are not available or affordable. Lack of awareness about disability combined with the limited access to disability services leads many families to see disabled family members as a burden and to restrict them to the home. Stress in the lives of caregivers is another underlying factor: caring for a child with disabilities can contribute to stress and depression, especially among caregivers who also suffer from poverty, food insecurity, and other hardships. These caregivers are then less likely to be responsive and stimulating toward their children, which in turn influences child development.

NGOs and private sector organizations have overcome all obstacles in their support for Bangladesh’s participation in the Special Olympics World Games and regional events, which engage people with intellectual disabilities from around the world in athletic training and competition. Bangladesh has achieved a distinguished record of achievement in these events.

CHILDREN’S RIGHT TO EDUCATION

The key areas where children’s access to their right to education is challenged are preschool attendance, primary school completion, secondary school enrollment and completion, the quality of education, and inequality and exclusion of various groups. Only 15 per cent of children of ages 3-5 years attend an early childhood education programme. Bangladesh has made remarkable progress in primary-school enrolment over the past two decades, but many children repeat grades, and possibly as many as half of primary school students drop out before completion. The Government and NGOs provide non-formal education for some children who have dropped out or never enrolled, but most of them remain unenrolled. The secondary net attendance rate is less than 40 per cent. The proportion of girls attending primary and secondary school has risen dramatically in recent years, and girls are now ahead of boys in primary attendance, enrollment, retention, and completion. At the secondary level, however, dropout rates are higher for girls after Grade 6, and fewer girls complete Grade 10 than do boys. Moreover, boys appear to outperform girls at all levels.

The quality of education is unsatisfactory for most students. Many children complete primary school without basic literacy and numeracy competencies, and many complete secondary school without the knowledge and skills needed for either the workplace or further education. Children are rarely provided opportunities to develop critical thinking and extra-curricular interests and skills. Primary-school class sizes are large, many primary schools run on double shifts, and student-teacher contact hours are among the lowest in the world. Preschool, primary, and secondary education institutions use very different approaches, and mechanisms are not in place to facilitate students’ transition from one level to the next.

The low availability of preschools precludes attendance for the majority of children of preschool age. At the primary and secondary levels, school availability and access are different for different children. The children of wealthy households and educated mothers have substantially greater educational opportunities than do others. Overall, children in urban areas have better educational opportunities than do those in rural areas, but the children of urban slums are severely deprived of the right to education. Children with disabilities, street children, working children, tribal children, and children living in urban slums, remote rural areas, and brothels are most likely to find schools unavailable, inaccessible, or lacking in relevance to them. Some schools become inaccessible during seasonal floods, and some parents
fear that traveling to and from school will expose their children to road accidents, violence, sexual abuse, trafficking, and other risks.

The levels of knowledge, awareness, and participation of caregivers and communities is an immediate factor influencing the right to education. Many caregivers lack knowledge of positive discipline, the importance of play and physical activity, and the skills children will need as they reach adulthood in the modern economy. Caregivers who have access to flows of information and understand modern teaching-learning methods are more likely to support learning at home. Community involvement with schools and community awareness about quality education are mutually reinforcing. School Management Committees (SMCs), parent-teacher associations, community learning centers, and programmes for adolescent and parent empowerment are examples of mechanisms that foster meaningful community involvement when they exist and function properly.

The quality of teaching, school infrastructure, and educational materials are also immediate determinants of whether children attend school and what they gain when they attend. Many teaching posts remain vacant, and corruption has been reported in teacher recruitment. Teacher training, performance assessment, professional development opportunities, and compensation are often insufficient to motivate and retain qualified teachers. As a result, teacher absenteeism is reportedly high, and many teachers focus more on private tutoring than classroom teaching. In addition, teachers commonly use physical and other negative forms of punishment. Most schools lack playgrounds and other recreational facilities, and schools are rarely accessible to children with disabilities. Basic supplies and quality inputs—such as teaching aids, libraries, and laboratories—are often unavailable or in poor condition. Primary school textbooks were recently revised and distributed, but their quality has drawn criticism. With support from UNICEF, the Government is gradually providing supplementary reading materials and teaching aids for primary schools and rolling out a school-level planning process that aims to enable improvements in infrastructure and other local priorities.

Bangladesh has a variety of Government-supported schools, private schools, NGO-operated schools, unrecognized madrasas, and non-formal education programmes. The different types of school and the lack of minimum standards and a common core curriculum may reinforce the disparities in society and undermine quality. A unified system could allow diversity in delivery modes while ensuring that children who complete the various levels of education have a common core of competencies and skills.

Families with children in school face substantial costs. Studies suggest that households provide more than half of the total spending for children to attend Government-supported schools. Government stipends for poor primary students and girls attending secondary school are credited for contributing to increased enrollment, but the stipends are small and do not extend to children in urban areas. Moreover, the primary stipends are not well targeted to the poor. Private tutoring has become essential for school performance—and in turn for a child’s eligibility for the stipend programme—and is beyond the reach of most poor students.

A number of underlying factors influence children’s right to education. Many caregivers are poorly educated themselves, leaving them unable or disinclined to provide learning support at home. Poor families who concentrate their energies on daily survival are often unable to make the financial and personal investments that education entails. Many children work in labor arrangements that prevent or hinder school attendance. The practices of child marriage and dowry result in withdrawal from school for many girls. Strategies for inclusive primary education have been adopted but have not yet had effect, and the laws and policies governing child labor and child marriage are inadequate and poorly enforced. Finally, at just 2.3 per cent of GDP, public expenditure on education in Bangladesh is low relative to that of other developing countries and other countries of the region.
CHILDREN’S RIGHT TO HEALTH AND NUTRITION

Children’s access to their right to health and nutrition is evident in the rates of maternal and child mortality and the threat of an HIV/AIDS epidemic. Child health and survival is closely related to the health and survival of mothers throughout the lifecycle. While maternal mortality is difficult to measure and track in Bangladesh, experts agree that maternal deaths are unacceptably common. The country has made significant progress in reducing child mortality and is considered on track for achieving the corresponding Millennium Development Goal (MDG 4), but success in meeting the MDG 4 targets is far from guaranteed. The neonatal mortality rate has been declining at a relatively slow rate. These deaths account for more than two-thirds of all infant deaths. Under-nutrition is a challenge to continuing progress in child survival. Neonatal, infant, and under-five mortality rates appear to be lower in urban than in rural areas, and a mother’s level of education and household wealth are inversely related to her child’s risk of dying.

By world standards, HIV prevalence remains low (about 0.2 per cent of the adult population), but Bangladesh is at risk for an epidemic. It shares borders with high-prevalence countries and countries where HIV infection is growing rapidly, and many of the behavioural patterns that fuel an epidemic are found in Bangladeshi society. The infection rate is significant among some vulnerable groups, especially injecting drug users. Women’s share of the population living with HIV has been rising. No data are yet available on the number of children living with HIV.

The most common immediate causes of maternal mortality are haemorrhage, sepsis, eclampsia/pre-eclampsia, unsafe abortion, and obstructed labour, all of which could be prevented or successfully treated without loss of life. For neonatal mortality, the most common immediate causes are infections, low birth weight, and birth asphyxia.

Infant and child deaths are most commonly caused by infections, under-nutrition, and injuries. The prevalence of under-nutrition among children has declined over the past two decades, but about two-fifths of children under five years of age are still underweight, and nearly half suffer from chronic malnutrition (stunting). Micronutrient deficiencies among children are common, affecting children’s cognitive and motor development. The nutritional status of children is highly correlated with that of their mothers and the socioeconomic level of their households. Drowning, road traffic accidents, falls, burns, animal bites, and other injuries cause 38 per cent of deaths in children of ages 1-17 and are the leading cause of death among children above the age of 5. For every injured child who dies, many others live on with varying degrees and durations of disability and trauma.

Injecting drug use is the primary immediate factor in the spread of HIV/AIDS in Bangladesh. Occurring mainly in urban areas, injecting drug use is increasing, and studies indicate that users often share needles and syringes. The most-at-risk populations also include female and male sex workers, clients of sex workers, transgenders, and migrants. There are significant bridging populations among these risk groups and links between them and the general population, including the risk of parent-to-child transmission. Condom use among risk groups is low.

Bangladesh’s rapidly declining child mortality rates have hinged on its control of vaccine-preventable diseases. Full immunization coverage of one-year olds with valid doses of all recommended antigens reached 75 per cent nationally in 2007. Some areas and population groups however, continue to be underserved.

Aside from immunization, the quality of health care accessible to most children and women is low. Recent trends in antenatal care are favourable, but still only about one-half of mothers receive antenatal care from a skilled provider. More than
four-fifths of births take place at home, and medically trained providers attend only one-fifth of births. The maternal care a mother receives is strongly correlated with her household wealth and her educational background. Access is higher in urban than rural areas and is particularly low in tribal areas. These disparities are seen also in the health care that children receive, though they are not as sharp. In recent years the Government has taken steps to improve the provision of emergency obstetric care and introduced a demand-side financing scheme that guarantees free maternal care services to participating pregnant women. Very few newborns receive appropriate care, and immediate and emergency newborn care is inadequate when available at all.

Public sector health services suffer from insufficient supplies of medications, staff shortages, and management and coordination problems. The vast majority of qualified health care providers are located in urban areas. Non-government health care providers serve the majority of the population, but information on their role is scarce. They range from traditional birth attendants, traditional healers, and unqualified allopathic service providers to trained NGO community health workers and private hospitals providing modern medical services. Taking children to non-formal providers often precludes an appropriate referral and leads to inappropriate or delayed treatment. Caregivers in rural areas often prefer non-formal service providers because they make home visits, follow up with patients, and allow flexibility in the mode of payment. In contrast, Government hospitals are widely perceived to be overcrowded, to have long waiting times, and to provide care that is rushed and impersonal.

Maternal nutrition and health are underlying factors determining child health and survival. Nutrition is important throughout the lifecycle. The nutritional status of girls affects the nutritional status of the adolescents and women they become. Their nutritional status during pregnancy, in turn, affects intrauterine development and the risks of complications during pregnancy and childbirth. In Bangladesh, interventions supporting maternal nutrition have very low coverage. One-third of women in the country suffer from chronic energy deficiency, and more than one-third of children are born with low birth weight. Child marriage often results in early motherhood, which is harmful to the health of both mothers and children. Violence against women is another pervasive problem affecting women’s health.

Family care practices—such as care seeking for maternal and child health, neonatal care, infant and young child feeding, hygiene practices, and injury prevention and care—are important determinants of child and maternal health. Poor quality of care, misperceptions regarding the need for care, and social barriers lead to low care-seeking. Care-seeking from trained providers for newborns is uncommon, and the care given to newborns at home is usually inadequate. Almost all Bangladeshi babies are breastfed during the first year, but the rates of early initiation of breastfeeding and exclusive breastfeeding for the first six months are low. Proper care for children with diarrhea, a leading contributor to child malnutrition and mortality, is widely practiced. Effective hand washing is critical to avoiding gastro-intestinal diseases and is not widely practiced, especially among the very poor. A prevailing culture of shame and embarrassment surrounding menstruation—combined with limited access to sanitation facilities—often leads to poor menstrual hygiene, which can cause illness and infection among women and adolescent girls. (Lack of access to safe water and sanitation contributes to respiratory and gastrointestinal illnesses, which in turn contribute to both malnutrition and mortality. Children’s right to safe water, sanitation, and hygiene is discussed further below.)

Knowledge and awareness among caregivers and children are also underlying factors. Caregivers are often poorly informed about when to seek treatment for acute respiratory infections. Many caregivers believe that allopathic medicines are too harsh for infants and therefore seek alternative care providers even when urgent medical care is needed for infection. Knowledge about injury prevention and care—and about HIV/AIDS and its prevention—is also low.
CHILDREN’S RIGHT TO PROTECTION

The key areas where children’s access to their right to protection is challenged in Bangladesh are abuse, exploitation, and the lack of a comprehensive system for protecting the rights of children without parental care. Three-quarters of child respondents to the Children’s Opinion Poll of 2008 reported that physical punishment takes place in their homes. Nine out of ten school-going children said it takes place at their schools, and one-quarter of working children said it occurs in their workplaces. Children in conflict with the law sometimes experience physical abuse during arrest and interrogation, and child victims and witnesses are treated similarly. In public areas, some children—especially street children, child sex workers, and the children of sex workers—are subjected to verbal, physical, and sexual abuse from police, mastaans (hoodlums), and the general public. Many Bangladeshi children are exposed to violence against the women in their families and communities.

Both at home and at school, higher levels of household wealth and better-educated parents are associated with better treatment of children. In schools, teachers tend to treat the children of non-poor households better than those of poor households because they wish to maintain favorable relations with influential parents or because they perceive that non-poor parents are more likely to complain about mistreatment of their children.

Adults tend to exhibit more positive than negative behaviors toward young children, but at some point before puberty children are typically expected to begin to work and/or study hard, and punishment is often viewed as necessary. Rebellion against authority is not considered a normal part of adolescence. After the onset of puberty, girls’ activities and movements are usually restricted. Children in the later years of childhood experience less punishment—but by then many of them are already leading adult lives, and indeed many girls are already mothers themselves.

National surveys indicate that 13 per cent of Bangladeshi children between the ages of 5 and 14 are working. Child labor is higher among children of the urban slums and tribal areas than any other groups surveyed. The National Child Labor Survey estimated that about 1.3 million children were engaged in hazardous labor, and nearly one-fifth of the working children who responded to the Children’s Opinion Poll felt that their working environments were unsafe. A large proportion of children’s work is hidden and unlikely to be captured in surveys. Many child workers, especially girls, are not paid regular wages, and they rarely have control over the use of their wages. Employers of children rarely consider the compensation they provide to child workers or their families as the fulfillment of duties to the children, nor do they see the children as rights holders entitled to claim their right to fair treatment and compensation.

Child domestic work is a sector of particular concern because of the large numbers of children involved and the risks associated with the work. Almost all child domestic workers live at their employers’ homes and work seven days a week. They often face restrictions on their mobility and freedom of association. Their vulnerability to sexual abuse is widely recognized in Bangladeshi society and creates a stigma that can damage girls’ reputations and marriage prospects. The stigma encourages silence among victims, which further empowers their abusers.

Many children are drawn into commercial sexual exploitation, sometimes when they are well below the age of puberty. Some of these children are based in large registered brothels, which are scattered throughout the country. Some work on the streets, in parks, or at bus or train stations. Within brothels, girls who are bonded sex workers are the most deprived of their rights. They are not allowed outside of the brothel, they cannot choose their customers, and they are under strict surveillance to prevent them from running away. Children of brothel-based sex workers are stigmatized from birth. Their acceptance into society is virtually
impossible, so they often start working in the brothel themselves. Street-based sex workers have greater independence and agency, but they are more vulnerable to physical and verbal abuse and to arrest and maltreatment in the criminal justice system.

Trafficking in women, men, girls, and boys—internal and international—takes place in Bangladesh for commercial sexual exploitation and forced labor. Some trafficked persons are physically coerced, while others are lured by promises of jobs or marriage. Some parents willingly send their children away to escape poverty, and some sell their children into bondage (usually domestic labor). Trafficking happens through legal and formal migration as well as through illegal, informal, and undocumented migration. For women and children who are rescued and repatriated, reintegration is difficult and sometimes impossible. Sometimes the traffickers are members of victims’ families or communities, making prosecution complicated and potentially harmful to the victim. Court cases tend to be lengthy, which can give traffickers time to reach illegal out-of-court settlements with victims or their families. These settlements may serve the interests of family members and traffickers more than those of the victims.

Formal arrangements for children without parental care are limited and almost exclusively institutional. The commonly held belief that moral character is inherited from one’s biological parents makes adoption difficult to address. The main Government-run facilities where children reside are orphanages, vagrant homes, juvenile detention facilities, and adult prisons. For a child to enter a Government orphanage, an adult must apply on his or her behalf, which closes their doors to many children without parental care. In addition to Government-run facilities, Bangladesh has madrasas that house and educate orphans and private or NGO-run orphanages and shelter homes. Many children without parental care resort to informal alternatives, such as living on the street or becoming live-in child domestic workers.

Children who live and/or work on the street are especially vulnerable to violence, sexual abuse, hazardous work, use in political activities, conflict with the law, and trafficking. They also suffer from abysmal sanitation and hygiene conditions, poor health, and limited access to any kind of education. Police officers have wide discretionary powers to arrest children in need of protection on the grounds of vagrancy, begging, truancy, smoking, alcohol abuse, or prostitution. Often children are incarcerated with adult prisoners, from whom they are vulnerable to abuse. The hardships in street children’s backgrounds lead many of them to experience a sense of freedom in the street life, despite the risks they face.

Abuse, exploitation, and the quality of care arrangements are often linked to one another, and they have multiple causes that are also interlinked. The immediate factors influencing children’s right to protection include the widespread acceptance in society of physical punishment of children, violence against women, child marriage, and child labor. Personal stress and family/social tensions are also immediate factors.

While the practice of child marriage has decreased in Bangladesh over the last three decades, it remains common in rural areas and urban slums, especially among the poor. Arranging early marriage for a girl is often financially beneficial for her family—she is no longer a financial burden, and the marriage of a younger daughter often requires a smaller dowry than the marriage of an older daughter. A child bride usually foregoes school to work full-time in her in-laws’ home. Because they cannot abstain from sex or insist on condom use, child brides are exposed to the risks of premature pregnancy, sexually transmitted infections, and HIV/AIDS. Husbands and their families sometimes abuse child brides to pressure their natal families into greater dowry payments. In addition, the notion that a child is eligible for marriage—and is therefore an acceptable sex partner—contributes to the social acceptance of men who patronize child sex workers.
The extent to which laws and policies on child protection are enforced is another immediate factor. Those regarding child labor, physical punishment, violence against women, sexual exploitation, imprisonment of children with adults, trafficking, child marriage, and other aspects of child protection are routinely violated. In some cases, people are not aware of the laws, but more commonly they are ignored because they conflict with social norms and established practices. The lack of birth registration for most children has been an enabling factor in the violation of laws to protect children, and the Government is now addressing this issue.

The underlying factors influencing child protection include the levels of knowledge and awareness about children’s rights and the responsibilities of duty bearers, the legal and policy framework for child protection, and institutional capacities for child protection. Bangladesh has significant gaps in all of these areas, though some improvements are evident. In terms of knowledge and awareness, for example, public policy and various initiatives have increased the priority that parents place on schooling relative to work for their children, contributed to a gradual decline in the prevalence of child marriage, and expanded knowledge, however slightly, about sexually transmitted diseases, including HIV/AIDS.

**CHILDREN’S RIGHT TO WATER, SANITATION, AND HYGIENE**

Safe water, adequate sanitation, and good hygiene practices are critical to the realization of children’s rights in Bangladesh. Their use reduces the risks of respiratory and gastrointestinal diseases, which disproportionately affect children, contributing to their under-nutrition, morbidity, and mortality. Menstrual hygiene is important for reproductive health, and access to adequate facilities for menstrual hygiene at schools can make the difference between going to school and not going to school for adolescent girls. Avoiding the consumption of excessive levels of arsenic—which contaminates much of Bangladesh’s drinking water—is necessary to prevent the debilitating and sometimes deadly effects of arsenic-related diseases. Safe water, sanitation, and hygiene also have potentially life-changing social impacts, as cleanliness and avoidance of disease can raise the social standing of the poor and influence the security of girls and women in marriage.

Safe drinking water coverage is about 80 per cent and has not changed much for many years. Water scarcity results from seasonal droughts, water management practices in India, and over-extraction of water for irrigation. Since the 1970s, households have invested substantially in improved sanitation facilities, usually relying on private sector providers, and the Government has stepped up its role in providing sanitation facilities to households in recent years. Still, only 39 per cent of households have access to latrines with functioning water seals or a similar or better level of hygiene. Flooding and droughts make many latrines unusable, and they are often not designed for hygienic emptying and sludge disposal. The availability of latrines in public areas is minimal, and the country lacks accessible sanitation facilities for people with disabilities.

Urbanization, growing slum populations, and poor provision of water and sanitation in the slums and public areas of cities and towns increase the vulnerability of many of the poor. Only about one-third of the hundreds of pourashavas (secondary towns) in Bangladesh have piped water networks, and they usually cover only a small part of the population. The lack of sewerage systems, household septic tanks, and solid waste management create unhygienic living conditions for the urban poor. Hygiene awareness is lowest among slum dwellers. The urban poor without security of tenure have little incentive to invest privately in water and sanitation improvements and face high costs if they choose to arrange private service provision.
Good water, sanitation, and hygiene practices are essential for preventing disease and other problems related to water and sanitation. Effective hand-washing practices are least common among the very poor. Even when latrines are available, they are often not used, or not used consistently by all household members. Improper water handling and storage practices can lead to contamination of drinking water. As mentioned above, menstrual hygiene is important for reproductive health and for girls’ school attendance. In addition, when sanitation facilities are appropriately hygienic and private, they provide women and girls with greater convenience and dignity. Latrines meeting requirements for menstrual hygiene are rarely available in schools.

The main threats to water quality in Bangladesh arise from arsenic contamination, bacteriological contamination, iron content, and saline intrusion. In many areas of the country, arsenic enters water supplies from natural deposits in the ground. Bacteriological contamination is common in densely populated areas where safe distances from latrines and other pollution sources are not maintained. Saline intrusion into drinking water sources is increasing in the coastal belt. Bangladesh does not have mechanisms in place for systematic water quality monitoring and surveillance.

The Government has a National Sanitation Strategy setting forth the target of 100 per cent access to improved sanitation by 2013. Under this strategy, funds are allocated for locally elected bodies to provide hygiene education and free materials for latrines to the hardcore poor. The strategy was pursued vigorously in 2005-2007, but progress slowed during 2007-2008. Studies show that the sanitation programme had significant impacts on local environments and enhanced the security of some women and children but had implementation problems, particularly in regard to monitoring, supervision, and targeting the poor. The strategy addresses sanitation at the household level only. Enabling full sanitation for all people at all times will require the introduction of sustainable sanitation facilities and maintenance arrangements in schools, markets, transportation terminals, and other public places.

In 2006, the Government adopted a Sector Development Programme (SDP) that sets forth a 10-year framework for development and cooperation in the water and sanitation sector. The degree of consensus among the key sector partners, however, was insufficient for the SDP’s effective implementation. The SDP also does not address climate change, contain an emergency preparedness or response strategy, or adequately recognize the special water and sanitation conditions of the Chittagong Hill Tracts. The formulation of a revision is underway. In regard to emergencies, the Water, Sanitation and Hygiene (WASH) cluster for emergency response, with the Government in the lead and UNICEF as the lead international partner, has helped to improve overall coordination of response activities in the sector.

**ROLE & CAPACITY ANALYSIS**

**Families.** Families and immediate caregivers are the duty-bearers with the most immediate responsibilities for ensuring children’s rights. They have duties to encourage children’s school attendance, to create a home environment conducive to learning, to maintain proper practices of feeding, hygiene, and the care and treatment of sick children, and to advocate for children’s rights within their communities. Many families face substantial constraints, including high private costs for social services (and, for some, little or no access to services). Many live in poverty and have to make choices on the basis of immediate survival needs. Families often lack the knowledge and skills they need. Prevailing gender norms prevent many mothers from seeking appropriate care for themselves or their children. Social and economic pressures encourage families to arrange child marriages, restrict the mobility of adolescent girls, and reject daughters who become victims of trafficking and/or sexual exploitation. Many families are unaware...
of the role they can play in supporting community services, and many are not sufficiently empowered within their communities to play such a role.

Communities and schools. Communities have the duty to create effective local demand for social services, to reject social and cultural norms that are harmful to children, to demand accountability when children’s rights are violated, and to support the reintegration of children who have been separated from their parents and communities for any reason. Communities and schools have the best information on which children are at risk and what could be done to ensure their rights. Some communities fulfill their responsibilities through School Management Committees, informal preschools, water and sanitation committees, and various types of community centers. Children have a right to participate in these community functions. Often, however, communities lack organizational capacity, social awareness, and effective linkages with service providers. Social and cultural perceptions of the roles of children obstruct their participation. Local government bodies are often not well attuned to providing support and responsiveness to communities, and the centralized system of government restricts communities’ ability to adapt schooling and other services to local conditions.

Teachers have duties to provide all children with high-quality and equitable teaching, to engage with parents and other community members in the learning process, and to avoid negative forms of discipline. Many teachers play important roles beyond the classroom—in improving health and hygiene, raising awareness of social and environmental issues, and assisting families in various ways. Teachers face the obstacles of inadequate training, low compensation, few opportunities for professional advancement, and heavy workloads. Most schools are under-resourced and have severely inadequate provisions for water and sanitation.

Civil society. In Bangladesh, civil society organizations—including NGOs, academia, the private sector, and the media—play a vital role and have substantial capacity in the promotion and protection of children’s rights. In many respects, NGOs have taken the role of duty-bearer in the provision of services for children who are poorly served by government providers. NGOs foster dialogue on policy development, promote positive behavior change, mobilize community demand for services, pilot innovative models of service delivery, provide training, support technological innovation, provide legal aid, and support disaster preparedness and response. NGOs and the media monitor human rights and raise public awareness about progress and setbacks. NGOs and private organizations have been the main providers of preschool education, though the Government is now also taking a role. The private sector plays the leading role in the provision of water and sanitation facilities. Insufficient trust and cooperation between civil society and the Government present a significant constraint to civil society’s effectiveness. The Government does not effectively regulate, monitor, or support the contributions of civil society in education and health care. To ensure that the children of Bangladesh benefit from the full range of national expertise, further efforts are needed to build a common understanding of the roles of civil society vis-à-vis the Government.

Local government institutions. Bangladesh’s local government institutions have responsibilities for delivering Government services to households and communities. Locally elected officials are expected to ensure the accountability of service providers for their performance. Social workers, administrators, police, and others at the local level are responsible for ensuring that socially disadvantaged and at-risk children receive appropriate services. Within the Government structure, local government institutions are most in touch with communities’ needs and perspectives and have the most knowledge about the performance of individual schools and other service providers. They are in the best position to ensure that service providers work together in the best interests of local children, and they are logical links between communities and policy makers. At present, however, they tend to play a passive role. Mechanisms for participatory local decision-making are limited. The centralized system of governance and inadequate funding often leave them without the authority or the human and financial resources needed to
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carry out their responsibilities. Top-down planning mechanisms allocate resources with inadequate reference to local circumstances. One consequence is insufficient development of technologies suiting the country’s different geo-hydrological environments. Concerns about abuses by the police and their lack of responsiveness arose repeatedly during the preparation of this Situation Analysis.

**Government of Bangladesh.** The Government of Bangladesh holds the ultimate responsibility for ensuring the rights of all people in the country. A variety of laws, policies, programmes, and institutions demonstrate the Government’s recognition of its role as duty-bearer and its commitment to children’s rights. For example, the Constitution of Bangladesh establishes free and compulsory education as a fundamental principle of state policy. The Second National Strategy for Accelerated Poverty Reduction (NSAPR II) commits the Government to improvements in the quality and coverage of early childhood development programmes and primary, secondary, and non-formal education. The Election Manifesto of the recently elected Government and the NSAPR II acknowledge many of the problems identified in this report and set forth a vision for addressing them. With support from a range of development partners, the Government is leading the Second Primary Education Development Programme (PEDP II) and the Health, Nutrition, and Population Sector Programme (HNPS). The ongoing birth registration drive is expected to enable better protection and service delivery for children. Bangladesh has an extensive institutional structure in place for the delivery of public services.

The Government faces many constraints in fulfilling children’s rights, however, and the system of governance has shortcomings that compromise its effectiveness in providing services to women and children. As mentioned above, the legal and policy structure is far from fully consistent with the CRC. The centralized structure of governance prevents the utilization of the full potential of the local levels of government, which are closest to children and their families and communities. Complaints of corruption are common. Coordination among the various government bodies with responsibilities for children’s rights is often weak. The levels of trust and cooperation between the Government and civil society are also insufficient to harness the full range of national capacity. Key government personnel are frequently transferred, and many sanctioned posts remain vacant for long periods of time. Unattractive work conditions and remuneration lead government doctors and teachers to provide private services, which detract from their accessibility to poor and disadvantaged women and children. Institutional and capacity limitations in monitoring and evaluation prevent timely and reliable needs assessments and measurement of progress toward fulfilling children’s rights. The country’s low revenue base and inefficiencies in revenue collection leave public programmes for children underfunded. Community-level nutrition services reach only a fraction of the population and are poorly linked with the public health system. A comprehensive network of social workers is in place, but at present most activities focus on institutionalization with little attention to preventive measures or the reintegration and rehabilitation of children at risk.

**International development partners.** International development partners have duties to ensure that the projects and programmes they support have national leadership and ownership and that they are effective and sustainable. Development partners have the potential to play a catalytic role in bringing about better trust and cooperation among national stakeholders. This requires deep understanding of the complexities of relationships in Bangladesh within and among the different Government bodies, political parties, and actors in the public sector and civil society. It also requires strong diplomacy to help bring about a culture of dialogue. Development partners are constrained in fulfilling their duties by the continuation of fragmented project-based approaches and the complexity of coordinating efforts with other development partners, NGOs, and the Government while fulfilling the special reporting requirements and other demands of their headquarters. Development partners also have frequent personnel changes and often lack sufficient mechanisms for institutional memory.
RECOMMENDATIONS

The causality and role analyses indicate that policy advocacy and support, technical assistance and capacity building, communication for development (C4D), and expanding the evidence base are key areas where UNICEF and other organizations can effectively support Bangladesh’s progress toward the realization of children’s rights.

The following are some areas where policy advocacy and support may be particularly important:

- Promotion of higher levels of public investment in children and more effectiveness, efficiency, and equity in the use of financial resources.
- Promotion of decentralized planning, management, and monitoring and advocacy for genuinely consultative processes, involving children and adults, in policy development.
- Advocacy for mechanisms to strengthen coordination among the various Government bodies responsible for children’s rights.
- Facilitating coordination among all stakeholders involved in protecting the rights of children affected by disaster and ensuring that children’s rights are respected in climate change adaptation.
- Advocacy for the high-level and inter-ministerial policy decisions needed to meet human resource requirements in the social sectors.
- Serving as a catalyst between the Government and civil society and supporting policies to recognize, support, and regulate non-government service providers.

In all cases, a first step in building capacity would be to ensure that duty bearers recognize children as rights holders who are entitled to claim their rights, not just to receive benevolence. Particular areas where technical assistance and capacity building support would be useful include monitoring and evaluation, the development and piloting of mechanisms for decentralized planning, strengthening of School Management Committees and other community organizations, screening for learning disabilities, expanding extracurricular activities, developing parenting skills, fostering mechanisms for the Government and civil society to work together, and introducing mechanisms for the age-appropriate participation of children in matters affecting them.

The use of methods of communication for development (C4D)—involving social mobilization, community-led social change, and advocacy—will be essential for expanding the realization of children’s rights. C4D processes require understanding of beliefs, practices, and social and cultural norms. They may take more time to yield results than other interventions, but their results are likely to be enduring.

A wide range of research initiatives could contribute to the evidence base for the development of policies and programmes to secure children’s rights. Assessments of the quality and quantity of child-related services provided by the private sector and NGOs will be particularly important for addressing children’s rights comprehensively. Qualitative and quantitative research can complement one another to provide a holistic picture of children’s experiences and the factors affecting them.
INTRODUCTION

Bangladesh, which is now home to about 63 million children, ratified the Convention on the Rights of the Child (CRC) in 1990. The CRC sets forth the rights of all children to health, education, participation, and protection. Based on the belief that nurturing and caring for children are the cornerstones of human progress, UNICEF helps to build a world where the rights of every child are realized. Toward this objective, UNICEF works globally with a wide range of partners to overcome the obstacles that poverty, violence, disease, and discrimination place in a child’s path. The Government of Bangladesh and UNICEF have cooperated in promoting children’s rights since Bangladesh attained independence in 1971. Recognizing the link between children’s rights and women’s rights, the current Government-UNICEF Country Programme of Cooperation, covering 2006-2011, aims for the progressive realization of both. This is to be achieved through improved survival, development, protection, and participation of children and women within the frameworks provided by the CRC, the Convention on the Elimination of Discrimination against Women (CEDAW), the Millennium Development Goals (MDGs), and the Millennium Declaration.

UNICEF conducts a comprehensive country-level Situation Assessment and Analysis of Children and Women (SitAn) approximately every five years. The SitAn is intended to serve as input for the subsequent Country Programme and, more broadly, to contribute to research and the formulation of policies, strategies, and programmes related to children’s and women’s rights. The last SitAn in Bangladesh was prepared in 1999 and updated in 2004.

UNICEF Bangladesh prepared the current SitAn with the support of an international consultant in the first half of 2009. The methodology involved a document review and consultations in Dhaka with relevant Government officials, international development partners, national and international NGOs and research institutions, and UNICEF staff. During a series of field visits, information was gathered through focus group discussions with children and women and through interviews with relevant local officials and project personnel. Preliminary results were presented and discussed in a stakeholder workshop in May 2009, and the SitAn report was subsequently finalized.

This SitAn dedicates separate chapters to the rights to education (Chapter II), health and nutrition (Chapter III), protection (Chapter IV), and water, sanitation, and hygiene (Chapter V). Children’s right to participation is interwoven into all chapters. Following a rights-based approach, the SitAn analyzes the immediate, underlying, and basic (or structural) factors influencing whether and to what extent children’s rights are realized. It then analyzes the roles, capacities, and capacity gaps of the duty bearers who are responsible for ensuring that children’s rights are respected, protected, and fulfilled. Each of the chapters on specific rights concludes with a set of recommendations for all those interested or directly involved in planning, budgeting, and/or implementing interventions for/with children—and those interested in supporting the development process in Bangladesh generally.
I. CHILDREN’S RIGHTS IN BANGLADESH: THE CONTEXT

This chapter provides an overview of the context in which women, children, and the duty bearers responsible for ensuring the realization of children’s rights operate in Bangladesh. This context includes legal, political, social, cultural, economic, demographic, and environmental aspects. The chapter starts with a summary of the general legal and policy framework for children’s rights. (Laws and policies related to specific rights are covered in subsequent chapters in the context of the Government’s role as duty bearer.) It then addresses the basic (or structural) factors influencing the realization of children’s and women’s rights. Unlike the immediate and underlying factors, which are different for different rights and are therefore covered in subsequent chapters, the basic factors are largely held in common across all rights. They include poverty and food insecurity, population growth and urbanization, the quality of governance, social and cultural norms and values, and the occurrence and management of natural disasters. This chapter also addresses children’s right to participation and the rights of children with disabilities, which are relevant to all of the child rights covered in later chapters: the rights to education, health and nutrition, protection, and water, sanitation, and hygiene.
I.A. LEGAL AND POLICY FRAMEWORK

The Government of Bangladesh ratified the Convention on the Rights of the Child (CRC) in 1990, and in 2008 the Government submitted its third and fourth progress reports to the Committee on the Rights of the Child. The National Strategy for Accelerated Poverty Reduction II sets forth a progressive vision for children’s advancement and rights, addressing issues of children’s health, nutrition, food security, education, access to safe water and sanitation, empowerment, and protection. National legislation relating to children, however, remains far from consistent with the CRC. Many of the rights guaranteed in the Convention are not yet supported with legislation, and in some cases existing laws and policies contradict international standards. Where appropriate laws and policies do exist, they are often ineffective due to the absence or weakness of mechanisms for enforcement.

As a first step toward harmonizing national laws and bringing them into compliance with international standards, the Committee on the Rights of the Child recommended a comprehensive review of all national legislation in Bangladesh relating to children. The National Strategy for Accelerated Poverty Reduction of FY 2005-2008 provided national support for this process by calling for the identification of legal provisions that are inconsistent with the CRC principles and for legal reform to address them. Accordingly, in 2008 UNICEF supported a review of the country’s principal law on children, the Children Act of 1974. The review found that the Children Act makes children the object of its provisions rather than the holders of rights. It addresses only children in conflict with the law and
children in need of protection, with little differentiation between the two groups. Moreover, it is oriented toward institutionalization and punitive justice rather than toward the concepts of recovery and reintegration that the CRC sets forth.

UNICEF is supporting the Government in the development of a Children Code that embodies all the rights in the CRC. This step requires substantial consultation, research, and time. The Committee on the Rights of the Child welcomes such statutes while emphasizing that all other relevant laws also need to reflect the CRC’s principles and standards. Hence, the Government is likely first to amend the Children Act to harmonize it specifically with the CRC’s provisions regarding children in conflict with the law and child witnesses and victims. At the same time, work can continue toward a comprehensive Children Code and the other legislative changes needed in specific sectors.

UNICEF has also supported a review of child-related legislation beyond the Children Act. This review identified the key areas where Bangladesh would need to make legislative adjustments in order to comply with international standards. These include specific references to the four general principles of the CRC: the child’s rights to health, education, participation, and protection. The multiplicity of age references in existing legislation would need to be replaced with a clear definition of a child, along with removal of legal gender discriminations, such as those regarding the minimum ages of marriage. Bangladesh has placed a reservation in respect of the CRC’s Article 14 on freedom of thought, conscience, and religion; the reservation would need to be removed and legislation set forth guaranteeing these rights. Laws that discriminate on the basis of gender, such as the law on the minimum age of marriage, would need to be changed.

I.B. BASIC FACTORS INFLUENCING CHILDREN’S RIGHTS

I.B.1 Poverty and Food Insecurity

Bangladesh is a poor country. Poverty had been declining for many years, but in 2005 about 40 per cent of the population still lived in poverty and more than one-quarter lived in extreme poverty, according to the most recent national Household Income and Expenditure Survey (HIES). The percentage of children living in poverty is even higher. A UNICEF study on child poverty and disparities in 2008 showed that 46 per cent of children were poor. The majority of children are deprived of adequate sanitation, information, and shelter, and a substantial proportion also face deprivations in regard to food, health, and education.

Moreover, poverty and food insecurity may have worsened since 2005. The poor are always the most severely affected by natural disasters, to which Bangladesh is prone, and in 2007 the country experienced two major floods and a devastating cyclone. In addition, the spike in food prices in 2007-2008 exacerbated hardships for many families throughout the country. The impact of the global financial crisis and economic downturn on Bangladesh is not yet clear, but these global events create risks for the country’s garment industry (which employs many women) and for the flow of remittances.
Children’s Rights in Bangladesh: The Context

from Bangladeshi expatriate labor (upon which many poor households rely). An FAO/WFP study in mid-2008 found that natural disasters and rising food prices had increased the number of poor people in Bangladesh by 7.5 million, to a total of 65 million.\(^1\) A household food security and nutrition assessment in 2008-2009 found that real household income had dropped by 12 per cent and one in four households had become food insecure, with female-headed households hit hardest.\(^2\) Food prices have subsequently declined, but the coping strategies families undertook in 2007-2008—reducing food intake, reducing health expenditures, withdrawing children from school, and taking on debt—are likely to have lasting impacts on health, education, and other children’s rights.

Poverty and food insecurity leave families with little time or energy to devote to pursuits beyond daily survival and often make them less accessible to initiatives focused on children’s and women’s rights. All of the measured indicators for primary and secondary education, health, and access to water, sanitation, and hygiene show high correlations with wealth.\(^3\) Poverty underlies caregivers’ own low levels of education, health, and nutritional status, which are transmitted across generations. The poor are more likely to be susceptible to pressures to arrange marriage or child labor for their children, and they are less likely to have knowledge about appropriate child-care practices. Twenty percent of households in the FAO/WFP study reported that they had stopped sending children to school in order to cope with the shocks of 2007-2008. Access to health care is lower for the poor than the non-poor—both because the poor are less comfortable in formal health care settings and because they cannot afford them. Many of the children who contributed to the Alternative Report on Children’s Rights in Bangladesh 2007 (prepared by a group of children’s organizations for the Committee on the Rights of the Child) said children lack medical treatment due to poverty.

Food insecurity is significantly correlated with under-nutrition. As a coping strategy during the shocks of 2007-2008, nearly three-quarters of households reduced the size of their meals, 62 per cent reduced the number of meals eaten per day, and 15 per cent went for entire days without food, according to the FAO/WFP study. The household food security and nutrition assessment of 2008-2009 found that households with seasonal or irregular income were more likely than others to have malnourished children. Household food expenditures as a share of total expenditures increased from 52 per cent in 2005 to 62 per cent in 2008, and malnourishment was more prevalent among children in households with high percent shares of food expenditures. Chronic malnutrition (stunting) among children of ages 6-59 months exceeded the WHO emergency threshold of 40 per cent in all divisions, and acute malnutrition (wasting) exceeded the threshold level of 15 per cent in two divisions (Barisal and Rajshahi). Fever, respiratory illness, and diarrhea were closely associated with wasting. Significant reductions in nutrition status since 2005 were not observed, but this could reflect the survey’s timing during the harvest season.

\(^1\) The FAO/WFP study conducted interviews with households and key informants in communities throughout Bangladesh. Most of the districts visited were Boro producing regions. Selected urban areas were included. A total of 37 of Bangladesh’s 64 districts were visited, covering all major livelihood and agro-ecological zones.

\(^2\) The Government, WFP, and UNICEF conducted the Household Food Security and Nutrition Assessment in Bangladesh between November 2008 and January 2009. The Assessment included a market survey and a survey of households with a representative sample for the country as a whole and for each of the six divisions.

\(^3\) One area where poverty does not seem to be a determining factor is preschool education, which is low for children in households of all wealth levels.

“In view of government’s commitment to halve poverty by 2015 the right to affordable, accessible and good quality health care achieves greater significance because of the crucial link between health and poverty: poor health is both a cause and a consequence of poverty.”

(Bangladesh Health Watch (2007), The State of Health in Bangladesh 2006)
The poor also have less knowledge and awareness about child protection and less access to legal and institutional structures for child protection. The lack of sustainable opportunities for families to escape poverty leaves many children vulnerable to exploitation and separation from their parents. Poverty also contributes to personal stress and social/family tensions, which result in negative behaviors of adults toward children (described in Chapter IV below). Among the respondents to the ILO survey of child domestic workers, two-thirds identified family poverty/hunger as one of their reasons for migrating from their family’s home to their employer’s home. The majority of the children who reside in children’s institutions, live on the street, and engage in hazardous work are from poor families. While violence against women and children is pervasive within all socioeconomic levels of society, the poor are especially vulnerable.

On the positive side, poverty reduction in the two decades leading up to 2005 may have contributed to the improvements in education, health, and sanitation that Bangladesh has experienced. Bangladesh has also shown that some progress toward the realization of rights can take place even while many people remain in poverty. Social mobilization and the strong public policy emphasis on primary education and sanitation have offset the influence of poverty to some extent. Poverty reduction may have played a role in improving the child protection situation for some children. For example, the expansion of employment opportunities and improved transportation and communication infrastructure appear to have enhanced children’s bargaining power in many child labor situations.

While poverty is a basic cause of rights violations, the role of poverty in causality is a complicated issue. Poverty must also be understood as a consequence of rights violations. The Education for All National Plan of Action (2003-2015) envisages that poverty will be “substantially reduced ... through and as a result of quality basic education and selective skills development training.” Breaking the cycle whereby poverty causes low levels of education and low levels of education cause poverty, reinforcing social and economic disparities, is a challenge for the education system. Similarly, the National Health Policy Update 2008 recognizes that “improvements in health would translate into higher incomes, higher economic growth, and accelerated declines of poverty” and that “any significant impact on poverty requires increased equity of access and improved coverage of health care services.” Illnesses can cause loss of income, high health care expenditures, and the depletion of household savings and assets. When health shocks occur among the poor, they deepen household poverty. Children whose right to protection is violated are similarly at risk of experiencing ever deepening poverty in their own lives and are also less likely to be able to ensure protection—and freedom from poverty—for their own children. People lacking access to safe water, hygienic sanitation, and hygiene awareness also lack the good health and social resources needed to pull themselves out of poverty.

The National Strategy for Accelerated Poverty Reduction II (FY 2009-2011) acknowledges the links between poverty and children’s rights. It recognizes that “the survival and development of many Bangladeshi children is still threatened by malnutrition, disease, poverty, illiteracy, abuse, exploitation and natural disaster.” In the context of reducing poverty, it addresses children’s health and nutrition, food security, education, early childhood education, sports and cultural activities, protection from abuse, exploitation, and violence, access to clean water and sanitation, and child participation.
The Government has recently undertaken poverty mapping exercises using a combination of data from the HIES 2005 and the Census 2001. These exercises allow more accurate estimation of poverty rates at sub-national levels than can be derived from the HIES alone. An example is shown in the map below. This approach—especially once it is linked with data on climatic conditions, education, health, nutrition, water and sanitation, and other data relevant to children’s rights—represents a potential breakthrough in the targeting of programmes to the poor and the extreme poor. WFP has introduced vulnerability mapping for use in pre-disaster contingency planning and post-disaster rapid emergency response.
I.B.2 Population Growth and Urbanization

Bangladesh is a densely populated country of about 148 million people. Despite the public policy successes in reducing fertility rates since the 1970s, the fertility rate remains 2.7 children per woman—far above the replacement rate of 2.1. The 2004 Population Policy envisions reducing the fertility rate so that the net reproduction rate is equal to one by the year 2010 and the population stabilizes by 2060. Nonetheless, the population is likely to almost double over the next century and to become predominantly urban in about three decades. Population density in the urban slums is already 200 times higher than the average for the country.

Population growth and urbanization directly influence the realization of children’s rights. The populations of the cities and towns of Bangladesh are growing rapidly from both natural population increases and the flow of people from rural areas in search of jobs. This process places enormous strain on the capacity of the Government, city corporations, municipalities, and NGOs to provide the services needed to protect the rights of the urban poor—including children’s rights to health, nutrition, education, water and sanitation, and housing. Historically, most development programmes and projects in Bangladesh have focused on rural areas. Urban planning has been minimal, and the policy agenda has largely neglected the burgeoning urban slums and the urban poor.

Box 1.1

Urbanization and development: A perspective on economic geography

“No country has grown to middle income without industrializing and urbanizing. None has grown to high income without vibrant cities. The rush to cities in developing countries seems chaotic, but it is necessary. It seems unprecedented, but it has happened before. It has to have, because the move to density that is manifest in urbanization is closely related to the transformation of an economy from agrarian to industrial to postindustrial…. All the evidence indicates that the shift from farming to industry is helped, not hurt, by healthy agriculture, which helps towns and cities prosper…. Growing cities, mobile people, and vigorous trade have been the catalysts for progress in the developed world over the last two centuries. Now these forces are powering the developing world’s most dynamic places…. Pull migration is better than push, but both are hard to stop or slow…. The challenge is not how to keep people from moving, but how to keep them from moving for the wrong reasons…. Spatially blind social services should continue as part of rural-urban integration, so that people are pulled to cities by agglomeration economies, not pushed out by the lack of schools, health services, and public security in rural areas….

“In highly urbanized areas,… targeted interventions may be necessary to deal with the problem of slums…. Targeted interventions will not be enough by themselves. These interventions will not work unless institutions related to land and basic services are reasonably effective, and transport infrastructure is in place…. Geographically targeted interventions should be used only when the challenge is especially difficult, but should always be used together with an effort to improve institutions and infrastructure.”

— Excerpts from World Bank (2009), World Development Report 2009: Reshaping Economic Geography

“Morbidity and mortality is the highest for children from urban slums…. Meeting the health needs of the fast growing urban poor of Bangladesh will continue to pose major challenges for the government.” (Bangladesh National Health Policy 2008)
The MDG target related to slums is “by 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers.” UN-Habitat has proposed a definition of slum households that includes those lacking access to safe water, access to sanitation, secure tenure, durable housing, and sufficient living space. In Bangladesh, the Centre for Urban Studies has identified specific locally relevant criteria along these lines, adding also an indicator for socioeconomic status. Achieving the urban MDG target is important, but all development goals and targets are relevant for urban areas.

According to the HIES 2005, the poverty headcount rate in urban areas was 28 per cent, considerably lower than in rural areas, where the rate was 44 per cent. Statistics on the urban population as a whole, however, mask the deprivations experienced in the urban slums. Not all the urban poor live in slums, and not all slum dwellers are poor, but the concentration of poverty within slums is alarming. A study of slums in the six largest cities of Bangladesh, led by the Centre for Urban Studies in 2006, found that 91 per cent of 5.4 million slum dwellers were poor and 37.5 per cent were extremely poor.

Access to education, parenting support, health care, and water and sanitation services are severely limited in urban slums. Children left alone in slums while their guardians work are highly vulnerable to abuse and exploitation, including trafficking. The rates of child labor are especially high among slum dwellers. Many street children moved to the city with their families but became lost or otherwise separated from them during their families’ adjustment to city life. The living conditions of street dwellers are probably even worse on average than those of slum dwellers. A recent ICDDR,B study found that one-fifth of births to women street dwellers took place on the street, and 6 per cent of them were self-conducted—without any trained or untrained assistance whatsoever. Morbidity among women, children, and newborns was extremely high. The sanitation and hygiene conditions of slum dwellers and street dwellers are deplorable. Most slum dwellers do not have latrines, and those that exist are typically pit, surface, or unhygienic hanging latrines. Slum dwellers and street dwellers typically defecate in drains, in open fields, on the roads, and on riverbanks. Girls and women often have to wait until sunset for defecation.

For many slum dwellers, the vulnerability to eviction underlies and compounds virtually all of the difficulties they face. Insecurity of tenure undermines long-term planning, inhibits investment in housing, water, sanitation, and other community improvements, and distorts the prices of land and services in ways that reinforce poverty and social exclusion. Slum upgrading projects often fail in the absence of secure tenure because powerful interests are able to intervene and reap the benefits of the resulting increases in land and housing values. Evicted communities lose more than housing and possessions. They often lose access to the places where they have found employment and any informal schooling and health care arrangements they may have developed. Community savings and investments in infrastructure and social capital are also lost. Some researchers have found that the psychological effects of forced evictions on children are comparable to those caused by exposure to armed conflict.

The most recent large-scale slum evictions from public land in Bangladesh took place during the anti-crime drive of the Caretaker Government in early 2007. Many of the evicted communities had been established for

“The Committee is deeply concerned that child poverty and inequality pose serious challenges, as do the rapid urbanization and the increasing number of slums and sub-standard housing, the insufficient allocation of resources and the unclear criteria for selecting beneficiaries of social safety net programmes.”

(Committee on the Rights of the Child, 2009)
decades. Whether undertaken by governments or private developers, forced evictions deprive cities’ most vulnerable residents of all of their human rights. They are also ineffective—they do not reduce the number or the size of slums. Evicted families re-settle in other slums, intensifying pressures on housing and services there, or establish new slums elsewhere. There is no evidence that evicted slum dwellers return to rural villages.

What happens to the cities and towns of Bangladesh—and to a large extent, what happens to the urban poor—will determine whether Bangladesh achieves its development aspirations, including the MDGs. Urbanization is a reality—no country in the world has succeeded in stopping it, and stopping it would not make sense even if it were possible. Cities are drivers of economic growth and development. They provide the dynamism that leads economic growth as productive activity moves up the value chain. They also provide markets and remittances that support development in rural areas. The urban poor make vital contributions to the economies of cities, towns, and even rural areas. They provide much-needed labor and services in urban areas and bolster urban-to-rural remittances. Yet the urban poor, and particularly slum dwellers, are rarely recognized for their contributions and are marginalized, sometimes by distance and almost always by a lack of access to affordable and reliable public services.

Bangladesh has abundant opportunities to absorb lessons learned internationally and adapt them to local circumstances. International experience shows that partnerships among poor communities, local governments, other service providers, and civil society can enable the economic growth of cities and towns while ensuring the rights of the urban poor who contribute to that growth. The challenge is to encourage a change of mindset among policy makers and other leaders in society—toward an understanding that the urban poor play an important role in urban economies and that cities are important for the achievement of national development goals.

I.B.3 Quality of Governance

The political situation has changed markedly during the years since the SitAn was last updated. After a period of civil unrest, a Caretaker Government came to office in January 2007, declared a state of emergency, and pledged to combat corruption and set the country on the path toward free and fair elections. In some respects, the Caretaker Government brought about improvements necessary for the realization of children’s rights, for example through the long-awaited separation of the judiciary from the executive. In other areas—such as the pursuit of improvements in water supply and sanitation—the Caretaker Government was less vigorous.

Peaceful and credible national parliamentary elections took place in December 2008. The new Government has promised a number of important reforms related to children’s and women’s rights. These include maintaining the independence of the judiciary, improving the quality of education, commissioning 18,000 community clinics, improving the nutritional status of children, ensuring access to birth control and reproductive health care, providing safe drinking water for all by 2011, providing hygienic sanitation facilities to all households by 2013, rectifying discriminatory laws against the interests of women and minorities, abolishing child labor, prohibiting the use of children in political
activities, ensuring housing for all by 2015, and taking measures to protect Bangladesh from the adverse effects of climate change and global warming. The Asia Foundation’s national public perception survey found that 83 per cent of citizens felt that things were going in the right direction in January 2009—a significantly higher proportion than in November 2008.

Bangladesh suffers from a range of governance problems. The Government’s structure has been highly centralized throughout the country’s history. This limits local officials’ authority and flexibility to adapt services to suit local circumstances and meet local demand. Efforts toward decentralization are much discussed and long promised. Elections at the upazila (sub-district) level were held recently for the first time in many years. Various policy statements in the sectors most relevant to women’s and children’s rights, such as health, education, and water and sanitation, have encouraged the delegation of greater authority to local levels, where communities can have greater influence. In practice, however, genuine progress toward decentralization remains a challenge for the future.

Achievements in the social sectors since the early 1990s have mainly involved expanded access, which is administratively easier and has more immediate political popularity than the deeper institutional changes needed to improve service quality and equity. The expansionary policies in health, education, and social protection—together with inadequate resourcing—are likely to have weakened service quality and created broader scope for corruption. Beneficiary selection for social protection programmes, including the education stipends, takes place at the local level. This has the advantage of better information about who is genuinely vulnerable but has the disadvantage of the potential for local elite capture. Partisan competition at the local level is believed to influence service delivery, while leakages higher up the system (e.g., in procurement) also take place. Formal accountability institutions are generally ineffective, but Bangladesh has informal mechanisms that help to fill the gap. According to a BRAC study of politics and governance in the social sectors during the 15 years of multiparty rule 1991-2006, these informal mechanisms include individual complaints, lobbying through social networks, collective protest, and the threat of mob violence. The population is politically engaged, and Bangladesh has a vibrant media and civil society. Informal accountability pressures, however, are unlikely to be sufficient to enable the reforms needed for improved service quality and equity.

The allocation of public expenditure to the social sectors is an important indicator of national priorities and a Government’s commitment to improving the quality of life in a country. The Government has allocated substantial amounts of public resources to improving water and sanitation facilities for the poor. Government data show that expenditure for the health sector as a share of GDP is quite low at less than 1 per cent. Bangladesh’s public expenditure on health as a share of GDP is only about half the average in South Asia. At just 2.3 per cent of GDP, public expenditure on education in Bangladesh is low relative to the public

4 Data on actual expenditures in the Ministry of Finance’s Monthly Report on Fiscal Position, June FY 2007-08 (http://www.mof.gov.bd/en/budget/mfr/mfr_june_08.pdf) show total public expenditure on health (from the revenue and development budgets) at 0.67 per cent of GDP in FY 2006, 0.84 per cent of GDP in FY 2007, and 0.77 per cent of GDP in FY 2008. The Ministry of Finance has published data on actual expenditures, rather than just budgeted expenditures, only since the start of FY 2007-08.

5 This is calculated from data in UNDP’s Human Development Report of 2008. The averages for South Asia are calculated from all countries that UNICEF lists for South Asia except Afghanistan, for which data are not provided.
expenditures per GDP of other developing countries (4.5 per cent) and countries of South and West Asia (3.8 per cent). Public spending on primary education per student is also low relative to that of other countries with similar levels of per capita income. Many experts argue that current levels of public spending on education are insufficient to achieve and maintain a minimum acceptable level of quality. Primary education’s share of total public expenditures on education, at about 40 per cent, has declined in recent years as rising primary enrolment and completion rates have increased the demand for post-primary education. The Government has not yet started to invest in pre-primary education but seems committed to doing so.

### Table 1.1 Costs of achieving the MDGs in Bangladesh, 2009-2015

<table>
<thead>
<tr>
<th>MDG</th>
<th>Cost (2009-2015)</th>
<th>Key challenges to achieving MDGs in Bangladesh</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDG 1: Poverty &amp; hunger</td>
<td>US$ 32.4 billion</td>
<td>Improving nutritional status of the population</td>
</tr>
<tr>
<td>MDG 2: Primary education</td>
<td>US$ 15.9 billion</td>
<td>Improving education quality and efficiency (reducing dropout and repetition rates, improving learning achievement)</td>
</tr>
<tr>
<td>MDG 3: Gender parity in primary &amp; secondary school</td>
<td>US$ 4.1 billion</td>
<td>Eliminating domestic violence and discrimination; ensuring gender equity in representation in Government and Parliament</td>
</tr>
<tr>
<td>MDGs 4-6: Health</td>
<td>US$ 21.3 billion</td>
<td>Reducing neonatal mortality, injury prevention and care, increasing coverage of ante/postnatal care and professionally attended birth deliveries, raising awareness and knowledge</td>
</tr>
<tr>
<td>MDG 7: Environment (including environment, energy, and water &amp; sanitation)</td>
<td>US$ 41.4 billion</td>
<td>Adoption and enforcement of sound environmental policies, ensuring safe water and hygienic sanitation for all, improving hygiene practices, managing urban growth</td>
</tr>
<tr>
<td>MDG 8: Global partnership for development</td>
<td>(No estimate)</td>
<td>Strengthening governance through decentralization and civil service reform; ensuring accountability of Government and development partners</td>
</tr>
<tr>
<td>TOTAL (MDGs 1-7)</td>
<td>US$ 115.0 billion</td>
<td></td>
</tr>
</tbody>
</table>

**Source for cost estimates:** Government of Bangladesh and UNDP (2009)

In addition to low levels of expenditure, governance issues in regard to funding for the social sectors include incidents of misappropriation of funds and the Government’s low revenue base. Bangladesh collects less than 9 per cent of GDP in tax revenue, well below the regional average of 12 per cent. The low revenue base relates to both the country’s poverty and weak institutional structures that preclude effective revenue mobilization.

A recent study by the Government and UNDP underlines the high priority that must be placed in the social sectors if the MDGs are to be achieved. The study estimated the public and private costs of MDG achievement between...
2009 and 2015 at US$ 115 billion. These costs and some of the challenges to achieving the MDGs in Bangladesh are shown in the table 1.1.

**Figure 1.1 Linkages among MDGs and interventions for children’s and women’s rights**

**I.B.4 Social and Cultural Norms and Values**

Many social and cultural norms and values in Bangladesh influence the realization of children’s rights. These norms and values underlie the low priority often placed on the development and/or enforcement of policies to promote and protect children’s rights. They include the social acceptance of child marriage, which is harmful to children and women. Acceptance of a child as a legitimate marriage partner is, in turn, connected with social acceptance of child sexual exploitation. The social acceptance of child labor is another norm that is harmful to children. This stems in part from views on the developmental stages of childhood and the expectation that children of school age should be tightly controlled, work or study hard,
and, often, contribute to family survival—as indeed many of their parents
did themselves. Many employers consider the ease of controlling children
(relative to adults) as a justification for employing them. Prevailing notions
of child development are also reflected in the low priority policy makers
have placed on preschool education. Social stigmas about disability
contribute to families’ tendency to hide disabled family members and not to
seek appropriate care for them. Discriminatory attitudes contribute to slow
progress in inclusive education and to low public investment in education
in the urban slums and remote areas. A low level of respect for the rule of
law—especially when it conflicts with other social norms—also contributes
to rights violations.

Prevailing norms and values link family honor with the behavior and
experiences of girls and women. This concept of honor is so entrenched
that girls and women who are victims of abuse—and even those who seem
likely to have been victims—suffer far greater social consequences than
do their abusers. For example, the social recognition that child domestic
workers are frequently sexually abused creates an obstacle to arranging
marriages for those girls, but it does not create a stigma for those who have
children working in their households. Similarly, commercial sex workers
are widely reviled by a society that often accepts those who patronize
them. The shame and guilt that girls experience in connection with abuse
lead them to maintain silence, further empowering their abusers. This
conception of family honor leads some families to reject children who are
caught up in trafficking and/or sexual exploitation, which is an enabling
factor for those who exploit them. Family honor is among the explanations
that families give for arranging early marriages. Some progress has been
seen in recent years as families have gradually increased the priority
they place on educating girls relative to placing them in domestic labor
situations or early marriage.

The low socioeconomic status of women is reflected in the health and
educational services provided to mothers and children, their food intake,
and their influence over the decisions that affect their lives. It reinforces
the low educational attainment and awareness of many mothers, which
is transmitted across generations. It also underlies the widespread social
acceptance of violence against women and the tendency for both women
and men to accept that a wife’s disobedience and neglect of traditional
household duties are justifications for violence against her. Gender norms
can prevent women from serving as health workers, which in turn makes
health care less accessible to women and children. Cultural restrictions on
the mobility of women and adolescent girls make it difficult for them to
seek safe water sources, adequate sanitation facilities, and health services
when they are not located near their homes. Gender norms include men’s
limited awareness regarding maternal and child health and their low levels
of constructive participation in these issues.

Gender inequality leaves women and girls with inadequate access to
information about HIV/AIDS and other sexually transmitted infections.
Many women and girls have little or no ability to refuse sex or negotiate
condom use. Social taboos regarding the discussion of sex and drug use
obstruct efforts to raise awareness of HIV/AIDS and to expand access to
testing, treatment, and care. Moreover, the high volume of internal and
international labor migration creates an increased risk for the spread of HIV/
AIDS in Bangladesh. Newfound freedom, disposable income, exploitation,
and abuse lead some migrants to high-risk behaviors, and undocumented

“States Parties shall
take all appropriate
measures ... to modify
the social and cultural
patterns of conduct of
men and women, with
a view to achieving the
elimination of prejudices
and customary and all
other practices which
are based on the idea
of the inferiority or the
superiority of either of the
sexuals or on stereotyped
roles for men and
women. ”
(CEDAW, Article 5(a))
or trafficked migrants are less likely to seek or access services, including health. Because of stigma, people engaged in high-risk behaviors often have limited access to health care. In addition, as a result of cultural norms that discriminate against homosexuality, many men who have sex with men do not identify themselves as gay and sometimes are heads of families, increasing the risk of heterosexual transmission of HIV.

One cultural barrier to good hygiene practices relates to the traditional use of the left hand only for anal cleansing. This makes bringing the two hands together for hand washing before contact with food an unfamiliar and uncomfortable practice.

Some social norms obstructing children’s and women’s rights require further research to understand and address. These include the propensity for home deliveries, resistance to exclusive breastfeeding for the first six months, and the low levels of postnatal care seeking.

UNICEF and other advocates for child rights are using communication for development (C4D) as a mechanism to address social and cultural barriers—such as those described above—to the realization of children’s rights. C4D involves social mobilization, community-led social change, and advocacy. In some cases, raising awareness is enough to bring about behavior change, but changing the fundamental ways people think about children, women, and their rights is a long-term, human-resource-intensive process in most respects. It requires addressing deep-rooted beliefs and inspiring changes in power relationships, which can be ardently resisted. It uses a combination of approaches, including social marketing and participatory communication to help inform, influence, and support households, community groups, and opinion leaders. Advocacy initiatives help to ensure that the voices of children, women, and men from marginalized groups are reflected in policy dialogue and decision making. The introduction of community radio in Bangladesh may provide a new avenue for projecting the voices and advancing the interests of ordinary people—including the poor, the marginalized, and children.

I.B.5 Occurrence and Management of Natural Disasters

Bangladesh has always been disaster-prone, and natural disasters—including floods, cyclones, storm surges, and droughts—could become more frequent and intense as a consequence of global climate change. Indeed, Bangladesh’s location, low elevation, poverty, high population density, poor infrastructure, and high dependence on natural resources make it one of the most vulnerable countries in the world to climate change. Bangladesh lies over the flood plains of three major rivers, which converge and discharge into the Bay of Bengal through the world’s largest river delta. Floods occur almost every year, causing the Government and development partners to view them increasingly as part of the development continuum, rather than as discrete geographical events. In 2007 alone, flooding and Cyclone Sidr affected more than 22 million people, about half of them children, some of whom were orphaned. Ninety percent of the 1,110 flood-related deaths were among children.

The Government has developed substantial capacity in disaster management and risk reduction, which mitigates the impact of disasters when they occur. For example, a highly effective early warning system is
in place for cyclones. The Bangladesh Meteorological Department collects meteorological data and issues regular bulletins that are transmitted to its divisional and upazila offices over high-frequency radio. These offices in turn pass information to villages, where teams of trained volunteers disseminate cyclone warnings and information about evacuation, rescue, first aid, and emergency relief throughout their communities. An early warning system for flooding also exists but is less effective because of the difficulty of accurately forecasting inundation.

With support from UNICEF and other development partners, the Government has established a strategy of pre-positioning food and other items for shelter, psychosocial recovery, clothing, water purification, and other immediate requirements. This has enabled prompt responses to recent disasters. Food rations were targeted specifically to young children and pregnant and lactating women. Measures were taken for the rapid rehabilitation of schools, including their water and sanitation facilities. Schools-cum-cyclone shelters are under construction. The Disaster and Emergency Response sub-group of the Local Consultative Group has developed systems for rapid initial reporting and rapid emergency needs assessments that involve all the major organizations involved in emergency response in the country. UNICEF is also supporting the Government in the development of mechanisms to reintegrate orphaned and vulnerable children into their families and communities.

The Water, Sanitation and Hygiene (WASH) cluster for emergency response— with the Government in the lead and UNICEF as the lead international agency—was activated after Cyclone Sidr in 2007 and has helped to improve overall coordination of response activities in the sector. A number of national and international organizations used the technical expertise and information management of the cluster to improve their planning. The WASH partners have developed emergency standard operating procedures, assessment and monitoring tools, and technical guidelines. A union-level analysis of emergency WASH vulnerability was carried out to enable locally specific preparedness and response interventions, and contingency planning is underway. The Government has decided to continue monitoring and preparedness activities through the cluster’s Strategic Advisory Group, which will re-activate the cluster during the early warning phase of any future disaster. Further efforts are needed to ensure that the WASH functions are fully integrated into Government systems and procedures. UNICEF is also the lead international agency in the nutrition cluster for emergency response, which is developing a comprehensive preparedness plan. These clusters are expected to further improve national and international response to future emergencies.

I.C. CHILDREN’S RIGHT TO PARTICIPATION

Children have the right to participate in decision-making processes that may be relevant in their lives and to influence decisions taken in their regard within their families, schools, and communities. They also have the right to express their views in all matters affecting them and for those views to be heard and given due weight in accordance with their age and maturity. Children have the potential to enrich decision-making processes,
Accordingly, participation is one of the guiding principles of the Convention on the Rights of the Child. A process of dialogue with children—in which adults provide direction and guidance—enables children to assume increasing responsibilities and become active, tolerant, and democratic.

Social norms with regard to childhood make the realization of children’s right to participation especially challenging in Bangladesh. Social awareness of the developmental stages of childhood and adolescence is low. The concept of adolescence—and even the Bengali words for adolescence—are not well known or understood. The transition from childhood to adulthood is often seen as a relatively abrupt event that can occur at different ages for different people, depending on their personal experiences and responsibilities. (See Chapter IV on child protection, especially Box 4.2, for elaboration on society’s perceptions of child development.) In the middle years of childhood—when children are developing the capacity for independent opinions and participation in decision making—children in Bangladesh are typically tightly controlled and expected to work or study hard. Parents often unilaterally make important decisions concerning their children’s lives, including where and whether they go to school, what they study, with whom they associate, and when and to whom they marry. Children rarely have opportunities to express themselves, and when they do, adults tend not to take them seriously.

In recent years, civil society organizations have taken the lead in promoting children’s participation and encouraging adults to share information with children and young people and to develop new kinds of partnerships with them. This has included support for children’s journalism and the development of children’s organizations at various levels. A National Children’s Task Force (NCTF) was formed at the recommendation of children who participated in consultations for the first National Plan of Action (2002-2006) for combating sexual exploitation and trafficking of children. Engaging more than 4,000 children of ages 12 and up, the NCTF now operates in all 64 districts. Its objectives have expanded to include the promotion of all children’s rights in the Convention on the Rights of the Child.

The district committees of the NCTF held public hearings on child rights issues with duty bearers in 2006 and are conducting another round of public hearings in 2009. The duty bearers who participate in these hearings include District Commissioners, teachers, lawyers, political leaders, female Union Parishad members, civil surgeons, doctors, representatives of child-protection NGOs, and other members of civil society. Children select the issues to be covered in the hearings. Examples of these issues include child marriage, child abuse and exploitation, child poverty, education, physical punishment, hazardous child labor, social exclusion, children’s health, and birth registration. The outcome documents of the public hearings are produced, published, and disseminated among Members of Parliament, political parties, civil society organizations, and other stakeholders. Children in the district committees have received journalism training and produce quarterly newsletters. Before the 2008 national parliamentary elections, the NCTF district committees met with candidates to discuss child rights issues and obtained commitments from the candidates. After the elections, they met with the candidates who won the election to discuss action plans for fulfilling their commitments to children’s rights.

“States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.” (CRC Article 12(1))
The NCTF supports the Child Parliament, which consists of two children (one boy and one girl) from each district. The Child Parliament aims to influence policy makers to formulate pro-child policies based on the CRC. Child Parliament sessions are held annually on topics such as budgetary allocations for children and the quality of health care and education. High-level government officials have attended as chief guests and have been called upon to comment and respond to questions posed by children. A press conference is held after each session of the Child Parliament. For the Child Parliament session in 2008, the child delegates decided—based on a survey—to focus on a proposal to ban the involvement of children in politics. In Bangladesh, the use of children had become common for picketing, participation in assemblies, carrying posters, working in school groups that political leaders use, collecting money, and other political activities. Child Parliament members met with 24 dignitaries, including Advisers of the Caretaker Government and the Central Election Commissioner. As a result, the election manifestos of the main political parties included a ban on the involvement of children in politics.

Some progress has been seen recently in children’s participation in the processes of formulating policies related to child rights. Extensive consultations are underway with children in all districts of the country on the design of a policy on child abuse. A similar process is envisioned for the development of a policy on commercial sexual exploitation and trafficking of children.

The media in Bangladesh has been criticized for projecting primarily a middle-class vision for children that focuses on positive role models and development messages without reporting on the harsh realities of many children’s lives. A review of print media between 2004 to 2007 for the Children’s Opinion Poll 2008 found very little reporting on issues related to minorities, disability, and physical punishment of children. Child rights advocates who promote sensitive and appropriate reporting on children’s rights violations have found that they must delicately balance their efforts against the potential for a backlash from those who object to some child rights principles and/or feel that these are inappropriate subjects for the media to address.

Some progress is evident, nonetheless, in engaging children—and a wider range of children’s rights issues—in journalism. The first children’s news agency in Asia, the Children’s Express, has operated in Bangladesh since 2005. The Children’s Express has recruited (through a competitive process) and trained teams of ten adolescents (half girls, half boys) in each of the country’s 64 districts to report on the challenges and opportunities of the children of Bangladesh. Their reporting appears widely in local and national newspapers and has led to some concrete results. For example, some children received school supplies after reports revealed that they could not afford them, some received time off from work to attend school, and some received pay increases. Some reports helped to stop child marriages, some exposed child abusers, and some motivated the transfer of adolescents from adult jails to child development centers. Some reports led to the reclamation of children’s parks, while others led to the closure of obscene video shows and games. Another promising opportunity for children to raise their voices may arise with the introduction of community radio in Bangladesh.

Despite the energy and momentum that the initiatives for child participation have generated, the number of children involved is very small relative to the...
country’s child population of 63 million. Many parents resist their children’s participation in such initiatives because they detract their attention from work or study and because speaking out, particularly for girls, is not regarded as appropriate. Consultations with children and adults during the preparation for this Situation Analysis showed that local understandings of the concept of child participation generally relate to children’s participation in sports activities, picnics, scout groups, and other events organized by adults. The value of children’s participation in decision-making is generally an unfamiliar concept. Similar to the findings of many qualitative research initiatives, the children and adolescents we met confirmed that their families do not take their views into account in decisions that affect their lives. Current steps toward respect for children’s right to participation remain small steps facing resistance from those with traditional views on the role of children.

This SitAn incorporates children’s perspectives, priorities, and voices wherever possible throughout the report. The report draws upon a series of consultations undertaken with children during the process of preparing the SitAn and a number of published studies and reports. Several documents are particularly important in this respect and are referenced repeatedly. One is the Alternative Report on Child Rights in Bangladesh 2007, prepared for the Committee on the Rights of the Child by a group of children’s organizations. Another is the Children’s Opinion Poll 2008, supported by UNICEF, which used quantitative and qualitative methods to gather information in 31 districts from children in the later years of childhood (ages 9-18 years), including children in urban areas (slum and non-slum dwellers and street children), rural areas, char lands, and adivasi populations. The study Abuse in Children’s Lives, supported by the Government, UNICEF, and Save the Children Alliance, explored the ways that adults and children in the middle childhood and young adolescent stages (6-14 years of age) experience and perceive the treatment of children in one rural and two urban areas of Bangladesh in 2003-04. A nationwide ILO survey of child domestic workers in 2005-06 also provided valuable insights.

UNICEF and other organizations promoting child rights could do more to ensure that their own programming activities always engage the meaningful participation of children and to encourage the participation of children in forums related to their rights at all levels. These include, for example, school management committees, water and sanitation committees, community care committees for the reintegration of children and women who have been trafficked or otherwise separated from their families and communities, community radio initiatives, nutrition management committees, community nutrition centers, and the para centers in the Chittagong Hill Tracts.

I.D. THE RIGHTS OF CHILDREN WITH DISABILITIES

The prevalence of disability is a matter of debate in Bangladesh. Surveys conducted by the Government and NGOs during the past decade have put forth estimates ranging from less than 2 per cent to one-tenth of the population. In what is perhaps the largest disability prevalence study to

date, Handicap International and the National Forum of Organizations Working with the Disabled (NFOWD) found that 5.6 per cent of the population living in Bangladesh suffers from some kind of disability. The study also reported that child mortality is three times higher among children with disabilities than for the country’s children overall. Hence, if more children with disabilities could survive their early years, the disability prevalence rate would be higher.

The disability prevalence rates for different groups reflect other inequalities in society. Those with low levels of income, food security, education, and access to sanitation are more likely to have disabilities. Overall disability prevalence is higher in rural areas than in urban areas (6 per cent versus 4 per cent), but the prevalence of physical and intellectual impairment is higher in urban areas, whereas the prevalence of hearing and visual impairment is higher in rural areas. People living in char areas (river-surrounded land) and hoar areas (marshland frequently under water) have a disproportionately high disability prevalence rate (nearly 7 per cent). The overall incidence of disability is higher among males than females (6 per cent versus 5 per cent), but among the population of childbearing age, the prevalence rate is slightly higher for females than males. The lower overall female rates may indicate that males are naturally more prone to disability—or that the disabilities of females may be under-reported and/or females may receive less care and die earlier. Some research indicates that families are more likely to seek care for boys with disabilities than for girls. Disability prevalence rises with age, but childhood is a critical stage for the onset of disabilities.

What are the causes of disability and the vulnerability of people with disabilities? The main immediate causes of disability among children are maternal and child under-nutrition, disease, birth and congenital problems, and accidents. Most of these causes are preventable.

Low access to adequate health and disability services is an important underlying cause of disability and the vulnerability of people with disabilities. Many temporary ailments become permanent when appropriate health services are not available or affordable. The children who contributed to the *Alternative Report on Child Rights in Bangladesh 2007* said they believe inappropriate treatment by doctors often causes disability in children. They also reported that disabled-friendly facilities are absent at schools and hospitals and that roads are unsuitable for children with disabilities. Early detection and screening for disabilities is uncommon in schools and health facilities. The study by Handicap International and NFOWD found that nearly one-third of people with disabilities had never visited a doctor in regard to their disability, mainly because of economic hardship. Most disability services are concentrated in Dhaka city, leaving residents of the rest of the country with little or no such services. Lack of awareness about disability combined with the limited access to disability services leads many families to see disabled family members as a burden and to restrict them to the home. Stress in the lives of caregivers is another underlying factor: caring for a child with disabilities can contribute to stress and depression, especially among caregivers who also suffer from poverty, food insecurity, and other hardships. These caregivers are then less likely to be responsive and stimulating toward their children, which in turn influences child development.

Social and cultural values and poverty are important basic causes of disability and the vulnerability of people with disabilities. Social stigmas

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_*States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community._*

(Committee on the Rights of the Child, 2009)
about disability contribute to families’ tendency to hide disabled family members and not to seek appropriate care for them. Many of the children contributing to the Alternative Report 2007 reported that parents and school authorities discriminate against children with disabilities. Consanguineous marriage is also a contributing factor to disability in many families.

As described by Handicap International and NFOWD, “Poverty and disability seem to be inextricably linked. Poverty is both a cause and consequence of disability, reinforcing each other and contributing to increased vulnerability and exclusion…. Poverty increases the risk factors such as communicable diseases, poor nutrition, hazardous living and working conditions, etc. Persons with disabilities, in turn, are handicapped in society due to physical, social and cultural barriers that prevent them from fully and equally participating in social, economic, political and cultural activities. The resulting dependency and marginalization of a disabled member in a family in the end affect the quality of life and opportunities of the whole family.”

“The Committee ... is concerned that children with disabilities, in particular girls, experience discrimination and prejudicial treatment throughout their development. Furthermore, the Committee is concerned that services for early detection of disabilities are inadequate.”

(Committee on the Rights of the Child, 2009)

Who is responsible for ensuring the rights of children with disabilities, and what constraints do they face? The duty-bearers responsible for the rights of children with disabilities include immediate caregivers, families, schools, communities, local governments, NGOs, health and social workers, the national Government, and the international community. Mothers—who are usually the immediate caregivers—are constrained by lack of awareness and low (if any) access to disability services. When services are available but not close to home, mothers often have problems accessing them because of transport costs and cultural restrictions on women’s mobility. Families, communities, schools, local government bodies, and NGOs often lack knowledge and organizational, institutional, and/or financial capacity.
Most health workers lack understanding of disabling conditions in children, the stress that disability can create in families, and the possibilities for children with disabilities to improve their skills. Social workers are rarely given responsibility for psychosocial counseling, where their services would be most advantageous.

One example where NGOs and private sector organizations have overcome all obstacles and made progress in addressing the social biases against people with disabilities is their support for Bangladeshi athletes’ participation in the Special Olympics, which engages people with intellectual disabilities from more than 180 countries in athletic training and competition. Bangladesh has achieved a distinguished record of achievement in the Special Olympics World Games and regional events.

The Government has begun taking steps to address the rights of people with disabilities. Bangladesh was among the first countries to sign and ratify the Convention on the Rights of Persons with Disabilities, which came into force in 2008. The Convention aims to ensure that persons with disabilities enjoy all human rights on an equal basis with others. Bangladesh’s current Disabled Welfare Act is welfare-based rather than rights-based, but the current Government pledged in its election manifesto to update and implement this law and to take special steps “to facilitate education, employment, movement and communication of the disabled and to enhance their social dignity.” With support from the World Bank, the Government recently initiated a Disability and Children at Risk Project that envisions strengthening institutional capacity to provide disability services and expanding access to these services.

What can be done? UNICEF and other organizations concerned with the rights of children and others with disabilities could provide valuable support to the Government in developing and implementing policies in line with the Convention on the Rights of Persons with Disabilities.

Support could also be provided for the piloting and scaling up of evidence-based initiatives. Research in Bangladesh shows that services for children with disabilities should include primary health care, feeding programmes, and rehabilitation. Home visits and community-based services may be particularly effective because of the difficulties many mothers face in visiting hospitals and the stress these visits can create. One study on this subject concludes that “the direct benefits from optimizing mothers’ mental and physical health may be an important intervention in helping children with disabilities in developing countries” (Mobarak et al., 2000). Services provided in the home or community also enable the use of approaches decided upon in consultation with families and that are most relevant to them, which may include support for changing negative attitudes of neighbors and extended family members. Home-based care can also be more cost-effective than center-based care. Adding psychosocial stimulation to the treatment of undernourished children (where such treatment exists) has been shown to improve cognitive, language, and personal-social development while enabling cost-effectiveness by using existing structures.

Other areas for potential support include the introduction of early detection of disabilities in schools and health centers, research on gender disparities in disability prevalence and care, and communication for development.
(C4D) approaches to raise awareness about disability and change social attitudes toward people with disabilities.

### Box 1.2

**Economic and social development in Sylhet**

Economic and social indicators in Sylhet—one of Bangladesh’s six administrative divisions—reveal some striking contrasts. Located in the northeastern part of the country, Sylhet has received a substantial flow of remittance income for several decades. The levels of household income, expenditure, and consumption in Sylhet are 15 per cent, 22 per cent, and 23 per cent higher, respectively, than the national averages. Yet Sylhet has the highest proportion of households receiving benefits from social safety net programmes, and the available indicators of health, education, and women’s empowerment show that the population of Sylhet is distinctly disadvantaged.

In terms of health, nutrition, and health care provision, Sylhet has the country’s…
- Highest rates of neonatal, infant, and under-five mortality
- Highest total fertility rate, lowest contraceptive prevalence rate, and largest household size
- Largest proportion of women who are undernourished
- Lowest proportion of births taking place in health facilities
- Lowest vaccination coverage
- Greatest imbalance in the doctor to nurse ratio (only one nurse for every ten doctors).

In terms of education, the Sylhet division has the country’s…
- Highest illiteracy rates
- Lowest performance on the National Assessment of Pupils of Grades 3 and 5
- Highest proportion of women and men with no education, lowest proportion with some education, and lowest proportion who have completed secondary education
- Lowest enrollment of poor girls of ages 6-10 years, and lowest enrollment of boys, girls, poor, and non-poor children of ages 11-15.

Comprehensive knowledge of HIV/AIDS is also lower in Sylhet than in any other division.

In terms of women’s empowerment, women in Sylhet have less freedom of movement than do women living in other divisions, and Sylhet has nearly the country’s lowest level of women’s participation in family decision-making (26 per cent, whereas the lowest is 25 per cent in Barisal). Among those with cash earnings, women in Sylhet have the least independence in deciding how to spend them. Interestingly, however, Sylhet has the lowest prevalence of physical violence by husbands against wives and the highest median age at first marriage for women.

Understanding the dynamics of social and economic development in Sylhet, and their implications for children’s and women’s rights, would require additional research—particularly qualitative research to explore in-depth the apparently contrasting findings of the existing surveys.

II. Children’s Right to Education

All children have the right to education and development. The Convention on the Rights of the Child commits States Parties to making primary education compulsory and free, making secondary education and vocational guidance available and accessible to all children, and taking measures to encourage regular school attendance and the reduction of dropout rates. Bangladesh also has commitments to education at the national level. The Constitution of Bangladesh and subsequent legislation provide for free and compulsory primary education. The National Strategy for Accelerated Poverty Reduction II places a priority on improving preschool, primary, secondary, and non-formal education. The election manifesto of the current Government commits the Government to improving the quality of education with particular attention to disadvantaged pupils.

This chapter explores the extent to which the children of Bangladesh realize their right to education, the causes of violations of their right to education, and the roles of the duty bearers who are responsible for children’s education. The chapter examines in particular (a) preschool attendance, (b) primary and secondary school enrollment and retention, (c) the quality of education, and (d) inequality and exclusion.
II.A. OVERVIEW OF THE SITUATION

II.A.1 Preschool Attendance

Preschool education is important for early childhood development. Research and experience in Bangladesh and abroad show that quality preschool education has multiple benefits for children’s lives. It motivates and prepares children to attend primary school and to thrive in a school environment. It also provides parents with information about new approaches to education and helps to prepare them to support their children’s schooling experience. Preschool attendance improves children’s enrollment and completion—and their academic performance—in primary school and beyond. By increasing their chances of pursuing secondary education, it can defer marriage, reduce fertility, and increase their lifetime economic opportunities. The preschool experience is particularly important for disadvantaged children, such as first-generation learners and children from poor households.

In Bangladesh, only 14.6 per cent of children of ages 36-59 months attend any form of organized early childhood education programme, according to MICS 2006. Attendance is slightly higher for girls than for boys. Geographic and socioeconomic differentials are not significant, but children whose mothers completed secondary or higher education are far more likely to attend preschool. Policy changes in 2008 and 2009 may lead to higher rates of preschool attendance in the near future. These include the adoption of

“All children, young people and adults have the human right to benefit from an education that will meet their basic learning needs in the best and fullest sense of the term, an education that includes learning to know, to do, to live together and to be. It is an education geared to tapping each individual’s talents and potential, and developing learners’ personalities, so that they [III.B.2] can improve their lives and transform their societies.”

an Operational Framework for Pre-Primary Education and the decision for all Government primary schools and registered non-government primary schools (RNGPS) to open pre-primary classes. Existing preschools are operated by NGOs and the private sector. Establishing public funding, human resource development, and know-how for preschool education are challenges facing the Government.

II.A.2 Primary and Secondary School Enrolment and Retention

Bangladesh has made remarkable progress over the past two decades in increasing primary enrolment. The absolute number of children enrolled nearly doubled between 1985 and 2005. The national Household Income and Expenditure Surveys (HIES) show net primary enrollment rising from 75 per cent to 80 per cent between 2000 and 2005. According to official data collected from schools, net primary school enrollment has continued rising since 2005—from 87 per cent in 2005 to 91 per cent in 2008.¹ When evaluating net primary attendance, MICS 2006 found a less impressive figure (81 per cent). Enrollment and attendance are higher among girls than among boys. The Government and NGOs are expanding and strengthening programmes of non-formal education for children who have dropped out or never enrolled, but the programmes are not yet able to reach most of these children.

![Figure 2.1 Net enrolment ratio in primary education by gender, 1990-2008](image)

Source: Bangladesh Basic Education Information System, Ministry of Primary and Mass Education

While the rising enrollment rates are encouraging, many Bangladeshi

¹Possible reasons for the difference between HIES estimates of enrollment and the official data from schools include non-representativeness of the school surveys at the national level, different population estimates, and the possibility of inflated enrollment figures from school administrators. (World Bank (2008), Education for All in Bangladesh: Where Does Bangladesh Stand in Achieving the EFA Goals by 2015?)

Children’s Right to Education
Children still repeat grades in primary school and many drop out before completing the five-year primary cycle. In 2008 the repetition rates were between 11.0 per cent and 14.5 per cent for Grades 1-4 and 5.2 per cent for Grade 5. The number of years of primary education input per graduate was 8.6 (slightly higher for boys than girls). MICS 2006 found that 10 per cent of children of secondary-school age were attending primary schools. In terms of dropout, the official data collected from schools indicate that nearly half of the children who enroll in primary school fail to complete Grade 5. HIES data for 2005 show that only 48 per cent of children of ages 10-15 had completed Grade 5 but nearly three-quarters of children of ages 15-19 had completed the cycle, again reflecting the high repetition rate. The completion rate for both age groups rose substantially between 2000 and 2005. Attendance and retention since 2007 may have been adversely affected by natural disasters and rising food prices. Studies in 2008 found that many households had stopped sending children to school as a coping strategy. Although food prices have subsequently declined, the interruption or cessation of studies for many children is likely to have a profound impact on education outcomes.

A child who completes primary school in Bangladesh has a good chance of entering secondary school. The official estimate of the transition rate to secondary school was 95.5 per cent in 2006, and MICS 2006 found a transition rate of 89 per cent. Transition rates are consistently higher for girls than for boys. The secondary school net attendance ratio was 38.8 per cent, with girls having much higher net secondary attendance than boys (41.4 per cent versus 36.2 per cent).

II.A.3 Quality of Education

Despite a dearth of concrete information on education quality, experts widely agree that the quality of education is unsatisfactory for the vast majority of primary- and secondary-school students in Bangladesh. Less than half (48 per cent) of the population of ages 15 years and above are literate, according to UNESCO data for 2008. The limited available information from various studies since 2000 suggests that learning achievement is improving in all subjects, but the levels of achievement remain low. Many children complete primary school without basic literacy and numeracy competencies, and many complete secondary school without the knowledge and skills needed for either the workplace or further education.

The Government is putting in place a series of national assessments of learning achievements of pupils in Grades 3 and 5. Two rounds have been completed, in 2006 and 2008, with a school sample from 64 upazilas in 32 districts and all six administrative divisions. The tests cover two subjects for Grade 3 students (Bangla and mathematics) and five subjects for Grade 5 students (Bangla, mathematics, English, science, and social studies). The results show that the proportion of students who achieved overall mastery in a subject was very low. National mean test scores increased markedly between the two test periods, but comparability of the two rounds (2006 and 2008) is not confirmed.

Improving the quality of education requires a strong evidence base, good analysis, and communication of results to all levels so that changes can be made accordingly. The assessment results for 2006 and 2008 are disaggregated only to the district level, so further disaggregation will be

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“The Committee is concerned at the limited number of leisure, recreational and cultural facilities for children of all ages, including playgrounds and sports facilities in school as well as for out-of-school children…. Committee encourages the State party to allocate adequate human and financial resources to the implementation of the right to rest, leisure and play.”  
(Committee on the Rights of the Child, 2009)
needed in future assessments. A balanced approach to student evaluation also requires qualitative research that evaluates students’ learning in terms of a full range of their talents. This type of information is not yet available in Bangladesh. While the national assessment provides an important proxy, it cannot capture all the dimensions of school quality.

The education system in Bangladesh has traditionally placed a high priority on students’ performance on standardized tests, such as the scholarship and terminal examinations given at the end of primary school and the examination for the Secondary School Certificate given at the end of Grade 10. One consequence of the emphasis on examination results is the tendency of parents to equate successful childhood with them. Achieving high examination results on these standardized tests requires a substantial amount of rote learning and memorization of ready-made information in textbooks. As with the national assessment of primary school students, the results of these tests do not reflect the quality of education—and the nature of a child’s development—in a complete sense. In addition, the emphasis on examination results creates tension and fear of failure. Many of the children and adults consulted in the preparation of this Situation Analysis observed that children are rarely provided opportunities to develop critical thinking and extra-curricular interests and skills. Schools at all levels have very limited provisions for music, dance, drama, and sports. Even playgrounds are uncommon.

**Box 2.1**

**Impact of education on rural girls: A “virtual revolution”**

“Education seems to have wrought a virtual revolution in the Bangladeshi countryside. When girls were asked how education has made their lives different from their mothers’, they typically replied that it had helped them ‘find a voice,’ allowed them to ‘have a say,’ to ‘speak,’ and ‘to be listened to.’ Education also appears to be changing relations between girls, their families, and their elders. While earlier the value was placed very much on girls’ silence and acceptance—a ‘pliable’ obedient girl had a high value in the marriage market—now girls seem to ‘speak’ more. The acceptance of and demand for equal education for boys and girls has pervaded regions and generations. Almost 75 per cent of those surveyed believe that girls should have as much education as boys.”

—World Bank (2008), Whispers to Voices: Gender and Social Transformation in Bangladesh

The provisional official figure for the pupil-teacher ratio in 2007 at Government-supported primary schools is 49:1. This is quite high, but the trend is favourable given that the figure was 54:1 in 2005. The pupil-teacher ratio is highest in Government primary schools. Class sizes are large—58 students per class on average in Government primary schools. This problem is especially acute in urban areas, where class sizes often exceed 100. Many primary schools run on double shifts to accommodate large numbers of students in small classrooms. Student-teacher contact hours in the primary schools of Bangladesh are among the lowest in the world. At the secondary level, the teacher-student ratio is 1:33. Teacher attendance rates are not known but are believed to be low (which may be more than offset by low student attendance rates). Preschool, primary, and secondary education systems face challenges in providing quality education to all children.
education institutions have very different approaches to teaching and learning, and mechanisms are not in place to link their curricula or facilitate students’ transition from one level to the next.

The children involved in non-formal education typically have the advantage of smaller class sizes. The Government programmes of non-formal education for out-of-school children in urban and rural areas and the BRAC primary schools maintain ratios in the range of 25-30 pupils per teacher.

II.A.4 Inequality and Exclusion

**Gender.** The proportion of girls attending primary and secondary school in Bangladesh has risen dramatically in recent years. This trend has eliminated the bias against girls in attendance, enrollment, retention, and completion in primary schools. The data now show that girls are ahead of boys in all of these indicators at the primary level, and the gender gap in favor of girls exists across all welfare groups. At the secondary level, girls outnumber boys throughout the cycle (Grades 6-10), but dropout rates are higher for girls after Grade 6, and far fewer girls complete Grade 10 than do boys (16.7 per cent versus 23.5 per cent). Gender parity in teaching has been achieved in Government-supported primary schools, but in secondary schools only about one-fifth of teachers are female. Little gender disparity is observed in literacy rates among the population of ages 15 years and above.

Some experts have suggested that a new reality in education may be emerging, wherein boys are at greater risk than girls. The World Bank has warned that the phenomenon of “boys left behind” could have serious impacts on social and familial cohesion. As mentioned above, however, more boys complete secondary school. Moreover, boys appear to outperform girls. In the 2008 national assessment of pupils in Grades 3 and 5, boys performed marginally better than girls. In an assessment of learning achievements of students in Grade 10, *Education Watch 2007* found that boys demonstrated significantly better performance than girls in all types of secondary institution, whether government or private, urban or rural, school or madrasa. The bias against girls was least pronounced in the government schools and most pronounced in the madrasas. Another study found that girls in Grade 6 in rural Bangladesh perform significantly worse than boys even after controlling for school/classroom factors and stipend status.

**Socioeconomic disparities.** In Bangladesh, like in many countries, the children of wealthy households and educated mothers have substantially greater educational opportunities than do others. This pattern has long-term consequences as educational advantages and disadvantages are transmitted across generations. The children of poor families and of families with low levels of maternal education are most likely to be similarly deprived, and to pass along the deprivation, in turn, to their own children.

At the primary school level, the net attendance ratio is 73 per cent among children from the lowest wealth quintile and 87 per cent for the richest, according to MICS 2006. Net primary enrollment rates rose between 2000 and 2005 for children from all welfare groups, according to HIES data, with

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2The Campaign for Popular Education (CAMPE), a network of over 1,000 NGOs working in education in Bangladesh, serves as secretariat of Education Watch, which conducts research and produces a report on a different education-related topic each year.
the largest proportional increases occurring at the ends of the spectrum, among the poorest and the richest quintiles (rising from 52.7 per cent to 56.8 per cent among the poorest and from 71.2 per cent to 77.3 per cent among the richest). Primary completion rates rose during the same period for children from all welfare groups, with the largest improvements occurring among those in the poorest quintile. The completion rates for the poorest quintile remain very low, however, at just 31 per cent for children of ages 10-15 and about 54 per cent for people of ages 15-19. The gender gap in favor of girls in primary completion for ages 15-19 is much higher in the poorest quintile (14 per cent) than in the richest (2 per cent).

Figure 2.2 Net attendance rates in primary education, 2006

The socioeconomic disparities in educational attainment become steadily more pronounced at higher grade levels, as children from poorer families drop out earlier. Nearly all children from rich families enroll in Grade 9, but less than one-fifth of the poorest children do. At the higher secondary level, less than 10 per cent of children from the poorest two quintiles enroll while about 70 per cent of those in the richest quintile do. Among children who attend secondary school, those from poorer families tend to attend schools with poorer facilities. CAMPE’s assessment of learning achievements in Bangla, English, mathematics, and science found that secondary-school students’ performance was strongly correlated with household food security status and parents’ (especially mothers’) levels of education.
Socioeconomic disparities in education may have increased in the past two years as a result of natural disasters and food price increases. A study by FAO and WFP in 2008 found that 20 per cent of households in 37 districts had taken children out of school as a strategy for coping with these external shocks. Another study (Raihan 2008) of school enrollment and dropout in selected poor and vulnerable areas in 2008 found that the price increases adversely affected children’s education in a number of ways. They led to lower intake of nutritious foods, which reduces learning capacities, and they led to lower household spending for kerosene, which reduces children’s time for studying after dark. A comparison of enrollment rates in the first terms of 2007 and 2008 shows that the dropout rate increased by 5 per cent at the primary level and 6 per cent at the secondary level. More girls dropped out of primary school than boys, and the reverse was observed for secondary school. The opportunity costs of keeping children in school (the costs of attending school plus the foregone income children could earn from working instead) amounted to about one-fifth of monthly household expenses for the surveyed families who experienced dropout. The opportunity costs of schooling were substantially higher in Sundorgonj, which is affected by monga (seasonal unemployment and hunger), and among female-headed households (about 30 per cent in both).

**Urban-rural disparities.** Overall, children in urban areas have better educational opportunities than those in rural areas. At the primary level, net attendance is about the same in urban and rural areas, but learning achievements appear to be greater for urban students. In the 2008 national assessment of students in grades 3 and 5, urban students outperformed their rural counterparts in all subjects. At the secondary level, net attendance and achievement are both higher in urban areas than in rural areas. Students in Government-run secondary schools, most of which are in urban areas, demonstrated the highest academic performance in the *Education Watch 2007* assessment of learning achievement among secondary-level students. Graduates of secondary schools and madrasas in urban areas were more likely to continue into further education than were graduates in rural areas. Literacy among the population of ages 15 years and above is higher among urban than rural residents (46 per cent versus 57 per cent, according to UNESCO data for 2008). These indications of the benefits of an urban education prevail despite the strain of urbanization on schools, which is evident in class sizes. Government data indicate the average number of students per classroom in the Government primary schools of 17 urban areas exceeded 100 in 2007.

These urban-rural comparisons mask the severe deprivations in education that the children of urban slums experience. According to MICS 2006, these children have the lowest rates of net school attendance—far below national averages—at all levels. Government programmes, some of which are supported by UNICEF, provide non-formal education for a small proportion of these children.

**Vulnerable groups.** Despite Bangladesh’s successes in increasing national rates of school enrollment, some groups have disproportionately limited access to education. These include children with disabilities, street children, working children, and children living in urban slums, remote rural areas, isolated indigenous communities, tea gardens, and brothels. Only a small fraction of children with disabilities enroll in school, and street children, working children, and children living in brothels have severely limited opportunities, as described in Chapter IV on child protection. Tribal children
are disadvantaged at the primary-school level, having a net attendance ratio of just 68 per cent, far below the national average of 81 per cent. Due to the establishment of UNICEF-supported preschools in the Chittagong Hill Tracts, however, preschool attendance among tribal children is relatively high, at 25.2 per cent. Net secondary attendance among tribal children, at 37.6 per cent, is just below the national average (38.8 per cent).

II.B. CAUSALITY ANALYSIS

As described above, the key areas where children’s access to their right to education is challenged in Bangladesh are preschool attendance, primary school completion, secondary enrollment and completion, the quality of education, and the extent of inequality and exclusion of various groups. This section outlines the immediate and underlying factors determining children’s access to their right to education, highlighting the patterns and issues that arose during the consultations and literature review for this report. (Basic factors, which are largely common across all children’s rights, are discussed in Chapter I above.)

II.B.1 Immediate Factors

The immediate factors influencing children’s right to education include (a) the level of knowledge, awareness, and participation of caregivers and their communities, (b) the quality of teaching, (c) the quality of school facilities, including infrastructure and educational materials, (d) the multiplicity of types of school offered in the country, (e) the private costs of education, taking into account the financial incentives that the Government offers to some families, and (f) the availability and accessibility of preschools, primary schools, and secondary schools meeting the needs of all students.

II.B.1 (a) Knowledge, awareness, and participation of caregivers and their communities

Many people in Bangladesh lack awareness that all children have a right to education. This results in low community demand for education, especially for children in vulnerable population groups and children of pre-primary-school age. Providing communities with access to information and learning opportunities can raise community awareness about children’s and women’s rights. It can also reach children and adolescents, directly benefitting them while also preparing them as the next generation of caregivers. Caregivers who have access to flows of new information are more likely to provide children with adequate support and encouragement for learning at home. In the absence of community-level access to information and learning, socioeconomic and educational disparities in adults are likely to be perpetuated in the lives of children.

Knowledge of the developmental psychology of childhood is limited in Bangladesh. Caregivers and their communities are generally unaware of the benefits of preschool education. Many of them lack knowledge of the harm that results from physical and other forms of negative punishment, the importance of play and physical activity for children’s development, and the skills children will need to function effectively as adults in the modern economy. The Government and NGOs are introducing innovative ways...
of learning that are very different from the traditional approaches familiar to most adults. For example, caregivers and other community members may consider children’s play to be frivolous, and they may interpret critical thinking on the part of children as rudeness or insubordination. Raising awareness is critical to ensuring the support of caregivers and their communities for the new teaching-learning methods.

Community involvement with schools and community awareness about quality education are mutually reinforcing. School Management Committees (SMCs), parent-teacher associations, community learning centers, and programmes for adolescent and parent empowerment are examples of mechanisms that can foster meaningful community involvement in the care and education of children.

Box 2.2
School- and family-related factors influencing education: Children’s views

The children who contributed to the Alternative Report on Child Rights in Bangladesh 2007 identified the following school-related reasons for “the present situation of education”:

- Teachers just force lessons on students and beat up children if they fail to learn them
- There is no scope for recreation, and students do not enjoy school
- Teachers discriminate between rich and poor children
- School Management Committees do not participate properly
- Teachers teach properly in private coaching classes instead of school
- Schools are closed for political meetings, processions, and hartals
- The number of teachers is inadequate relative to the number of students
- Some children are not allowed in school as they lack uniform, school shoes, etc.
- Schools are located far away.

The family-related reasons given by these children include the following:

- Parents are unaware about education
- Poverty
- Superstition
- Girls are married off at an early age
- Children’s opinions are never heeded
- Family members discriminate between boys and girls
- Family members compel children to work.

School Management Committees. Many functions of a school depend on the capacity and motivation of the SMC. Where SMCs are strong and effective, they build community demand for quality education and communicate that demand to education officials. This will become increasingly important as the decentralization process unfolds. At present,
however, many schools do not have functioning SMCs, and some have SMC selection processes that reflect local political influences more than community choice and members’ commitment to education. In a country where public resources are insufficient for the requirements of quality primary education, the most effective SMCs tend to be those with wealthy and influential members who can mobilize resources (and sometimes contribute their own resources) for school infrastructure and quality enhancements. This composition of an SMC can serve the short-term need for resources but is unlikely to reflect the perspectives and interests of less advantaged groups. The need for strengthening the process of selecting SMC members and building members’ capacity for planning, management, monitoring, and utilization of resources—and encouraging them to serve as a link between the community and education authorities—is evident. In addition, linkages between the SMCs of primary schools and NGO-run preschools—and between primary schools and secondary schools—are needed to enable smooth transitions.

**Parent-teacher cooperation.** In some primary schools, parent-teacher associations and other mechanisms both to inform parents and to engage them in the education process are emerging. Most existing preschools have strong parent-teacher cooperation; this will need to be ensured in the new pre-primary classes as coverage expands under current policies. At a large, relatively well operating school visited during the preparation of this Situation Analysis, we found that regular meetings were held with guardians, who received useful information on matters such as school attendance, stipend distribution, hygiene, and textbook care. Building commitment to education will require two-way communication where parents receive information and also have a voice in the way a school operates. Children too have a right to participate. The children who contributed to the *Alternative Report 2007* suggested that SMCs invite children to participate, which is not currently practiced.

**Community learning centers.** One promising initiative in expanding access to information and learning opportunities among communities is the establishment of multi-purpose community learning centers, or *Gonokendros*. In cooperation with the Government and local communities, BRAC has helped more than 2,000 communities throughout rural Bangladesh to establish these centers, which provide libraries, cultural activities, debates, competitions, IT services, and skills training. They are located within or near secondary school complexes. They also provide mobile libraries to reach women, people with disabilities, and the elderly in remote areas. The *Gonokendros* are designed to become financially self-sustainable in two years’ time. Users pay a nominal annual fee, which is discounted for girls and women, people with disabilities, ethnic minorities, and the very poor. This type of initiative is important for reaching all community members, and it also provides direct benefits to school-going children. *Education Watch 2007* found that secondary-school students with access to non-academic books and newspapers demonstrated greater learning achievement than did those without access to such learning resources.

**Adolescent empowerment.** Empowerment of adolescents is another aspect of raising community awareness. Where initiatives to empower adolescents are effective, they directly benefit adolescents, enable them to become better caregivers, and create positive changes in the ways communities view adolescents’ capabilities and rights. The Government and NGOs,
with support from UNICEF and other development partners, have piloted and expanded various initiatives to provide adolescents—especially adolescent girls—with life skills and other opportunities for empowerment in collaboration with their communities. BRAC is the NGO reaching the largest number of adolescents in this way. BRAC supports 8,600 adolescent clubs involving 300,000 adolescents of ages 11-19 in almost all districts of the country. Each club has 25-40 members who meet for two hours twice a week to play games and sports, read books and magazines, participate in cultural activities, receive livelihood training, and increase their life skills and awareness regarding reproductive health and the many social issues facing adolescents. Most of the centers are in rural areas, though BRAC and other NGOs are starting to expand this type of initiative into urban areas.

At present, almost all members of the adolescent clubs are girls. Raising awareness of boys and men regarding gender issues is also important for motivating lasting changes in attitudes and practices. Pilot activities to bring girls and boys together in the clubs are underway, but they are proceeding with caution because of cultural sensitivities about mixing adolescent girls and boys. Another indirect benefit the clubs provide is increased mobility among adolescent girls, many of whom would be socially isolated otherwise, as they regularly visit their meeting place, the NGO office, and training centers.

II.B.1 (b) Quality of teaching

The quality of teaching is central to a child’s experience of education and to families’ decisions on whether to send—and continue sending—their children to school. In Bangladesh, teaching quality is challenged in many ways. The Government’s ability to develop preschool teaching capacity alongside its introduction of preschools into all primary schools will largely determine its success in expanding preschool attendance and ensuring its quality. Teacher recruitment for primary schools has accelerated recently under the Government’s Second Primary Education Development Programme (PEDP-II), but many teaching posts remain vacant.\(^3\) Corruption has been reported in the teacher recruitment process. Teachers’ pre-service training, performance assessment, professional development opportunities, and compensation are all inadequate to motivate and retain qualified teachers. In addition, teachers in Government schools often have non-teaching responsibilities—such as those related to birth registration, animal registration, immunization days, census taking, and voter registration—which detract from the time and attention they devote to teaching. PEDP-II has addressed the gender gap among teachers in Government-supported primary schools, which reached parity in 2007, but more than three-quarters of head teachers are male.

The Primary Teaching Institutes, which are located in most districts, suffer from staff shortages and inadequate libraries, information and communication technology, and other facilities. Upazila Resource Centers offer training, but the content is determined centrally with little if any input on training needs from the upazila level. The Government, NGOs, and private organizations have provided various training programmes for teachers, but they have taken place in an ad hoc manner without a consensus on minimum competencies and without a mechanism to measure their results. Teacher shortages have led to the placement

\(^3\)Government data in April 2009 show that 2.5 per cent of the approved head teacher posts and 12 per cent of the approved teacher positions in Government primary schools are vacant.

“States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child’s human dignity....”
(CRC Article 28(2))
of teachers into classrooms without any pre-service training and then withdrawing them for training without assigning substitute teachers for their classes. This reduces student-teacher contact time, which, as mentioned above, is already far too low.

As described in Chapter IV on child protection, teachers commonly use physical and other negative forms of punishment, making learning an unpleasant experience for children. This occurs despite an official prohibition on physical punishment in government-supported schools. The children who contributed to the Alternative Report 2007 reported other kinds of teacher misconduct as well, such as sleeping or speaking on mobile phones during class, requesting students to carry out personal tasks for them, collecting bribes in exchange for grades, and withholding part of children’s Government stipends. Teacher absenteeism is reportedly high, though data are currently unavailable on this problem.

Many teachers provide private tutoring for extra income. This detracts from their dedication to classroom teaching, on which less advantaged students rely. A recent study using Education Watch data shows that nearly one-third of primary-school students had private supplementary tutoring in 2005, and this proportion was rising rapidly (Nath 2008). The incidence of private tutoring was greater among boys and urban students than their counterparts, and students with educated parents and those from wealthier families were more likely to have private tutoring. An Education Watch
study of students in Grade 10 found that 86 per cent had private tutors in the previous grade (Grade 9) and over 40 per cent of their teachers were involved in private tutoring. Private tutoring was almost universal among students of Government secondary schools. More of the urban secondary students of both private schools and madrasas had private tutors than their rural counterparts.

The gender, urban-rural, and socioeconomic disparities in tutoring may contribute to the disparities observed in learning achievement. The finding that private tutoring is more common among boys than girls in primary school particularly merits further analysis. A recent study of educational financing by CAMPE reached the seemingly contradictory finding that families do not exhibit significant disparities in the overall amount of private educational expenditures they allocate to girls and boys. This finding held true in both urban and rural areas and regardless of the type of school.

II.B.1 (c) Quality of school facilities: Infrastructure and educational materials

The quality of school infrastructure and facilities is very low in general across the education system. The existing preschools (which cover only a small proportion of preschool-age children) generally have acceptable classroom environments and access to materials but face challenges in room size, location, and outdoor space. Substantial progress has been made in implementing the infrastructure component of PEDP-II, but the need for construction, renovation, and repairs is so great that it remains an obstacle to providing quality education for all children. The existing classrooms are too few and too small to accommodate current and future numbers of children. As a result, most schools operate on double shifts. Many local administrative facilities are also in poor condition. Most schools lack playgrounds and other recreational facilities. Little attention has been given to making schools physically accessible to children with disabilities. Basic supplies are often unavailable or in poor condition. The children who contributed to the Alternative Report 2007 mentioned the scarcity of furniture, lights, fans, chalk, dusters, blackboards, fences, books, exercise copies, pencils, and school uniforms.

Quality inputs such as teaching aids, teachers’ guidebooks, libraries, laboratories, and supplementary reading materials are also scarce. Primary school textbooks were recently revised and distributed to schools, but quantity seems to have received priority over quality—the textbooks have been criticized for containing mistakes, insufficient relevance to the curriculum, and poor physical quality. Teachers often “teach the textbook” instead of the curriculum, particularly in the absence of good teachers’ guides. Supplementary materials are especially important given that most children have little or no access to other print resources—or any other form of reinforcement of school lessons—outside of their classrooms. With support from UNICEF, the Government is gradually developing and providing supplementary reading materials and teaching aids for primary schools.

In general, infrastructure and the provision of educational materials is better in urban areas than rural areas, but again this comparison masks deprivations in the urban slums.
II.B.1 (d) A system of many systems: Diversity or fragmentation?

Many different types of preschools, primary schools, and secondary schools operate in Bangladesh. Among the eleven or more types of primary schools, enrollment in Government primary schools (GPS) is by far the largest. Registered non-government primary schools (RNGPS), which are privately operated but receive public subsidies for teacher salaries and some facilities and supplies, account for nearly one-quarter of primary school enrollment. Just over 5 per cent of primary school students attend madrasas, and 2.6 per cent attend community schools. The Government oversees the primary schools serving 83 per cent of primary school students. At the secondary level, the Government runs less than 2 per cent of schools. Almost 80 per cent of secondary students are enrolled in the general secondary schools, 18 per cent are enrolled in madrasas, and just under 3 per cent are enrolled in vocational schools. Approaches to teaching and learning at the preschool, primary, and secondary levels are not coordinated, their curricula are not linked, and mechanisms to facilitate students’ transitions from one level to the next are absent.

Disparities in the quality of education provided in the different types of school are evident. The 2006 and 2008 national assessments of pupils in Grades 3 and 5, which covered only GPS and RNGPS, found that GPS students outperformed RNGPS students in all subjects in both grades. Some of the non-formal education programmes and NGO primary schools offer relatively high quality education to selected populations, as described further below. At the secondary level, *Education Watch 2007* found that only a small proportion of mostly urban institutions met acceptable standards for educational provisions and facilities. The Government and urban private secondary schools had better facilities, personnel, and learning provisions than the rural private schools and the madrasas in general.

The multiplicity of types of school and the lack of minimum standards and a common core curriculum are widely believed to reinforce the disparities in society and to undermine the quality of education. Accordingly, many education experts inside and outside of the Government are calling for the development of unified systems for primary and secondary education. The children who contributed to the *Alternative Report 2007* mentioned that “many children dislike having different education systems in the country, such as English medium, Bangla medium, madrasa, etc.” *Education Watch 2005* concluded that the current system of secondary education “is less a vehicle for social mobility than a means of reinforcing existing social divisions.” A realistic vision for a unified system in Bangladesh could allow the diversity in delivery modes to continue while ensuring that children who complete the various levels of education have a common core of competencies and skills.

The remainder of this section will elaborate on three types of education provision in Bangladesh that are outside of the mainstream but enroll large numbers of children and have a substantial impact on educational outcomes: madrasas, non-formal education, and NGO primary schools that do not receive financial support from the Government.

**Madrasas.** Bangladesh has two broad categories of madrasas, known as Alia and Qawmi madrasas. Alia madrasas are recognized by the Government and
receive public funding for teacher salaries, facilities, and supplies. Enrolling about 1.4 million and 1.9 million students at the primary and secondary levels, respectively, the Alia madrasas account for about 5 per cent of primary and 15 per cent of post-primary enrollment in the country. They offer a curriculum that combines religious studies with Bengali, English, mathematics, science, and social science. Graduates from Alia madrasas are eligible for admission into general secondary schools and universities, and many of them do transfer into the general stream. They also compete with secular-school graduates for employment in the public sector. Qawmi madrasas, which are not recognized by the Government, offer primarily religious education that prepares students to serve as maulvi (religious preacher) and to run the day-to-day operations of mosques. Their enrollment is about 1.5 million. Most Qawmi madrasas house and educate orphans as well as children whose guardians have enrolled them. In addition to the primary and secondary madrasas, some madrasas in Bangladesh provide religious education in the early mornings and afternoons, enabling children to attend other schools simultaneously, and some accept children of pre-primary ages.

Box 2.3
Education is more than numeracy and literacy: Introducing life skills based education to the Government’s secondary-school curriculum

Young people today face many challenges. Those related to alcohol, tobacco, and other drug use, HIV/AIDS and other sexually transmitted infections, sexual and other forms of exploitation, the changing roles of men and women, and discrimination are only a few examples. These challenges are significantly different from those affecting previous generations. Some of them did not exist before, while others have intensified or become more complex. Facing them requires more than even the best numeracy and literacy skills.

Psychosocial competence is important for the physical, mental and social wellbeing of young people. For this reason, UNICEF supports a school environment that includes life skills based education (LSBE). Life skills are the psychosocial competencies needed to deal with the demands and challenges of everyday life in a healthy and productive manner. Bangladesh and the other nations committed to the Dakar Framework for Action on Education for All have recognized life skills as a basic learning need for all young people. LSBE is an interactive process of teaching and learning that enables learners to acquire knowledge and to develop attitudes and skills that support the adoption of healthy behaviors. It is designed to facilitate the use of life skills in culturally and developmentally appropriate ways. It helps young people to make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with emotions and stress.

In Bangladesh, the Ministry of Education has approved the mainstreaming of an LSBE package into secondary education, and this process is currently underway. The curriculum addresses issues of personal safety, drugs, puberty and reproductive health, personal hygiene, and HIV/AIDS in a child-friendly way as part of the secondary-school student’s overall learning. As of April 2009, 6,000 teachers from 14 Government teacher-training colleges have received training on LSBE, and an additional 6,000 teachers are scheduled to complete training by June 2010. The initiative expects to reach 800,000 students in 4,000 secondary schools across the country.
Recent years have seen a rapid expansion in the number of madrasas and in their enrollment. The number of Alia madrasas grew 11 per cent annually between 1999 and 2005, and their enrollment grew 5 per cent annually. This rapid growth may relate largely to increased demand for education of girls in rural areas, stimulated since 1994 by the Female Secondary School Stipend Programme. Between 1994 and 2005, girls’ share of enrollment in Alia madrasas increased from 8 per cent to 46 per cent, while the share of female teachers increased from nearly none to about 7 per cent.

The quality of the secular education provided in madrasas appears to lag behind that of the secular schools. *Education Watch 2007* concluded that the curricula and textbooks used for secular studies in the secondary Alia madrasas were of substantially lower quality than those of the general secondary stream. Madrasa teachers usually have no training on teaching methods. Studies of learning achievements at the secondary level have shown that the performance of madrasa students is generally lower than the performance of their counterparts in secular schools. One recent study supported by the World Bank, however, found no difference in test scores between students of madrasas and secular secondary schools when selection into madrasas was taken into account. The explanation offered for this finding is that parents who send their children to secular schools may also instill in their children a stronger desire to learn secular subjects and/or support this learning more effectively at home. This is particularly likely given the *Education Watch* finding that the parents of madrasa students are less well educated on average than those of students in secular schools.

A USAID-supported study team in 2004 asked students from general primary schools, primary madrasas, and Qawmi madrasas what they liked and disliked in their madrasa/school. In all three settings, “teacher” was the most common response to what students liked, and “punishment” was the most common response to what they disliked. The findings suggest that madrasa students are generally happier with at least some of their teachers than are students of general primary schools. A smaller proportion of the general-school students responded that teachers were what they most liked (50 per cent) than did those in either kind of madrasa (66 per cent for primary madrasas and 62 per cent for Qawmi madrasas), and “teacher” led the list of what they disliked for 20 per cent of the school students and only 1-2 per cent of the madrasa students.

Another notable difference between what students most liked in the different primary settings relates to sports. Thirteen percent of general primary students, 10 per cent of primary madrasa students, and none of the Qawmi students listed sports as what they most liked. This reflects the low availability of sports facilities in all settings—and their absence in Qawmi madrasas.

**Non-formal education.** Millions of children are working or otherwise unable to attend school, and millions of adults remain illiterate. Recent years have seen accelerated progress in the extension of non-formal education to children, adolescents, and adults. Given the magnitude of child labor in Bangladesh and its acceptance in society, as described in Chapter IV on child protection, the Government is aiming for the elimination of child labor in the long term but taking a pragmatic approach to the short and medium term by seeking ways for working children to realize their rights within the current realities of their lives. One of the rights that are most commonly violated for working children is the right to education.

*Children’s Right to Education*
Non-formal education services remain under separate projects, though the Government is considering unifying them into a comprehensive programme, possibly within the next primary education subsectoral programme. Some of the main avenues for non-formal education in Bangladesh at present, and their impacts on children, are the following:

- In the six divisional cities of Bangladesh, 166,000 working children of ages 10-14 years—about one-fifth of the estimated number of urban working children of this age group—receive non-formal primary education through a project called “Basic Education for Hard-to-Reach Urban Working Children” (BEHTRUWC). The Government and NGOs implement the project with support from UNICEF and two main donors, Sida and CIDA. Aiming for equivalency with the formal primary curriculum, the project provides basic education in a 40-month programme divided into five learning cycles. Bangla, mathematics, social studies, English, and life skills are included in the curriculum. Most of the learners are slum dwellers with linkages to their biological families. Sixty percent are girls, and more than one-third are child domestic workers. The teachers are mostly women recruited from the local community who have at least Secondary School Certificates (SSC). Twenty-five learners attend each class. The programme is planned for 2.5 hours a day, at times determined by the learners’ availability, six days a week.

- In selected rural areas of the country, local learning centers provide non-formal education to out-of-school children of ages 7-14 years through the Government’s project “Reaching Out-of-School Children” (ROSC), which the World Bank supports. The ROSC project has reached about 5 million children, half of whom are girls. Most of the teachers are women, and most have SSC-level education. The project provides education allowances to some of the learners, which help to offset the opportunity cost for those who are working.

- The Government’s “Post Literacy and Continuing Education for Human Development” Project, which targets people of ages 11-45 years (almost half of whom are children), helps to ensure the right to education in mostly rural areas. This project is funded by the Asian Development Bank and implemented by NGOs. Its first phase covered half of the country’s districts, and the current phase is covering the remaining half.

NGO schools. NGOs play an important role in delivering preschool and primary school education, especially among the poor and in rural areas. The largest NGO engaged in the education sector is BRAC. Having delivered primary education in Bangladesh since 1985, BRAC now operates more than 38,000 non-formal primary schools (8,000 of which are run by smaller, partner NGOs) and enrolls nearly 1.2 million students. The classes are usually organized in a single room with a female teacher, and two-thirds of the students are girls. BRAC provides primary education services and related materials to students free of charge. The programme aims to enable these children to mainstream into the formal school system at the secondary level. More than 90 per cent of BRAC’s graduates—about 3.5 million as of December 2008—have enrolled in formal secondary schools. The BRAC schools’ flexibility, innovation, and proximity to communities have resulted in high performance. In recent years, nearly all BRAC graduates have passed the Government’s terminal primary-school exam. BRAC initially served

Technically the services the NGO primary schools provide are classified as non-formal education because they fall outside the purview of MoPME and PEDP-II.
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only in rural areas but is expanding into urban areas, where it now operates about 2,700 primary schools enrolling nearly 90,000 urban children.

**II.B.1 (e) Private costs of education**

Families that choose to send their children to school face substantial costs. CAMPE’s study of primary and secondary school financing found that well over half of total spending per child in Government primary schools and Government-assisted secondary schools—the most numerous type of institution in each category—came from household sources. Most of these costs are for school fees (admission and other), private tuition, books, stationery, school uniforms, transportation, meals, health care, and fuel. The poorest families cannot afford to make these payments. In addition to the direct costs of education, many face a trade-off between educating their children and the financial benefits of engaging them in child labor. Many also face social and economic pressures to arrange marriages for girls.

To promote demand for primary education among the poor, the Government has operated a primary school stipend programme for students since 2002. For each eligible family, the programme provides Taka 100 per month (about US$ 1.40) to the first child and Taka 25 (about US$ 0.36) to each additional child. The poorest 40 per cent of children who enroll in any Government-recognized primary school in a rural or non-metropolitan area are eligible. The stipend scheme has helped to offset the private costs of primary education for recipients and is credited for contributing substantially to the increase in primary enrollment rates that Bangladesh has experienced in recent years. Since it does not extend to children in urban areas, it does not benefit the severely deprived children living in urban slums. Problems in targeting the poor have also raised concerns that the programme is not effective as a mechanism for pro-poor redistribution of public funds.

Since some schools have higher proportions of students who are poor than do other schools, the system of distributing stipends to the 40 per cent poorest in each school—even without other complications—would fail to reach some poor children while providing the stipend to some non-poor students. In fact, based on HIES 2005 data, the World Bank found that nearly one-quarter of stipend recipients were from the 40 per cent richest households and only 52.5 per cent were from the 40 per cent poorest. By division, pro-poor targeting appeared least efficient in Chittagong, where only 27 per cent of recipients belong to the 40 per cent poorest students. About one-third of all recipients who belonged to the richest quintile lived in the Dhaka division, indicating that a substantial amount of resources were leaking to wealthy families in Dhaka. Another problem is that some teachers have reportedly withheld all or part of the stipends from the intended beneficiaries.

Questions have therefore arisen about whether the stipend programme should be redesigned for better targeting and/or scaled back to allow the redirection of funds toward quality inputs that might reach the poor more effectively. At present, the stipend programme accounts for one-third of the Government’s development budget for education, and the recurrent budget is used mostly for teacher salaries. Current indications are that the Government intends to expand the stipend programme while seeking ways to make it more efficient.
At the secondary level, the Government provides a stipend scheme as an incentive for families to enroll girls. Since 1994, girls completing primary school and enrolling in a government-recognized secondary school have been automatically eligible for a stipend in all rural and non-metropolitan areas. This programme has been highly effective in increasing girls’ enrollment in secondary schools. The amount of the stipend is not sufficient, however, for the poorest girls to cover the private costs of attending school, and the programme does not reach girls in urban areas.

The female secondary-school stipends are intended to boost learning among girls as well as their enrollment. Eligibility for the stipend payment is conditional on a minimum achievement in school examinations and regular attendance in school. No financial incentives for learning are provided for boys. Nonetheless, as described above, studies of learning achievement indicate that boys outperform girls at both the primary and secondary levels. Boys are falling behind girls in enrollment but are ahead of girls in performance. Exploring the reasons for the gender disparity in school performance is a potentially useful area for future research.

The Government’s Reaching Out-of-School Children project, which provides non-formal education for rural children who otherwise would not attend school, offers education allowances to some of the learners, which help to offset the opportunity cost for those who are working.

II.B.1 (f) Availability and accessibility of schools meeting the needs of all students

The main immediate factor influencing preschool attendance in Bangladesh is the availability of preschools. Until this year, the formal education system did not include pre-primary education. Parents and communities have set up informal “baby classes” in some primary schools, several ministries run pre-primary classes under development projects, many private kindergartens have opened, and about 150 NGOs offer preschool programmes. Many of the NGO-run preschool programmes are located on the compounds of Government-supported primary schools and aim for their graduates to enroll in those schools. The largest NGO provider of preschools in Bangladesh is BRAC, which focuses on reaching girls, first-generation learners, and children from poor households. Despite these initiatives, preschools are simply unavailable in many parts of the country, especially in urban slums and remote rural areas.

At the primary and secondary levels, the availability of schools and access to them are different for different children, depending on their personal and family characteristics and their areas of residence. Children with disabilities, street children, tribal children, and children living in urban slums, remote rural areas, and brothels are most likely to find schools unavailable to them or lacking in relevance to their needs and circumstances. Mainstreaming of children with mild disabilities is not common, and the human and infrastructural resources needed to enable education for the disabled are absent. The children who contributed to the *Alternative Report 2007* mentioned that disabled children are rarely admitted to schools even if they are able to pay, and those who are admitted do not receive proper attention from school authorities. They also mentioned that separate schools for disabled children are generally unavailable, and existing schools for children with disabilities are poorly equipped for the mobility of students.
Numerous initiatives are underway to provide education and other services for street children, but their mobility and social marginalization still leave most of these children without meaningful opportunities for education. The *Alternative Report* mentioned that street children are not allowed in school because they wear dirty clothes. Mother-tongue education has not yet been introduced for tribal children, making schooling less relevant to them. Children living in urban slums are severely deprived of access to education. The Government, NGOs, and development partners have started interventions in urban areas to provide schooling to poor children, working children, and street children, but coverage is low and these efforts are not yet coordinated. In addition, Government stipends do not extend to the cities and municipalities.

Government school facilities and personnel are sometimes used for non-educational purposes, such as birth registration, animal registration, immunization days, census taking, and voter registration. These activities cause the closure of schools and reduce students’ contact time with their teachers. Political activities also sometimes interrupt classes.

Insecurity and physical inaccessibility are also issues for some children. Some schools become inaccessible for long periods during seasonal floods. Some parents fear that traveling to and from school will expose their children to a variety of risks, including road accidents, teasing of adolescent girls (“eve teasing”), violence, sexual abuse, and trafficking.

### II.B.2 Underlying Factors

The underlying factors influencing children’s right to education in Bangladesh include (a) caregivers’ own levels of education, (b) the priority that many poor families must place on meeting daily survival needs, (c) the prevalence of child labor, (d) the prevalence of child marriage, (e) the appropriateness of policies regarding inclusive education, child labor, and early marriage and the extent to which good policies are implemented and enforced, and (f) public investment in education.

Many caregivers are poorly educated themselves. This leaves them with little capacity to participate in learning opportunities and little motivation to seek them. Poorly informed about new teaching-learning methods, many of them retain traditional views toward child rearing and education. They are thus unable or disinclined to provide the support at home that quality education requires. Poor families who concentrate their energies on daily survival are often unable to make the financial and personal investments that education entails. Accordingly, the demand for education is low in some communities.

Many children work in labor arrangements that prevent or hinder school attendance. Some families perceive child labor to be their only option or to have greater returns than education. The private costs of education, low quality and/or availability of education, and curricula that are not clearly relevant to the job market can make education less attractive or feasible than work. The social acceptance of child labor and the availability of employment for children also contribute. (Chapter IV on child protection covers issues related to child labor in greater detail.)

The practices of child marriage and dowry result in withdrawal from school for many girls. As girls get older, the amount of the dowry their families...
anticipate having to pay for their marriages typically increases. The longer they remain in school and unmarried, the longer they place a financial burden on their families. (Chapter IV on child protection covers issues related to child marriage and dowry in greater detail.)

Box 2.4
Gender and secondary schooling

A gender gap in favor of girls persists throughout primary school, and girls have higher overall rates of attendance and enrollment in secondary school. In the later years of secondary school, however, girls begin to lose their advantage. After the first one or two years of secondary school, girls begin to drop out more often, and they are less likely to complete secondary school. During a focus group discussion in preparation for this Situation Analysis, adolescent girls in a poor rural area gave the following perspectives on why the dropout rate among girls increases as they progress through secondary school:

- Some parents believe that mixing adolescent girls and boys is sinful, and mixing happens both at school and on the way to and from school.
- Some parents are not educated themselves and do not consider girls’ education important.
- Some parents cannot afford to send girls to school.
- Boys’ secondary education is expected to raise boys’ income-earning potential, which will benefit the entire family, whereas girls are not expected to earn income.

Strategies for inclusive primary education have been developed and adopted under PEDP-II but have not yet made substantive improvements in disadvantaged children’s access to quality education. The current legislative and policy framework for child labor is inadequate, and existing laws and policies are poorly enforced. Child marriage is prohibited by law, but early marriage is so deeply embedded in the culture of many communities that the law is unenforced and routinely broken. (Policies regarding child labor and child marriage are both covered in more detail in Chapter IV on child protection.)

Public investment in education is an indicator of the Government’s commitment to education. At just 2.3 per cent of GDP, public expenditure on education in Bangladesh is low relative to public expenditure on education as a percentage of GDP in other developing countries (4.5 per cent) and in countries of South and West Asia (3.8 per cent). Public spending on primary education per student is also low relative to that of other countries with similar levels of per capita income. Many experts argue that current levels of public spending on education, which have changed little as a share of GDP over the past decade, are insufficient to achieve and maintain a minimum acceptable level of quality. Primary education’s share of total public expenditures on education, at about 40 per cent, has declined in recent years as rising primary enrolment and completion rates have increased the demand for post-primary education. The Government has not yet started to invest in pre-primary education or to pursue information campaigns to raise awareness of the importance of early learning for child development, which is poorly understood among all sectors of society.

Investment in education is paltry in the urban slums. Neither the Government nor the NGO/private sector has invested substantially in these areas.
II.C. ROLE AND CAPACITY ANALYSIS

II.C.1 Families

Families have duties to encourage their children to enroll in school, regularly attend school, and succeed in school. They are also obligated to create a home environment that facilitates children’s education, to discuss their children’s learning progress with teachers, and to serve as advocates within their communities for quality education services at all levels, including preschool. The study on *Abuse in Children’s Lives* shows that most parents recognize their duty to support their children’s education, and the fact that 94 per cent of six-year-old children do enroll in Grade 1 suggests that parents are doing their best to fulfill their responsibilities. Yet many of them face extraordinary constraints. The private costs of education are high—too high for many families, especially compounded with the opportunity costs of foregoing child labor. Social and economic pressures to arrange girls’ marriages compromise the prospects of education for many girls. Poverty often forces families to prioritize daily survival needs over education. Moreover, families in urban slums, remote rural areas, and isolated indigenous communities—and the families of children with disabilities—often have little or no access to education for their children.

The knowledge of most caregivers regarding early childhood care and development is very low. The MICS 2006 survey, for example, found that the households of less than half of under-five children had engaged those children in four or more activities that promote learning and school readiness—such as reading books, looking at picture books, telling stories, singing songs, going outside the home/compound/yard, and naming, counting, or drawing things—during the three days preceding the interview. The lack of knowledge on child-care practices is often associated with parents’ own illiteracy.

II.C.2 Teachers

Teachers have duties to provide all children with good quality teaching and fair grading, to engage parents in the learning process, to participate in community governance, and to seek appropriate training. They also have duties to reject informal payments from students and ensure proper distribution of textbooks and stipends. In a recent study on *Abuse in Children’s Lives*, teachers identified a number of additional roles that they play. Urban poor teachers, in particular, said they play a wide-ranging role in the lives of the children they teach. These include teaching children about health and hygiene, raising their awareness of social and environmental issues, investigating the cause of a child’s absence, helping students to resolve clashes between attending school and the other demands on their time (such as work and caring for siblings), checking on their wellbeing after they finish school, and helping to improve their families’ financial situations.  

Teachers face many obstacles to fulfilling their duties. The low levels of investment in education generally leave them with inadequate training opportunities and poor compensation. The Government currently has

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5The study *Abuse in Children’s Lives*, supported by the Government of Bangladesh, UNICEF, and Save the Children Alliance, explored the ways that adults and children of ages 6-14 years experience and perceive the treatment of children in one rural and two urban areas of Bangladesh in 2003-04.
no standard mechanism for training pre-primary-school teachers. Low teacher pay and poor support systems, supervision, and monitoring—alongside weak performance assessment procedures and opportunities for professional advancement—lead to teacher absenteeism and cause teachers to focus on private tutoring more than classroom teaching. Double shifts mean many teachers teach a full day without any preparation time. Teachers also face conflicting demands on their time, such as responsibilities for government tasks that are not related to education (voter registration, etc.) and training courses that require their absence from class. Teachers’ own poverty and experience of external shocks, such as natural disasters and food price increases, often reduce their time, energy, and motivation to teach effectively.

II.C.3 Communities

Communities have the duty to build coherent, organized, and well-informed demand for quality education for all children of the community. In some cases, communities in Bangladesh are fulfilling this duty. Some School Management Committees are active and dedicated, for example, and some communities have established schools, contributing land (often donated by local elites) and funds for some of the schools’ operating costs. Registered non-governmental primary schools (RNGPS) have provided most of the increases in school capacity that have taken place to meet the needs of the growing child population in recent years. In areas without preschools, many communities have set up “baby classes” attached to primary schools. In many other cases, however, communities do not recognize the importance of their role in demanding and contributing to quality education, particularly early learning. They also often lack the organizational capacity to motivate effective demand.

The centralized system of government undermines communities’ full contribution to children’s right to education. Knowledge of who is regularly attending school, who is attending irregularly, who has dropped out, who has transferred to another school, and who never enrolled is held at the community and school levels. Schools and communities have the best information on which children are at risk, the difficulties they face, and what could be done to ensure the realization of their right to education. They have the most direct knowledge of how effectively reform efforts and resources are reaching children. In the current system, however, they lack the authority to respond to the specific difficulties that their most disadvantaged students face and the flexibility to adapt schooling to local conditions.

II.C.4 Civil Society

In the Dakar Framework for Action on Education for All, adopted by the World Education Forum in 2000, all participants pledge to “ensure the engagement and participation of civil society in the formulation, implementation and monitoring of strategies for educational development.” In Bangladesh, civil society organizations play a vital role and have substantial capacity in the education sector. NGOs have effectively taken the role of duty-bearer in many areas where the provision of government schools is lacking, especially in rural areas. NGOs and private organizations have been the main providers of early learning opportunities, though the Government is now taking steps to incorporate pre-primary education
into Government-supported primary schools. Some NGOs are supporting education for vulnerable children, such as street children, working children, and those with special educational needs. They have not yet, however, helped substantially to meet the educational needs of urban poor children. Rapid urbanization and the difficulties of working in urban slums, such as crime and high costs, have constrained their ability to contribute substantially to education in these areas.

Since 1991, NGOs involved in Bangladesh’s education sector have cooperated in a network called the Campaign for Popular Education (CAMPE), which now includes over 1,000 NGOs. CAMPE serves as secretariat of Education Watch, which conducts research and produces a report on a different education-related topic each year. The Education Watch reports are widely regarded and referenced by development agencies, NGOs, and the Government. In the area of early childhood development (ECD), the ECD Network—consisting of about 200 organizations representing the Government, NGOs, academia, and development partners—has played a critical role in advocacy, coordination, and information sharing on ECD since 2005. The Institute of Educational Development (IED) of BRAC University, which serves as the secretariat for the ECD Network, supports the development of curricula and learning materials, offers regular professional development training, and has recently established post-graduate programmes in early childhood development.

A significant constraint to civil society’s effectiveness in the education sector relates to the level of cooperation and trust between civil society and the Government. One persistent area of concern is the extent to which NGOs are seen as—and function as—contractors to the Government rather than partners with the Government. Fazle Hasan Abed, the founder of BRAC, has summed up this concern as follows: “NGOs are increasingly being co-opted into government programmes as sub-contractors at the behest of bilateral and multilateral donors. Their involvement in the implementation of state administered programmes opens up new avenues for their funding and growth. Through this process, however, NGOs risk losing their autonomy and legitimacy as civil society institutions. It is imperative that ... NGOs reflect on these dynamic processes and remain vigilant in protecting their roles as advocates for the distressed and disenfranchised.” Spoken in 1999, these words are still relevant and reflect concerns that arose during the preparation of this Situation Analysis.

The insufficient degree of trust and cooperation may have resulted in missed opportunities. For example, the Government is sometimes reluctant to accept for trial the educational materials developed by civil society. In the most challenging aspects of PEDP-II, such as improving equitable access to quality education, the engagement of academia and other non-governmental practitioners in research and development could substantially strengthen the programme. The Government has initiated a primary education journal that would benefit from civil society contributions. In sum, the expertise in civil society is not fully utilized in national programme and policy development. As Chairperson of CAMPE, Mr. Abed observed in Education Watch 2007 that the findings of the Education Watch series “have not been adequately used in the national education planning and development or advocacy and lobbying for quality education.” He concluded that “we have to identify new and innovative ways of how this can be done more effectively.”

“...The Committee appreciates the cooperation between the State party and civil society organizations relevant to the rights of the child, but is concerned that this cooperation reflects mainly a use of non-governmental organizations (NGOs) as contractors by the State party for the implementation of projects. The Committee also notes with concern the limited participation of NGOs in the formulation and monitoring of policies and strategies to implement the Convention [on the Rights of the Child] ... The Committee encourages the State party to consider more proactive measures to systematically involve NGOs in research, policy formulation, monitoring and evaluation of the implementation of the Convention.”

(Committee on the Rights of the Child, 2009)
Substantial efforts are needed on the part of all stakeholders to strengthen the partnership between civil society and the Government in the education sector so that the children of Bangladesh can benefit from the full range of national expertise. This is especially true as the Government proceeds with implementing the Operational Framework for Pre-Primary Education and developing a successor programme to PEDP-II. Strengthening the partnership between civil society and the Government will require deeper understanding and firmer agreement on their respective roles. The Operational Framework for Pre-Primary Education represents a step in this direction by recognizing the following role for civil society: “The non-government organizations, including education and development NGOs, community organizations and the private sector, are the principal providers of services and mobilizers of resources for this purpose; their participation and effective involvement in policy making, planning, monitoring and assessment and all other significant decision making at national and local levels, therefore, are essential.” If the Operational Framework is fully implemented, primary schools are expected to provide pre-primary education to 1.8 million children at the most. Since about 3 million children enroll in Grade 1 every year, NGOs will continue to have an important implementing role.

A number of suggested roles for civil society in the education sector emerged during the preparation for this Situation Analysis. These include the following:

- Service provision for populations that Government services do not reach
- Development and piloting of innovative models of education service delivery
- Advocacy for quality, decentralized education services
- Participation in national programme development (including and beyond information sharing) and fostering of national dialogue on goals and strategies for education
- Research, including qualitative research, to create an evidence base for advocacy and programme development
- Technical assistance to the Government in monitoring and evaluation
- Liaison between communities and public education officials, e.g., through development of School Management Committees
- Watchdog services—reviewing progress in education and raising public awareness about achievements and constraints
- Establishing and managing community learning centers, ICT centers, and education programmes for youth and adults (in cooperation with the private sector)
- Resource mobilization.

II.C.5 Local Government Institutions

The districts, upazilas, city corporations, and municipalities have duties to hire and transfer teachers (within the district), assist in teacher training,
ensure supervision of teachers, and allocate funds for education properly. Locally elected officials (at the union, city corporation, and municipality levels) have the duty to ensure the accountability of schools, administrators, and teachers for their performance. All local government institutions have the potential to serve as vital links with communities. They have the best knowledge of which schools in a particular region have advantages and disadvantages relative to one another, and they are in the best position to ensure that service providers in their area work together in the best interests of local children.

The centralized system of education in Bangladesh and the shortage of funding for education impair the ability of local government institutions to fulfill their duties. Resources are not yet allocated on the basis of upazilas’ particular needs. Mechanisms for participatory local decision-making are at an early stage of development. In recent years, the Government has delegated some authority for the management and development of primary education to the local levels, but the policy environment for comprehensive decentralization of primary education remains unfavorable.

II.C.6 Government of Bangladesh

The Government of Bangladesh holds the ultimate responsibility for ensuring the rights of all people in the country. Its education-related duties include providing legal guarantees of free and compulsory basic education, ensuring inter-sectoral coordination and alignment of policies, allocating adequate public funding to the education sector, and ensuring the quality of education by setting minimum standards and monitoring performance.

A variety of laws, policies, and programmes demonstrate the Government’s recognition of its role as duty-bearer in regard to education rights and its commitment to fulfilling related duties. The Constitution of Bangladesh establishes free and compulsory education as a fundamental principle of state policy and obligates the State to establish “a uniform, mass-oriented and universal system of education.” The Primary Education Compulsory Act of 1990 provides specifically for five years of free and compulsory education for children of ages 6-10 years. The National Strategy for Accelerated Poverty Reduction II acknowledges that, while the numbers of institutions and enrolment have grown, the quality of education has deteriorated. It commits the Government to improvements in the quality and coverage of early childhood development programmes and primary, secondary, and non-formal education. The Government is now leading the PEDP-II with funding from eleven donors and has adopted an Operational Framework for Pre-Primary Education. The Government recently announced the intention to introduce a new education policy within the next few months.

Two ministries are responsible for education in Bangladesh: The Ministry of Primary and Mass Education (MoPME) is responsible for primary education and general non-formal education, while the Ministry of Education (MoE) is responsible for post-primary education and all education provided by registered madrasas. MoPME provides direct support to primary schools serving 83 per cent of primary school students. Overall, the Government has shown far greater dedication to improving indicators related to primary school than to improving preschool or secondary-school quality and access. The focus on primary education may reflect the emphasis set forth in the MDGs, to which the Government and donors are committed.
Box 2.5
Decentralization and School Level Improvement Plans

The primary education system in Bangladesh consists of over 82,000 primary schools serving more than 16 million children. For the size and complexity of the system, Bangladesh’s management, governance mechanisms, and practices are among the most centralized in the world. PEDP-II envisions progress toward decentralization and the devolution of authority, responsibility, and accountability to the local level. An important initiative in this direction is the School Level Improvement Plans (SLIPs). UNICEF supports the Government with the development, piloting, and scaling-up of the SLIP initiative. The SLIPs aim to enable schools to develop a local vision for school improvement and to increase community participation in school decision-making and management.

The process involves the establishment of a SLIP Committee and the training of head teachers and selected School Management Committee members on school-level planning. The SLIP Committee undertakes a school assessment exercise, identifies activities and resources required to improve quality and equity at the school level, and develops the SLIP. The Committee raises funds through local community contributions and receives an annual grant (equivalent to about US$ 300) from the Government to implement the SLIP. The SLIPs involve measures for physical improvements and for improvements in the quality of teaching and learning. For example, they cover the costs of extra teaching and reading materials, furniture, repair and construction of school facilities (including ramps for disabled access), cleaning supplies, sports days and prizes, musical instruments, gardening services, and uniforms for poor students. In some cases they include the hiring of para-teachers to ameliorate the shortage of teaching staff.

By June 2009 the SLIP initiative is expected to reach almost 7 million students in nearly 32,000 schools in 241 upazilas (half of the Government-supported schools), and the Government is aiming for nationwide coverage. With funding from AusAID, UNICEF has provided technical assistance for the development of the SLIP initiative, training support, and cash for the block grants to nearly 11,000 schools. The Ministry of Mass and Primary Education (MoPME) and the development partners supporting PEDP-II, including UNICEF, are advocating for the Ministry of Finance to amend the Government’s financial rules to ensure the sustainability of the mechanism.

SLIPs aim to empower parents, teachers, and local communities to work together. Participation in decision making about the needs of the school can foster a sense of ownership among everyone involved. Teachers involved in the SLIP process report feeling more motivated in the classroom because they have greater control over school resources and the learning environment.

As discussed above in the section on the role of civil society, a clearer understanding and agreement between the Government and civil society on their respective roles could help to harness the full range of national capacities for ensuring children’s right to education. During the preparation of this Situation Analysis, various stakeholders offered their views on the most important roles of the Government in this regard. These included the following:

- Leadership, vision, priority-setting, and coordination
- Establishment of a common curriculum and minimum standards
- Service provision in cooperation with service providers in civil society and the private sector
• Monitoring and quality assurance

• Development and maintenance of an integrated, publicly accessible database of all education service providers in the country

• Encouraging research and development in civil society, engaging in joint research and development, and accepting for trial the educational materials prepared by civil society when they conform with the national curriculum and standards

• Engaging civil society and the private sector in dialogue on the development of new education policies and programmes and in reviews of existing policies and programmes

• Resource mobilization.

**Government role in preschool education.** As described above, the vast majority of children in Bangladesh lack access to preschools. The Government has recently recognized the importance of early learning in preventing primary school dropouts and committed to supporting preschool education. Building linkages between pre-primary and primary education requires inter-ministerial coordination, especially between MoPME and the Ministry of Women and Children’s Affairs (MoWCA), which has lead responsibility for early learning. Both ministries were involved in the formulation of the Operational Framework for Pre-Primary Education, which MoPME approved in 2008. In addition, MoWCA is currently developing an Operational Framework for Early Childhood Care and Development.

The Operational Framework for Pre-Primary Education states that MoPME, on behalf of the Government, “has the responsibility of developing the policy framework, facilitating coordination among all stakeholders and service providers, setting standards for child friendly facilities and teaching-learning, helping mobilize necessary resources, and ensuring that the children’s rights, wellbeing, and interests are protected.” The Operational Framework aims initially to establish one year of pre-primary education in or adjacent to all GPS, RNGPS, and NGO-run primary schools (or, if necessary, in another suitable place agreed by the community) and ultimately to ensure preschool access to all children of ages 3-5 years.

This year MoPME instructed all GPS and RNGPS to open one-year pre-primary classes. Large numbers of children appear to be enrolling in these classes. At most, this policy can be expected to reach just over half of the number of children who enroll in primary school every year, leaving a substantial continuing role for civil society in the provision of preschool education. Partnership with NGOs is especially important in the areas without primary schools, such as urban slums, remote areas, and tea gardens. MoPME has assigned the National Curriculum and Textbook Board to develop the pre-primary curriculum, and the Directorate of Primary Education has initiated plans to provide learning materials and a teacher guide to preschools until the curriculum is ready. At present, however, public funding has not been allocated for the pre-primary schools, and standards, guidelines, and curricula are still under development. In the many primary schools that did not have preschools already, the requirement to start a pre-primary class has required head teachers and SMCs to informally arrange unqualified preschool teachers and/or to place further demands on the workload of the current teaching staff. A consensus is emerging among the Government and development partners to include
early learning as a component of the next subsector wide programme on primary education, which is expected to start in 2010.

**Government role in primary education.** With support from eleven development partners, the Government is leading the Second Primary Education Development Programme (PEDP-II), a subsector-wide approach covering the period 2004-2010. The PEDP-II aims to provide quality primary education to all eligible children in Bangladesh. The programme has four components: organizational development and capacity building, quality improvement in schools and classrooms, infrastructure development, and improved access to quality education (inclusive education). Progress has been most substantial in the quantitative dimensions, such as construction of classrooms, teacher recruitment, and distribution of textbooks. It has been slower in the areas of inclusive education, classroom teaching-learning, decentralized planning, data management, and capacity building. In addition to its measurable inputs and outcomes, some argue that the importance of PEDP-II lies in its role in promoting sectoral thinking and bringing education development into the mainstream of the Government’s operations. While there are varying views on the success of PEDP-II in this regard, stakeholders widely agree that the programme approach is the right one for primary education.

The development of PEDP-II and its start-up phase took more time and effort than most of the participants in the process envisioned. This stemmed from the paradigm shift involved for both Government and donors in the change from reliance on individual projects to coordinating the efforts of all partners within a programme. Many earlier projects had successfully reached their individual targets, but they were uncoordinated and often heavily dependent on external technical support. They had not led to sustainable policy and institutional reform or to the development of overall national capacity in primary education. Responsibility for implementing PEDP-II fell upon a government body already struggling to manage one of the largest primary education systems in the world. In this environment, the Government is gradually establishing the capacity to manage the full spectrum of a programme—planning, implementation, monitoring, and results reporting. The complexity of this process was underestimated in the formation of PEDP-II, leading to unrealistic expectations for near-term results in reaching all eligible children with quality primary education. Some stakeholders are disappointed with the programme’s progress to date, while others see success in the ongoing process of creating a system that can deliver national objectives for primary education in the future.

The Government’s centralized structure is a major constraint to its achievement of national objectives in primary education. Different levels of the education system have different comparative advantages, and the allocation of authority according to those comparative advantages is widely viewed as essential for improved planning, management, and accountability. In Bangladesh, the levels closest to children and their families are not adequately utilized. Accordingly, the central government is heavily burdened, and its ability to focus on broad issues of policy, inter-sectoral coordination, and resource mobilization is compromised. The devolution of authority to local levels is constrained by administrative and financial rules that are beyond the control of the MoPME. Eliminating legal constraints and creating an overall favorable policy environment for decentralization will require political decisions at the highest level of Government.

“States Parties agree that the education of the child shall be directed to ... the development of the child’s personality, talents and mental and physical abilities to their fullest potential.”

(CRC Article 29(a))
Within existing constraints, the Government has taken steps to decentralize the management and development of primary education within PEDP-II. For example, local officials now have the authority to transfer teachers and to adjust the school calendar and school hours. The Government has also adopted guidelines for School Level Improvement Plans (SLIPs) and Upazila Primary Education Plans (UPEPs), created a cell with dedicated staff to coordinate these planning processes, and begun disbursing funds to schools accordingly. Universal coverage of SLIPs is one of the end-targets of PEDP-II. The success of this process is constrained, however, by a number of factors. The size of the resources transferred to the schools that implement the SLIPs is not commensurate with the effort and time required at both school and upazila levels. The SLIPs increase the workload of the head teachers, whose job descriptions and level of authority have not been adjusted accordingly. The application process seems to limit activities to physical improvements. The UPEP is the key interface among schools in an upazila and between schools and the central government, and the development of the UPEPs has not yet started.

Another set of constraints on progress in primary education relates to human resources. The Government lacks a primary education cadre, key personnel are frequently transferred, and many sanctioned posts are vacant—at the center, districts, upazilas, primary training institutes, and schools. These human resource problems compromise institutional memory, the effectiveness of training, and the motivation of education professionals. Addressing these issues will require high-level political decisions and action on the part of several ministries.

The Government has taken policy steps to address the problems of inequality and exclusion in primary education. These include the provision of free textbooks to all students and stipends to rural poor students. The Government is considering the provision of meals to primary school students. If well designed and implemented, school meals would provide an additional incentive for children to attend school regularly. By boosting children’s health and nutrition levels, a programme of school meals would also contribute to students’ attentiveness and learning. With UNICEF support, the Department of Primary Education has formulated strategies for inclusive education that specifically address gender, indigenous children, poor children, and children with special needs. An Access and Inclusive Education Cell was established in the Department of Primary Education.

The efforts to address inequality and exclusion face a number of challenges. The new inclusive education initiatives have not yet shown results. The stipends intended for poor children are not well targeted (as described above), do not reach children in urban areas, and are often insufficient to keep poor children in school. Children in the urban slums and children with disabilities are seriously disadvantaged, yet no strategy exists for them to realize their right to education. Moreover, unregistered refugee children’s right to education has not been addressed, and mother-tongue education is not yet available for indigenous children. Differentiated approaches are difficult to design and implement without effective decentralization and the active engagement of communities, civil society, and local government institutions.

Since the quality of education depends largely on the quality of teaching, the Government has an important role in designing effective systems for teacher training, recruitment, and career development. The Dakar
Framework for Action on Education for All pledges participants to “enhance the status, morale and professionalism of teachers.” Within PEDP-II, the Government is developing a new teacher education diploma that will undergo international peer review. The Government is also developing quality-based minimum teacher competencies, transparent criteria for teacher recruitment and deployment, and a system for tracking teacher demand and supply. Teacher recruitment has accelerated, but a large number of vacancies remain. To increase performance and accountability, incentives for professional growth—linked with the minimum competencies—will be needed. Ultimately, the decentralization process should allow the demand for training to be determined at the upazila level with input from schools.

**Government role in secondary education.** In contrast to the primary level, where the Government runs or supports most schools, at the secondary level the Government’s role is mostly funding and regulation. Only 2 per cent of all secondary schools are Government schools. They are mostly in the older metropolitan areas, and entry to them is highly competitive. The expansion of secondary schools follows an unplanned and demand-driven process that leads to the absence of secondary schools in many deprived areas. In remote rural areas and urban slums, secondary schools are largely unavailable.

As described above, the Government’s programme of stipends for secondary-school girls has been successful in encouraging girls to enroll in secondary school, but the amount of the stipend is not sufficient for the poorest girls to cover the private costs of attending school, the programme does not reach girls in urban areas, and it appears not to have succeeded in improving the learning achievements of girls at the secondary level.

The Ministry of Education has stated its intention “to move towards a devolved system of governance within the current administrative structure,” wherein the central government will be responsible for formulating policies, financing, setting quality standards, and monitoring and evaluation while the district and upazila levels will be responsible for administering the system and will take greater responsibility for monitoring school performance and ensuring public disclosure of information related to school quality.

**Government role in non-formal education.** Non-formal education provides educational opportunities to working children and others for whom the formal education system does not match the realities of life. Since the early 1990s, the Government has supported non-formal education programmes that have promoted increased literacy. A Directorate of Non-Formal Education operated under the Government’s development budget from 1995 to 2003, and the Bureau of Non-Formal Education (BNFE) was established under the revenue budget in 2005. BNFE provides management and oversight of non-formal education initiatives in all 64 districts and leads the Basic Education for Hard-to-Reach Urban Working Children (BEHTRUWC) and the Post Literacy and Continuing Education for Human Development projects described above. It envisions establishing a comprehensive information system for non-formal education, setting national standards, and conducting monitoring and evaluation. The Directorate of Primary Education leads the Reaching Out-of-School Children project. PEDP-II has a mechanism to provide innovation grants to NGOs, which creates another window for Government support to non-
formal education, though inflexibilities in the programme have limited the distribution of grants until recently.

The Government’s current non-formal education initiatives promote literacy among adults and children and basic education for children in selected areas who are working or otherwise not attending school. Their purpose is not explicitly to mainstream children into the formal education system but rather to provide them with basic education that will strengthen their potential in the job market and open up avenues for further training. A general consensus in favor of a programme-based approach to non-formal education has emerged among stakeholders. This would enhance coordination, national ownership, and sustainability. Whether such a programme should be part of the next subsector-wide approach to primary education or a separate programme is under discussion. Some envision that this would bring the advantages of experience with a programme approach to the non-formal sector, while others fear that it would stifle the capacity for innovation among non-formal education initiatives.

Government role in monitoring and evaluation. Institutional and capacity limitations in monitoring and evaluation hamper the Government’s effectiveness in the education sector. The Government currently has no system or structure to monitor and evaluate preschool activities or to collect related data. Developing relevant indicators for the assessment of preschool outcomes also remains a challenge. At the primary and secondary levels, the collection, analysis, and reporting of school census data have gaps in coverage and are often delayed. This has prevented timely and reliable measurement of progress in enrollment, retention, completion, school quality, learning outcomes, and literacy. Data on Government-supported primary schools are collected at decentralized levels, but they are compiled and analyzed only at the central level and are rarely used at the district level. Ultimately, disaggregation of data to the upazila and school levels will be needed for local accountability and to enable local authorities to take appropriate action. UNICEF is supporting the integration of data in one district, capturing all types of primary schools and all school-age children, as a basis for replication in all districts and the creation of a comprehensive national database. At present, information technology is not well integrated into the education system, and regular vertical and horizontal flows of information are not yet established. Some district and upazila offices have computers that sit idle because of insufficient information technology training.

Data on primary school dropout is particularly problematic because the methodology used to determine the official dropout rate does not take into account children who transfer from one school to another and children who are double enrolled. With UNICEF support, the Government is now conducting a study to deepen understanding of the causes of primary dropout. The 2009 MICS will include information on transfers and double enrollments, which will enable the Government to estimate the real dropout rate and will provide useful input for revising the Government’s methodology for calculating dropout rates.

No systematic information is currently available on teacher qualifications or teacher needs. An ongoing teacher demand and supply study for primary education is expected to enable the creation of a teacher database. It will also enable the projection of primary teacher recruitment and training needs.
In terms of learning achievements, internationally comparable scholastic testing has not been conducted, but the Government is introducing a series of national assessments of pupils in Grades 3 and 5. These were conducted in 2006 and 2008. (Their results are discussed above.) Institutionalizing the process of conducting the assessments and reporting on them is in an early stage. Comparability across the two rounds of the assessments has not been confirmed, and so far they have covered only Government primary schools and RNGPS. Also, a balanced approach to student evaluation will require qualitative research that explores a fuller range of students’ talents than can be captured in an assessment test.

II.C.5 International Development Partners

International development partners have a responsibility to ensure national leadership and ownership, effectiveness, and sustainability of the projects and programmes they support. The most substantial area of donor support for education in Bangladesh is in the primary education subsector through PEDP-II. Development partners are constrained in fulfilling their duties by the continuation of fragmented project-based approaches outside of PEDP-II, their own process of adjusting to the programme-based approach within PEDP-II, and the complexity of coordinating efforts with other development partners, NGOs, and the Government while fulfilling the special reporting requirements and other demands of their headquarters. Development partners also have frequent personnel changes and often lack sufficient mechanisms for institutional memory. Donors have been gradually adjusting to an environment where they have less control over specific interventions but greater participation in education policy dialogue. To some extent, different donors have different priorities and expectations. In particular, some emphasize the need for carefully and gradually establishing systems that will boost educational outcomes in the long term, whereas others anticipate more rapid demonstration of results. This has led to some coordination challenges.

An area where international development partners could play a more active role is in supporting the Government and civil society to find effective mechanisms of cooperation that enable the children of Bangladesh to benefit fully from the wide range of national capabilities in the education sector. As described above, children’s right to education is compromised by insufficient cooperation and trust between the Government and civil society.

The main international partners involved in the education sector in Bangladesh are the following:

- Asian Development Bank
- Australia
- Canadian International Development Agency
- European Commission
- Japan
- Netherlands
- Norway
- Sweden
- U.K. Department for International Development
- United States Agency for International Development
- World Bank.
Box 2.6
Building blocks for a subsector-wide programme: The IDEAL project

One of the first projects in Bangladesh to focus on the quality of primary education was the Intensive District Approach to Education for All (IDEAL). To make schooling more enjoyable, effective, and participatory, the IDEAL project (1996-2004) introduced interactive teaching-learning methods, child-friendly school environments, and the concept of local-level planning for schools. Its approach of directly engaging schools and communities in improving children’s experience at the classroom level was innovative and unique. IDEAL is among the largest education projects that UNICEF has supported anywhere in the world. It covered more than half of Bangladesh’s primary schools (nearly 40,000), trained more than 150,000 teachers, and reached more than 10 million children in 38 districts.

By the end of the project, the mean test scores of children in the IDEAL schools were significantly higher than those of children in other schools, but overall learning achievement remained poor. Many issues cannot be addressed with a project approach, and this became increasingly apparent. IDEAL was one of eight projects under the first Primary Education Development Programme (PEDP). PEDP was designed before the Government and donors reached an agreement on the advantages of a programme-based approach. As such, it was a programme in name only. The PEDP projects were not well coordinated, and each had a separate management system—an arrangement that contributed little to meeting the overall capacity needs of the Government’s implementing agency. IDEAL was the only PEDP project with funding from multiple donors. (The Directorate of Primary Education implemented IDEAL with technical and financial support from UNICEF and funding from AusAID, Japan, the World University Service of Canada, the Asian Development Bank (ADB), and the Swedish International Development Agency (Sida).)

Important lessons were learned from IDEAL in terms of both donor coordination and good practices for improving education quality. These lessons contributed substantially to the design of PEDP-II, which is a genuine subsector-wide programme. Drawing upon its experience with IDEAL, UNICEF played an important role in advocating for a programme-based approach and in the coordination of partners during the development of PEDP-II. PEDP-II’s school- and upazila-level planning and in-service teacher training are building on the pioneering work of IDEAL. Government leadership and the coordination of activities and partners within PEDP-II’s overall strategy hold the promise of sustainable improvements in the quality of primary education in Bangladesh.

II.D. RECOMMENDATIONS

The causality and role analyses indicate that policy advocacy and support, technical assistance and capacity building, communication for development, and expanding the evidence base are key areas where UNICEF and other organizations promoting child rights can effectively support Bangladesh’s progress toward the realization of children’s right to education.

Policy advocacy and support. UNICEF and other organizations will need to remain vigilant for policy development opportunities and needs as
they emerge and be ready to respond accordingly. The following are suggestions of areas where policy advocacy and support may be most important in regard to children’s right to education.

- **Promotion of higher levels of public investment in education and more effectiveness, efficiency, and equity in the use of financial resources.** This would involve, for example, dialogue on the targeting of education subsidies, the trade-offs between budgetary allocations for subsidies and quality improvements, and ways to improve the allocation of resources to currently underserved populations.

- **Promotion of decentralized planning, management, and monitoring.** The allocation of some decisions to local levels and the introduction of School Level Improvement Plans (SLIPs) have started the process of decentralization. Maintaining the momentum of this process will require progress toward implementing the Upazila Primary Education Plans (UPEPs), which will link the SLIPs to the central Government planning process. Sustainability of the decentralized approaches will require changes in the Government’s financial rules.

- **Advocacy for mechanisms to strengthen coordination among the Government bodies responsible for different levels and types of education and for the establishment of common curricula and standards.** Coordination and common curricula and standards are necessary to ensure the quality and effectiveness of the education system as a whole, to ensure that children who complete the various levels of education have a common core of competencies and skills, and to facilitate transitions. The transitions from preschool to primary school and from primary school to secondary school are especially important. Many children in madrasas, non-formal education programmes, and other types of education would also benefit from official equivalency with the formal curricula and opportunities to transition into the general stream. The Government might also welcome support in realizing its intention to bring more madrasas into its oversight and support systems.

- **Advocacy for the high-level and inter-ministerial policy decisions needed to meet human resource requirements in education.** These include, for example, the creation of a primary education cadre, reductions in the transfer of key personnel, and the filling of vacancies.

- **Serving as a catalyst between the Government and civil society.** Strengthening trust and cooperation between the Government and civil society—in the delivery of education services, the development of educational materials and curricula, and policy formulation—is essential for Bangladesh to harness the full range of national capacities at all levels of education.

- **Linking education policy with nutrition policy.** This is especially important given the low nutritional status of many children in Bangladesh and the impact of nutrition—starting from birth—on learning outcomes.

- **Mobilizing commitment and ownership among stakeholders for the forthcoming national education policy.** This would facilitate the implementation of the policy and its effectiveness in improving the realization of children’s right to education.
**Technical assistance and capacity building support.** Technical assistance and capacity building support could be useful in a variety of areas. Improvements are needed in monitoring and evaluation throughout the education sector. The Government will need support in establishing pre-primary education within the public education system, incorporating the lessons learned from existing preschool providers, and ensuring coordination and mutual support between Government and non-government programmes for early learning. Training and the continual incorporation of lessons learned will be needed for effectiveness of the new mechanisms for decentralized planning. The members of School Management Committees have pressing needs for capacity building in planning, financial management, monitoring, and mobilizing and communicating community demand. Support for expanding the coverage of community learning centers merits consideration. Vocational education and the relevance of primary and secondary curricula to the job market require strengthening. Broadening the measurement of learning achievement to reflect the quality of education and the nature of a child’s development will require the piloting and introduction of new tools (including qualitative assessments) and corresponding capacity building. Screening for learning disabilities, the development of ways to ensure appropriate education for children with special needs, and the expansion of extracurricular opportunities will also require support. In all initiatives, child participation—including child participation in School Management Committees and SLIP Committees—should be encouraged.

**Communication for development.** The use of methods of communication for development (C4D)—involving social mobilization, community-led social change, and advocacy—will be essential for expanding the realization of children’s right to education. Improved understanding is needed among children, families, community leaders, and policy makers of the importance of early learning, the need for meaningful community participation in education, and the rationale behind the new teaching-learning methods.

**Expanding the evidence base.** The following are key areas to consider for research that would contribute importantly to the evidence base for policy and programme development in the education sector:

- The causes of gender disparities in learning achievement, particularly the factors influencing girls’ lower performance despite their higher enrollment rates.
- The role that madrasas play in Bangladeshi society (in both education and child protection), the factors influencing families’ choices between madrasas and the general stream, and the social and educational consequences of the recent increases in girls’ enrollment in madrasas.
- Linkages between the distribution of resources and disparities in education outcomes.
- The different types of exclusion from education—children who never enroll in school, children who drop out, and children who stay in school but do not learn adequately—and ways to address them.
- The interactions among the various characteristics (such as poverty, geographical location, disability, low educational attainment of parents, and poor health) that are associated with poor learning outcomes and the effectiveness of innovative approaches to addressing them at the
community and school level (where knowledge of vulnerabilities among students is greatest and interventions are most likely to succeed).

- Qualitative assessments of learning achievements and child development to complement the existing assessment test results.

- The gaps in ensuring the right to education for children with disabilities and the options for addressing their rights in locally relevant and effective ways.

- Educational access and achievement among children in ethnic minorities and the factors influencing their education—to reconcile counterintuitive findings in current research.⁶

- The developmental impact of the involvement—through their parents’ working conditions—of children under five years of age (who are not captured in current statistics on child labor) in child labor and/or hazardous work.

- The impacts of nutrition programmes—ranging from those related to infant and young child feeding (IYCF) practices to the provision of school meals—on learning outcomes.

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A group of tribal (Chakma) children in the Chittagong Hill Tracts.

⁶MICS 2006 found that the net attendance ratio of children in tribal communities is substantially lower than the national average at the primary level (67.9 per cent and 81.3 per cent respectively) but only slightly lower than the national average at the secondary level (37.6 per cent and 38.8 per cent respectively), and Education Watch 2007 found that non-Muslim students and ethnic minorities have higher levels of learning achievement at the secondary level.
III. Children’s Right to Health and Nutrition

All children have the right to health and nutrition. The Convention on the Rights of the Child commits States Parties to taking measures to diminish infant and child mortality, to ensuring the provision of health care to all children, to combating disease and malnutrition, and to ensuring appropriate prenatal and postnatal health care for mothers. It also commits States Parties to ensuring that parents and children have basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation, and injury prevention.

This chapter explores the extent to which the children of Bangladesh realize their right to health and nutrition, the causes of violations of this right, and the roles of the duty bearers who are responsible for children’s health and nutrition. The chapter examines child health and nutrition in Bangladesh with a focus on three key outcomes that reflect children’s access to their right to health and nutrition: (a) maternal mortality, (b) child mortality, and (c) the threat of an HIV/AIDS epidemic.
Children’s Right to Health and Nutrition

III.A. OVERVIEW OF THE SITUATION

III.A.1 Maternal Mortality

Child health and survival is closely related to the health and survival of mothers throughout the lifecycle. While maternal mortality is difficult to measure and track in Bangladesh, experts agree that maternal deaths are unacceptably common. The most recent national survey of maternal mortality—conducted in 2001 by the Ministry of Health and Family Welfare with funding from USAID—found a maternal mortality rate of 320 maternal deaths per 100,000 live births. The Government is conducting a new maternal mortality survey in 2009 with support from UNFPA, USAID, and other partners. UNICEF’s 2008 Countdown to 2015 finds that Bangladesh is one of only six countries that are making good progress toward the MDG for reducing child mortality but are not making good progress toward the MDG for maternal mortality.

III.A.2 Child Mortality

Bangladesh has made significant progress in child survival over the last few decades. UNICEF’s 2008 Countdown to 2015 places Bangladesh among only 16 countries in the world that are on track to achieve MDG 4 on reducing child mortality. Between 1990 and 2006, the country’s annual average rate of reduction in the under-five mortality rate was 4.8; a rate of 3.6 will be required to achieve the MDG in 2015. According to the Bangladesh

MDG 5: Improve maternal health

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
Demographic and Health Survey (BDHS) of 2007, the under-five mortality rate per 1,000 live births declined from 88 in 1999-2003 to 65 in 2002-2006, while the infant mortality rate declined from 65 to 52.

Despite this encouraging trend, the achievement of MDG 4 is far from guaranteed. The prevalence of under-nutrition presents a serious challenge to continuing progress. Moreover, progress in preventing neonatal deaths (deaths in the first month after birth) has been slow. The neonatal mortality rate declined from 41 in 1999-2003 to 37 in 2002-2006, showing far less improvement than under-five mortality. The average rate of reduction in mortality between 1991 and 2004 was 9.4 per cent among children of ages 1-4 years but only 2.6 per cent among neonates. As a result, neonatal deaths as a share of under-five deaths increased from 39 per cent to 57 per cent during this period, according to BDHS data. Deaths in the neonatal period account for more than two-thirds of all infant deaths (deaths before the first birthday), and most neonatal deaths occur within the first week of life. Addressing under-nutrition and neonatal mortality will be essential for Bangladesh to achieve MDG 4.

Neonatal, infant, and under-five mortality rates appear to be lower in urban than in rural areas, according to the report on BDHS 2007. Wide variations were found in these mortality rates among divisions, with Sylhet having the highest for many years. Socioeconomic status is highly correlated with child mortality; a mother’s level of education and her household wealth are inversely related to her child’s risk of dying. The under-five mortality rate for children whose households are in the top quintile is about half that of the bottom quintile.

**Figure 3.1 Trends in newborn, infant, and under-five mortality rates**

![Figure 3.1 Trends in newborn, infant, and under-five mortality rates](source: BDHS 2007)
III.A.3 Threat of an HIV/AIDS Epidemic

By world standards, HIV prevalence is low in Bangladesh, at about 0.2 per cent of the adult population (12,000 people). No data are yet available on the number of children living with HIV. The prevalence of HIV among women has been rising; the share of all HIV infections that occurred among women rose from 1.3 per cent in 2001 to nearly 17 per cent in 2007. Despite the low overall HIV prevalence, the country is at risk for an epidemic. Bangladesh shares borders with HIV/AIDS high-prevalence countries and countries where HIV infection is growing rapidly, and many of the behavioural patterns that fuel an epidemic are found in Bangladeshi society. According to serological surveillance, the infection rate is significant among some vulnerable groups, especially injecting drug users. In 2004 the National AIDS/STD Programme estimated that between 2.2 and 2.9 million people were at risk of HIV infection, most of whom were injecting drug users, commercial sex workers and their clients, men who have sex with men, and migrant workers.

III.B. CAUSALITY ANALYSIS

This section outlines the immediate and underlying factors determining children’s access to their right to health and nutrition, highlighting the patterns and issues that arose during the consultations and literature review for this Situation Analysis. (Basic factors, which are largely common across all children’s rights, are discussed in Chapter I above.)

III.B.1 Immediate Factors

The immediate factors influencing maternal mortality are the incidence of haemorrhage, sepsis, eclampsia/pre-eclampsia, unsafe abortion, and obstructed labour. All of these conditions could be prevented or successfully treated without loss of life. The immediate factors influencing neonatal mortality are the incidence of birth asphyxia (causing one-fifth of neonatal deaths), infections (causing 45 per cent), and prematurity and low birth weight (almost two-fifths). The immediate factors influencing infant and child mortality include the nutritional status of children (maternal nutrition is discussed in the next section as an underlying, rather than immediate, factor), infections, and injuries. Infections cause 72 per cent of post-neonatal child deaths, with acute respiratory infections as the single biggest killer. Injuries cause about one-fifth of deaths among children of ages 1-4 years, with drowning as the single biggest cause of injury-related child deaths. Among all under-five children, prematurity of the newborn, low birth weight, and malnutrition together contribute to about 45 per cent of all deaths. Unsafe sex and drug use practices are immediate factors influencing the threat of an HIV/AIDS epidemic.

Nutritional status of children. Well-nourished children perform better in school, grow into healthy adults, and are likely to pass along good nutrition to their own children. Undernourished children have lowered resistance to infection and are more likely to die from common childhood diseases, such as diarrhea and acute respiratory infections. Illness, in turn, compromises the nutritional status of children, creating a vicious cycle of recurring sickness and faltering growth.
Box 3.1
MDG target on reducing hunger: A challenge in Bangladesh

The Millennium Development Goal (MDG) 1 is to eradicate extreme poverty and hunger. This goal includes the target to halve, between 1990 and 2015, the proportion of people who suffer from hunger. One of the indicators for this target is the prevalence of underweight children under five years of age. In Bangladesh, this means reducing the underweight rate from 66 per cent in 1990 to 33 per cent by 2015. The prevalence of childhood under-nutrition declined markedly throughout the 1990s but remained high at the turn of the decade. The 2007 BDHS found that nearly half (46 per cent) of under-five children are still moderately to severely underweight. At the current rate of decline, Bangladesh is unlikely to achieve the MDG target.

Similar trends are seen in the other nutrition indicators. More than one-third (36 per cent) of under-five children suffer from moderate to severe stunting (chronic malnutrition). While stunting rates, a long-run stock indicator of nutritional well-being, decreased by 7 percentage points between 2004 and 2007, probably due to gains in nutrition during the 1990s, the underweight prevalence decreased by just 2 percentage points from 48 per cent to 46 per cent. Of even greater concern is that the rates of wasting actually increased over the same period, from 13 per cent to 16 per cent, pushing the rate above the WHO threshold level to trigger emergency action (15 per cent). This situation could be further aggravated by the global financial crisis and economic downturn and the effects of household coping strategies during the food price hike of 2007-2008, which included reduced intake of nutritious food for many families.

In Bangladesh, the prevalence of under-nutrition among children has declined over the past two decades, and UNICEF’s 2008 Countdown to 2015 places Bangladesh among 16 countries on track for achieving the underweight target of MDG 1. Nonetheless, under-nutrition remains a serious problem in Bangladesh. About two-fifths of children under five years of age are underweight, and nearly half suffer from chronic malnutrition (stunting). As described in Chapter I, the natural disasters and rising food prices of 2007-2008 have intensified food insecurity. Underweight prevalence, particularly wasting (weight-for-height), follows a seasonal pattern. It is normally higher during the monsoon season from June to September, when agricultural production is low, seasonal unemployment is high, and many people fall ill. Wasting is also more common in the aftermath of natural disasters, such as floods and cyclones.
BDHS 2007 found that 41 per cent of children under five years of age were underweight, and a national Household Food Security and Nutrition Assessment (HFSNA) conducted between November 2008 and January 2009 found an underweight prevalence of 37.4 per cent for this age group. This apparent improvement may only reflect the timing of the HFSNA, which was conducted during the harvest season. The HFSNA found that 48.6 per cent of children under five years of age were chronically malnourished (stunted)—even worse than the level of 43.2 per cent found in BDHS 2007. The rate of acute malnutrition (wasting) among under-five children in the HFSNA was 13.5 per cent.¹ A conservative estimate of the number of under-five children suffering from wasting in Bangladesh is 2.2 million. More than half a million of these children are in the severe category of acute malnutrition and face elevated risks of mortality.

The nutritional status of children is highly correlated with the nutritional status of mothers, socioeconomic status, and where children live. Children whose mothers are malnourished are more likely to be malnourished themselves. Children whose mothers have no education and children from poor households are more likely to be malnourished than other children. Rural children are more likely to be malnourished than urban children. Girls and boys have similar nutritional status.

The pattern of under-nutrition by age group reveals poor infant and young child feeding practices. The HFSNA 2009 found that children of ages 6-23 months were more likely to be malnourished than children of ages 24-59 months. The youngest children presented the highest acute malnutrition rates: one-fifth of among infants of ages 6-11 months and 16 per cent among children of ages 12-14 months. (For a discussion of breastfeeding practices, please see section III.B.2(f) below on family care practices.)

¹These estimates are all calculated using WHO 2006 growth standards.
Micronutrient deficiencies among children are also a major public health problem. Anemia—which is often used as a proxy indicator for the prevalence and severity of iron deficiency—can affect the cognitive and motor development of an entire generation of children, ultimately reducing productivity, creating economic losses, and transmitting poor health and nutrition to the next generation. Its causes include low iron intake due to poor dietary quality and parasitic infections. A study by the Government and UNICEF in 2004 found that more than two-thirds of children under five years of age were anemic, with the highest prevalence among infants of 6-11 months of age (92 per cent). The prevalence of anemia was lower among children who had received de-worming treatment.

Box 3.2
Violations of the right to health: Experiences of street dwellers

The streets of urban Bangladesh are home to many people. A recent study by ICDDR,B on *Health Needs and Health Seeking Behaviors of Street Dwellers in Dhaka City* provides insights into the violations of the right to health that these people experience. Among the women surveyed, nearly three-quarters were sick at the time of data collection. Only 28 per cent of the pregnant women sought antenatal care, and only 13 per cent of them received tetanus toxoid vaccines. Of the women who had given birth during the last 12 months, one-fifth of deliveries were conducted in the street, four-fifths were conducted by untrained personnel, and 6 per cent were self-conducted. Two-thirds of newborns had neonatal health problems. Nearly two-thirds of mothers experienced problems during delivery, and postpartum morbidity was high. All the surveyed street dwellers who had children under five years of age reported that their children had at least one symptom of an acute respiratory infection during the last two weeks (most having more than one symptom), and more than one-third reported that their youngest child had diarrhea during the preceding two weeks. Childhood vaccination coverage was alarmingly low: the women and men respectively reported that 87 per cent and 66 per cent of their children aged 12-23 months had received any vaccines, and none of them could show an EPI card.

Iodine deficiency disorder (IDD)—the world’s leading cause of preventable mental disability and impaired psychomotor development in young children—was found among 34 per cent of school-age children in Bangladesh in 2004-2005, and scarcely half of household salt was found to be adequately iodized. MICS 2006 found that 84 per cent of households were using iodized salt, but the study was unable to determine whether the salt was adequately iodized. Socioeconomic disparities are evident in the use of iodized salt, with the MICS 2006 finding 75 per cent in the poorest quintile and 96 per cent in the richest. Calcium-deficiency rickets, giving rise to physical disability, is prevalent among children of ages 1-15 years in the Cox’s Bazaar district. A national survey is underway to determine whether this condition is prevalent in other parts of the country as well.

The country’s Vitamin A supplementation programme for children is a success story, having kept night blindness in under-five children below 1 per cent since 1997. UNICEF’s global *Countdown to 2015* reported a decline in Vitamin A supplementation for children, from 87 per cent to 82 per cent, between 2003 and 2005, but this trend appears to have reversed. The BDHS 2007 reports coverage at 88 per cent in 2007, and MICS 2006 reports 89 per cent (for children aged 9-59 months who received Vitamin A within the previous six months.) Coverage was lowest for children in the tribal areas.
(82 per cent). As described in the section below on maternal malnutrition, however, Vitamin A supplementation among pregnant and lactating women has not kept pace with the successes in Vitamin A supplementation among children.

**Child injuries.** Three decades of efforts to prevent and treat common childhood diseases have driven down mortality rates from these causes, while death rates from injuries have not declined. As a result, injuries as a share of the causes of death among children have risen. The Bangladesh Health and Injury Survey of 2003—the largest injury survey ever conducted at the community level in a developing country—found that injury causes 38 per cent of all classifiable deaths in children of ages 1-17. Taken together, drowning, road traffic accidents, falls, burns, animal bites, and other injuries killed more than 30,000 children in 2002, amounting to an average of 83 injury-related child deaths each day. As children get older, the proportion of deaths caused by injuries rises; they become the leading cause of death once children reach the age of 5. (Figure 3.3 shows the proportion of mortality caused by injury, non-communicable disease (NCD), and infection for different age groups.) Drowning is the most common cause of injury deaths among children of ages 1-17. Road traffic accidents represent a growing threat to children as the number of vehicles on the roads continues increasing. In early adolescence (ages 10-14 years), road traffic accidents are the most common injury-related cause of death. In late adolescence (ages 15-17), the majority of injury-related deaths are by suicide. For every injured child who dies, many others live on with varying degrees and durations of disability and trauma.

![Figure 3.3 Proportional mortality of children from injury, non-communicable disease (NCD), and infection by age](image)

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**Unsafe sex and drug use practices.** Injecting drug use, commercial sex work, and men having sex with men are the practices most associated with the spread of HIV in Asia. This is in contrast to findings in Africa, where unprotected heterosexual sex fuelled the HIV epidemic. In Bangladesh,
injecting drug use is the primary immediate factor. In one location in Dhaka city, serological surveillance has found that HIV prevalence exceeded 10 per cent. Occurring mainly in cities in the northern part of the country and in the capital, injecting drug use is increasing, and studies indicate that injecting drug users often share needles and syringes. A recent UNICEF-supported study of child drug use found that 17 per cent have shared syringes/needles. During the main age range for the initiation of drug use—11 to 15 years—79 per cent of the surveyed child drug users were initiated to sex.

The most-at-risk populations also include female and male sex workers, clients of sex workers, transgenders, and migrants. Bangladesh has a large-scale sex industry, and communities of injecting drug users and those of sex workers often overlap with one another. The survey of child drug users, for example, found that 82 per cent of the surveyed girls had performed sex in exchange for money. Many men who have sex with men also have sex with women. Clients of sex workers constitute a risk group themselves and also a bridging population between risk groups and the general population. The risk of transmitting HIV to infants is high among girls and women of childbearing age who are in—or whose partners are in—the most-at-risk populations. Bangladesh relies on professional blood-sellers to meet most of its transfusion needs, and about one-fifth of injecting drug users sell their blood. Bangladesh also has high rates of sexually transmitted diseases, especially syphilis and genital herpes, which increase vulnerability to HIV infection. Family Health International recently found rates of active syphilis among female sex workers at 10-12 per cent.

Condom use among risk groups is low. Just over half of sexually exploited girls report consistent condom use, and condom use is far less common among sexually exploited boys, according to a recent study by UNICEF/INCIDIN. Other studies have similarly found that female sex workers use condoms more regularly than do male sex workers. Street-based sex workers use condoms less often than do brothel-based sex workers, who have more collective bargaining power. Data on condom use at last high-risk sex (an MDG indicator) is currently unavailable.

On the positive side, the factors typically cited for the continued low prevalence of HIV/AIDS in Bangladesh include the country’s relatively small population of injecting drug users, the relatively few sexual partners reported by injecting drug users, a low prevalence of HIV among female sex workers, the uncommonness of concurrent, multiple partner sexual behavior among the general population, and the near-universal practice of male circumcision.

III.B.2 Underlying Factors

The underlying factors influencing children’s right to health and nutrition in Bangladesh include (a) access to immunization, (b) access to quality maternal, neonatal, and child health care, (c) the nutritional status of women, (d) maternal age at the time of delivery, (e) the prevalence of violence against women, (f) family care practices, (g) knowledge and awareness, and (h) access to safe drinking water and adequate sanitation facilities.
Box 3.3
Reaching the unreached: An immunization strategy

The Expanded Programme on Immunization (EPI) is one of Bangladesh’s greatest success stories in public health. The Programme prevented an estimated 2 million deaths between 1987 and 2000, and it has continued to prevent about 200,000 deaths every year since then. Nationally, the full immunization coverage of one-year olds with valid doses of all recommended antigens reached 75 per cent in 2007. Substantial disparities exist, however, in the coverage across districts.

The EPI activities include advocacy, social mobilization, training of vaccinators and programme managers, cold chain management, procurement of vaccines, and monitoring and evaluation. UNICEF, WHO, and the Global Alliance for Vaccines and Immunization (GAVI) have continuously supported the Ministry of Health and Family Welfare in strengthening Government capacity at various levels (national, district, and upazila) for the implementation of nationwide and targeted EPI activities.

UNICEF also supports a Reach Every District (RED) strategy that specifically targets 15 chronically low-performing districts, including the Chittagong Hill Tracts and urban poor communities. Thousands of children have directly benefitted from RED implementation. The proportion of 12-month-old children in the RED intervention areas who are fully immunized at the recommended ages and intervals rose from 52 per cent in 2005 to 73 per cent in 2009. Local level micro-planning and quarterly reviews at the upazila level contributed to the success, and the Government has decided to scale up this approach nationwide. Implementation of the RED strategy paved the way for Bangladesh to receive rewards from GAVI (amounting to US$ 16 million since 2004) for expanded coverage of the DPT3 vaccine.

Other examples of EPI progress include the elimination of neonatal tetanus in 2008, re-gaining of polio free status within a few months after polio was imported in 2006, and the control of measles.

Children of ages 12-23 months with full valid immunization by age 12 months in RED districts (%)

Sources: Government of Bangladesh, EPI Coverage Evaluation Survey
**Ill.B.2 (a) Access to immunization**

Bangladesh’s rapidly declining child mortality rates have hinged on the control of vaccine-preventable diseases. As a result of the country’s successful programme of immunization, vaccine-preventable diseases are not major causes of child death. The following are examples of this success in the period 2005-2007:

- Full immunization coverage of one-year olds with valid doses of all recommended antigens increased from 64 per cent to 75 per cent nationally.
- The proportion of one-year-old children immunized against measles, an MDG indicator, rose from 71 per cent to 81 per cent. In 2006, the world’s largest measles campaign achieved 98 per cent coverage of children of ages 9 months to 10 years. No measles outbreaks were reported in 2007.
- Neonatal tetanus elimination was confirmed in 2008.
- After importation of polio in early 2006, polio-free status was regained by the end of the year and has been sustained.
- The central cold chain capacity doubled, and a control room was established to electronically monitor the cold rooms 24 hours a day.

**Box 3.4**

**Improving neonatal health and survival: Home visits from community health workers**

The World Health Organization has concluded that severe infections cause more than one-third of neonatal deaths around the world, with neonatal sepsis and pneumonia causing one-quarter of them. In Bangladesh, infections—including sepsis, acute respiratory infections, and diarrhea—cause 45 per cent of neonatal deaths. The factors contributing to high neonatal mortality from infection include under-recognition of illness, delays in seeking care, and lack of access to quality health services to manage illness. Because the signs and symptoms of neonatal sepsis are non-specific, diagnosing the disease is difficult even in the most sophisticated settings.

Home visits from community health workers may provide the key to improving neonatal health and survival. This is the finding of recent studies in Bangladesh and other developing countries. Importantly, the studies find that raising awareness among pregnant women and their communities about the importance of peri-natal care and the signs of serious illness can improve care practices, but they are not enough to reduce neonatal mortality. Preventing newborn deaths requires early postnatal visits (within 48 hours of birth) from community health workers who are able to appropriately classify illnesses, make hospital referrals, and provide antibiotics as needed. It also requires the availability of referral services and strong supervisory systems. Nonetheless, this approach can bring results cost-effectively. In Bangladesh, the Government and NGOs already have structures in place that could be deployed for routine home visits and newborn assessments.

With support from UNICEF and WHO, the Government is implementing a “Reach Every District” (RED) strategy that specifically targets chronically low-performing districts, including the Chittagong Hill Tracts and urban poor communities. Full immunization coverage of one-year olds with valid doses of all recommended antigens in the 15 districts where this programme was initially launched has increased from 52 per cent in 2005 to 73 per cent in 2009. The strategy was recently expanded to cover two additional low-performing districts.

Some vulnerable groups continue to be underserved. These include street children, as described in Box 3.2, and children living in urban slums. Among all the groups surveyed in the MICS 2006, slum dwellers were the group with the lowest percentage of children aged 12-23 months who had received all recommended doses of BCG, DPT, polio, and measles vaccines. At 69 per cent, the average for slum children was far below the national average of 84 per cent and even lower than the averages for children in the poorest wealth quintile and those whose mothers had no education (78 per cent for both).

III.B.2 (b) Access to quality maternal, neonatal, and child health care

Most children and women in Bangladesh lack access to quality health care. The MICS 2006 shows that only 48 per cent of mothers who gave birth in the two years preceding the survey received antenatal care from a skilled provider and only 20 per cent of the births were attended by medically trained providers. The majority of births took place at home (82 per cent). While recent trends are favorable, the coverage of maternal care remains insufficient. This is shown in the BDHS data, which are based on the most recent delivery of women who had a live birth in the five years preceding each survey. These trends are shown in Figure 3.4.

“The health sector seeks to support creation of an enabling environment whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. With a vision that recognizes health as a fundamental human right the need to promote health is imperative for social justice. This vision derives from a value framework that is based on the core values of access, equity, gender equality and ethical conduct.”

(Bangladesh National Health Policy Update 2008 and the Second National Strategy for Accelerated Poverty Reduction)
The maternal care a mother receives is strongly correlated with the socio-economic status of her household, her educational background, and her area of residence. Mothers whose households are in the highest wealth quintile are more than three times as likely to access antenatal care. The same holds for mothers with secondary or higher education relative to those with no education. Access is higher in urban than rural areas and is particularly low in tribal areas. These disparities are seen also in the health care that children receive, though they are not as sharp.
Skilled birth attendants can play a critical role in preventing maternal and neonatal deaths by providing assistance in delivery and postpartum care. Progress in ensuring skilled attendance at delivery has been very limited in Bangladesh, increasing from about 9 per cent in 1993-1994 to 18 per cent in 2007. Only 18.5 per cent of newborns in the 2007 BDHS survey received care from a medically trained provider within two days of birth, and 68.6 per cent received no check-up at all within 41 days. As described above, most neonatal deaths occur in the first few days of birth. Newborn infections (including sepsis, acute respiratory infections, and diarrhea) cause half of neonatal deaths, and case management for these infections is severely lacking. Immediate and emergency newborn care is generally inadequate when available at all. When delivery facilities are properly equipped and staffed with skilled medical professionals, they can rapidly intervene to prevent or manage asphyxia. The low proportion of births that take place in qualified facilities in Bangladesh translates into high risk of birth asphyxia, which causes one-fifth of neonatal deaths.

Figure 3.6 Proportion of births attended by skilled health personnel, 2006

In the last few years, the Government has begun to address the need for improved provision of emergency obstetric care. Emergency obstetric care facilities are now available in 132 of the country’s 410 Upazila Health Centers and in all District Hospitals. The Government rates about 15-16 of the Upazila Health Centers as “A+” facilities, meaning that they handle more than 100 normal deliveries and at least 30 Cesareans per month. The internationally recommended number of comprehensive emergency
obstetric care (CEmOC) facilities is one for every 500,000 people, with four basic facilities for every 500,000 people. (CEmOC facilities provide Cesareans and blood transfusions in addition to basic care.) If all of Bangladesh’s facilities were functioning, they would meet these standards. Often, however, construction at the facility or the absence of one or both of the critical medical professionals (anesthesiologist and obstetrician) prevents the Upazila Health Centers from providing comprehensive services. If a facility does not provide comprehensive care for three months, it is reclassified as a basic emergency obstetric facility. In early 2009, the Government classified 115 of the Upazila Health Centers and all District Hospitals as CEmOC facilities.

Another area where Government services are beginning to influence maternal and neonatal health outcomes is through a demand-side financing scheme. Under this programme, nearly 200,000 pregnant women have received vouchers that guarantee them free maternal care services from Government facilities. (The facilities are in turn compensated for serving them.) This helps to ensure that private costs—or the anticipation of private costs—do not exclude women from maternal care. The participating women also receive cash transfers to offset their transportation and food costs.

Box 3.5
Transforming the role of women while transforming rural health

The Government and NGOs in Bangladesh have engaged women as community health and nutrition workers in ways that transform not only health at the community level but also the lives of the women health workers themselves and community awareness of women’s professional capacity. For example, the BRAC Health Programme has about 70,000 Shasthya Sebika (SS)—women who provide basic preventive, promotive, and curative services for common illnesses in their communities, reaching about 90 million people in rural areas of the country. A recent article in BRAC University Journal describes the process as follows: “The process of becoming an SS has changed the scenario for these poor rural women; they have been transformed from an ordinary, relatively unknown figure to a well-known public entity in the community. Initial disapproval from the husband and other family members usually gives way to appreciation as they could see tangible economic benefits of the SS work. With the passage of time, they are also gradually accepted by the community and recognized as daktarni (female doctor) of which they feel proud.” Traditional views of the role of women are persistent, however, and not all of the Shasthya Sebika have such positive experiences. The reasons some of them withdraw from serving in the programme include the disapproval of husbands and other family members and criticism from neighbors. (Ahmed 2008)

Information on the role of non-government health care providers is scarce, leaving an enormous gap in understanding about the quality of health care that is provided overall in Bangladesh. According to Bangladesh Health Watch, private health care providers serve about 80 per cent of the population. The quality of their services varies widely. Some provide unnecessary and/or harmful medications and fail to make appropriate and timely referrals for serious cases. Many non-formal health care providers practice traditional medicine, and many practice allopathic medicine without appropriate qualifications. Most pharmacies are unlicensed and unregulated, and their salespeople have no formal professional training, yet they often diagnose and treat illnesses. At the same time, the non-
government sector includes health care providers who offer a high quality of care. A number of NGOs have trained community health workers, most of whom are female, who make household visits for health communication, identify and treat common ailments, and refer complicated cases to qualified health facilities. BRAC alone has over 70,000 community health workers. (See Box 3.4)

Non-formal service providers, such as traditional birth attendants and traditional healers, are the primary providers of maternal health services. When formal health care services are sought for maternal care, families often turn to private providers rather than Government facilities. A UNICEF study of the availability of maternal and neonatal health services in four districts found that 93 per cent of the health facilities were private clinics. The BDHS 2007 concluded that the increase in births attended by a medically trained provider (from 13 per cent in 2004 to 18 per cent in 2007) mostly reflected an increase in institutional deliveries in private facilities. Given that private facilities are relatively expensive, the implications for access to facility-based delivery care among poor women are obvious.

Box 3.6
Children’s perceptions of formal health care services

Families’ perceptions of health care providers are important determinants of care-seeking behavior. In Bangladesh, many families seek care for sick children from non-formal service providers, if any at all. Children’s perceptions can shed light on both the quality of services and the discomfort that many people feel in seeking formal medical care. The following are some of the observations on formal health care made by children who contributed to the Alternative Report on Child Rights in Bangladesh 2007:

- Patients are harassed in the hospital. Sometimes payment of money is needed in government hospitals, even though their services are supposed to be free, and poor patients are not allowed to enter.
- In many cases children become disabled due to wrong treatment of doctors, and sometimes patients die due to the negligence of doctors and nurses.
- Doctors ask to do unnecessary medical tests and prescribe more medicine than is needed.
- Some children have heard that some doctors are engaged in drug peddling, and some heard that doctors sell organs of children.
- Government doctors sometimes provide more time to their private clinics than to the government hospital.
- The price of medicine is high in hospitals, and often medicine is not available.
- Hospitals lack modern equipment, beds, and water, and they have dirty rooms and toilets.
- There are too few hospitals, and they are located far away.

Similarly, when caregivers seek care for sick children, they most often turn to non-formal service providers. The children who contributed to the Alternative Report on Child Rights in Bangladesh 2007 said that many parents take their children to traditional or faith healers “who sometimes torture physically in the name of treatment.” In cases of serious illness, taking children to non-formal providers often precludes an appropriate referral and leads to inappropriate or delayed treatment. The BDHS 2007 found that advice or treatment was sought from a health facility or provider

“The Committee notes with appreciation the progress in child and maternal health including a reduction in the under-five mortality rate, increased measles coverage rate, and decreased underweight prevalence in children under five…. Nonetheless, the Committee remains concerned that health improvements have not yet reached the most vulnerable children [and] that the number of cases of preventable waterborne and communicable diseases still continues to be high....” (Committee on the Rights of the Child, 2009)
for only 30 per cent of children with symptoms of an acute respiratory infection. Mothers with lower levels of education and socioeconomic status are less likely to provide or seek appropriate treatment, for their children or for themselves, than are more educated and wealthier mothers.

The annual review of the Government’s Health, Nutrition and Population Sector Program (HNPSP), conducted in May 2009, concluded the following: “Little progress has been made in improving utilisation of public sector health services, especially by the poorest segments. Major problems affecting utilisation are lack of sufficient drugs, staff shortages (especially in remote facilities), poor prioritisation of spending, and pervasive problems of management and coordination. MoHFW has not yet tackled the internal reforms to address these problems, nor has it exploited the potential to improve the contribution of non-public sector service providers. These issues now need to be given higher priority, because Bangladesh has already achieved most of the reduction in mortality that can be achieved through vertical programmes; future progress will increasingly depend on more complex interventions requiring a more efficient, effective and equitable health system.”

Table 3.1 Densities of health care providers per 10,000 population

<table>
<thead>
<tr>
<th>Type of health care provider</th>
<th>Density per 10,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional healers (Kobiraj, totka, herbalists, faith healers)</td>
<td>64.2</td>
</tr>
<tr>
<td>Traditional birth attendants (trained and untrained)</td>
<td>33.2</td>
</tr>
<tr>
<td>Village doctors and rural medical practitioners who mostly practice allopathic medicine</td>
<td>12.5</td>
</tr>
<tr>
<td>Sellers of allopathic medicine from pharmacies (providing diagnosis and treatment)</td>
<td>11.4</td>
</tr>
<tr>
<td>Community health workers (mostly trained by NGOs) who practice allopathic medicine</td>
<td>9.6</td>
</tr>
<tr>
<td>Qualified modern practitioners (physicians, nurses, dentists)</td>
<td>7.7</td>
</tr>
<tr>
<td>Paraprofessionals (medical assistants, sub-assistant community medical officers, Family Welfare Visitors, lab technicians)</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Source: Bangladesh Health Watch (2008), The State of Health in Bangladesh 2007

With regard to human resources, reports of vacancies, absenteeism, frequent transfers, and low levels of supervision are reported in the formal system. Bangladesh Health Watch concludes that Bangladesh suffers from shortages, maldistribution of staff, skill mix imbalance, negative work environment, and a weak knowledge base. Qualified modern practitioners (physicians, dentists, and nurses) constitute only about 5 per cent of all health care providers. Whereas the WHO standard is three nurses per doctor, Bangladesh has 2.5 doctors for every nurse. Bangladesh Health Watch has calculated that the country has a shortage of over 60,000 doctors, 280,000 nurses, and 483,000 technologists—i.e., that Bangladesh has only 39 per cent of the doctors, 5 per cent of the nurses, and 2 per cent of the health technologists that are needed.2 The Government has

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2 The needed number of doctors is based on the average for low-income countries; the needed number of nurses and technologists is based on the WHO recommended ratio of among doctors, nurses, and technologists of 1:3:5.

Children’s Right to Health and Nutrition
Family Welfare Assistants and Health Assistants, some of whom are trained as community-based skilled birth assistants (CSBAs), but CSBAs are in short supply (only about 3,400 are practicing) and they face obstacles to attending home deliveries, including objections from their supervisors in the health facilities where they work. The vast majority of qualified health care providers are located in urban areas, though rural areas have a higher density per population of total health care providers. Only 16 per cent of qualified physicians—in contrast to 84 per cent of community health workers—are residents of rural areas.

The type of facility caregivers use depends largely on their socioeconomic situation. The poor dominate consumption of public health care at the primary level, while the rich dominate consumption at private hospitals and public facilities at the tertiary level. Caregivers in rural areas often prefer the services of unqualified allopathic practitioners because they make home visits, follow up with patients, and allow flexibility in the mode of payment. Many have social relationships with informal health care providers and feel comfortable with them. In contrast, Government hospitals are widely perceived to be overcrowded, to have long waiting times, and to provide care that is rushed and impersonal. (For an account of children’s perceptions of formal health care, see Box 3.6)

**III.B.2 (c) Maternal nutrition**

Nutrition is important throughout the lifecycle, and nutritional status is transmitted from one generation to the next. The nutritional status of girls affects the nutritional status of the adolescents and women they become. Their nutritional status during pregnancy, in turn, affects intrauterine development. Pregnant women with poor nutritional status face greater risks of complications during pregnancy and childbirth and of having children with low birth weights. One-third of the women in Bangladesh suffer from chronic energy deficiency (body mass index less than 18.5). Hence, many women (and adolescent girls) become pregnant when they are malnourished. More than one-third of children are born with low birth weight. Acute malnutrition
was found in 18 per cent of mothers whose children were surveyed in the HFSNA 2009. The likelihood of malnutrition among children is highly correlated with the nutritional status of their mothers.

Micronutrient deficiencies, morbidity, and poor quality and quantity of food compound the risks of birth complications and low birth weight. Interventions supporting maternal nutrition—such as postnatal Vitamin A, iron, and folic acid supplementation and supplementary food—have very low coverage in Bangladesh. The prevalence of night blindness, which results from Vitamin A deficiency, remains high among pregnant and lactating women despite significant progress in reducing night blindness among under-five children. Vitamin A supplementation reaches only 17 per cent of postnatal women according to MICS 2006. The MICS also finds large socioeconomic disparities in postnatal Vitamin A supplementation. About three times as many mothers in the richest quintile receive Vitamin A supplementation as do those in the poorest quintile, and the same disparity exists between mothers with secondary education relative to those with no education. As a result of infections and poor intake of food rich in iron and folic acid, anemia affects 46 per cent of pregnant women, 39 per cent of non-pregnant women, and almost one-third of adolescent girls in Bangladesh.

**III.B.2 (d) Maternal age at delivery**

In Bangladesh, many parents encourage the marriage of their daughters while they are still children in the hope that the marriage will relieve financial burdens on the family and benefit their daughters socially and financially. The MICS 2006 found that one-third of girls/women of ages 15-49 were married before their fifteenth birthday and nearly three-quarters of women of ages 20-49 were married before their eighteenth birthday. Of the girls/women of ages 15-19 at the time of the survey, 42 per cent were already married. Child marriage often results in early motherhood. The median age of mothers at first birth is about 18 years according to BDHS 2004. Six percent of women aged 15-19 reported having their first child before age 15. Early motherhood has deleterious effects on the health of both mothers and children. Complications with delivery and intrauterine development directly affect children’s health, while the physiological and psychological effects on mothers tend to compromise the quality of family care that infants and children receive.

**III.B.2 (e) Violence against women**

Violence against women in Bangladesh is a pervasive problem. More than half of the ever-married women of ages 15-49 responding to the BDHS 2007 reported that they had experienced some form of physical and/or sexual violence by their husbands in their current or most recent marriage. One-quarter had experienced physical and/or sexual violence in the past 12 months. Women who are poor and who marry at early ages face particularly high risks of experiencing violence. Physical violence is perpetuated from one generation to the next. The BDHS 2007 finds that women who saw their fathers beat their mothers are more likely to report that they have experienced physical violence by their husbands. Similarly, men who saw violence against women in their childhood homes were more likely to report that they recently committed violence against their wives.

The officials met during the preparation of this Situation Analysis in the
health sector and at refugee camps indicated that domestic violence is common. They attempt to deal with it as well as they can, but their capacities are severely constrained by social norms, weaknesses in the system of justice, and their own limited staffing and training.

III.B.2 (f) Family care practices

Family care practices—such as care seeking for maternal and child health, neonatal care, infant and young child feeding, hygiene practices, and injury prevention and care—are important determinants of child and maternal health. Poor quality of care, misperceptions regarding the need for care, and social barriers underlie the low level of care seeking. As described above, most families choose for childbirth to take place at home and seek the services of informal health care providers, if any, for maternal and child health care. With so many births occurring at home, family care practices in the early postnatal period are critical. The BDHS 2007 found that only one in five newborns received care from a trained provider within two days of birth. Clean cord cutting instruments were used for more than 80 per cent of births, but the WHO recommendation to apply nothing to the cord was followed for only 56 per cent. Drying and wrapping the newborn immediately after delivery and delaying the first bath are recommended to prevent hypothermia and vulnerability to infection, but these practices are rare in Bangladesh. According to BDHS 2007, the rates of immediate drying and wrapping were only 6 per cent and 2 per cent respectively, and less than one in five newborns had their first bath delayed beyond 72 hours.

Box 3.7
Changes over time: A perspective from Community Nutrition Promoters

During the preparation for this Situation Analysis, a group of Community Nutrition Promoters with the National Nutrition Project (NNP) in Cox’s Bazar district described the main changes they have seen in their communities since NNP’s inception in 1999. One of the Community Nutrition Promoters has been working with NNP since its inception. She said she has observed that breastfeeding, especially within the first hour after birth, has increased, and more postpartum women are taking Vitamin A capsules. Pregnant women now allow the Community Nutrition Promoters to enter their homes and take their weight, whereas earlier many people believed that weighing a pregnant woman could harm the baby. Also, many people believed that if a woman ate well during pregnancy, the delivery of her baby would be more painful. The Community Nutrition Promoters observed that this belief has been largely overcome in their intervention areas.

Breastfeeding for the first two years protects children from infection, provides an ideal source of nutrients, and is economical and safe. Almost all Bangladeshi babies are breastfed during the first year, but the rates of early initiation of breastfeeding and exclusive breastfeeding for the first six months are low. Initiation of breastfeeding within the first hour is only 36 per cent, according to MICS 2006, though it has shown an increasing trend since the early 1990s. HFSNA 2009, BDHS 2007, and MICS 2006 reported the exclusive breastfeeding rates at 49 per cent, 43 per cent and 37 per cent respectively. The rates of exclusive breastfeeding have not improved since the early 1990s, indicating that the initiatives to promote exclusive breastfeeding in Bangladesh have had minimal impact, if any (Arifeen
The report on BDHS 2007 concludes that, to encourage exclusive breastfeeding in the first six months, “we need to reach each and every mother and her family in Bangladesh, especially those having their first babies, with individualized counseling support.” On the positive side, the HSFNA 2009 found rates of continued breastfeeding at one year were 93 per cent, and 89 per cent of children continued breastfeeding up to two years of age. The median duration of breastfeeding has remained unchanged at about 32 months since the early 1990s.

The introduction of complementary foods at an appropriate time, the quality and quantity of complementary foods, feeding methods, and the frequency of feeding contribute to child survival and development. BDHS 2007 reports an increase in complementary feeding among children of ages 6-9 months from 62 per cent to 74 per cent between 2004 and 2007, but the HFSNA 2009 reports complementary feeding for this age group at just 58 per cent. This indicates the need for reassessment and strengthening of support for infant and young child feeding and caring practices.

As mentioned above, the percentage of children with symptoms of an acute respiratory infection for whom advice or treatment was sought from a health facility or provider is very low, at only 30 per cent according to BDHS 2007. This proportion was strongly correlated with household wealth and maternal education.

Hygiene practices are among the family care practices that affect health. Effective hand washing is critical to avoiding gastro-intestinal diseases, and studies show that the very poor are least likely to practice effective hand washing. Menstrual hygiene is important for the reproductive health of women and girls. Limited access to sanitation facilities—combined with a prevailing culture of shame and embarrassment surrounding menstruation—can lead to poor menstrual hygiene and, in turn, to illness and infection. A UNICEF study in 2007 found that one-third of adolescent girls in the rural areas of 22 districts were not practicing proper menstrual hygiene. (These issues are covered further in Chapter V on water and sanitation.)
III.B.2 (g) Knowledge and awareness

Knowledge and awareness among caregivers and children, especially adolescents, is important for children’s health and nutrition. In some cases, nutrition awareness alone is enough to prevent micronutrient deficiencies; for example, an NGO that works with disabled children in Cox’s Bazar finds that calcium-deficiency rickets in patients under the age of six years can often be treated with affordable changes in diet and food preparation. Knowledge about appropriate methods of oral rehydration for home treatment of diarrhea is widespread in Bangladesh, but caregivers are often poorly informed about when to seek treatment for acute respiratory infections and therefore delay treatment. In addition, many caregivers believe that allopathic medicines are too harsh for newborns and infants. They therefore seek alternative care providers even at times when urgent medical care is needed for infection. Many families lack knowledge about injury prevention and care. Men in particular lack knowledge and awareness about maternal and child health. In a patriarchal society where men make many decisions affecting the wellbeing of women and children, this is a matter of particular concern.

Many people lack correct information about HIV/AIDS and its prevention. Regarding the MDG indicator “percentage of 15-to-24-year-olds with comprehensive correct knowledge of HIV/AIDS,” data are available for women only. Less than 16 per cent of women in this age group have this knowledge, and women in urban areas are more than twice as likely to have this knowledge as those in rural and tribal areas (MICS 2006). Other studies indicate that while the level of knowledge of HIV/AIDS remains low among the general population, it has been rising in recent years. In a recent study of child sexual exploitation, UNICEF/INCIDIN found that three-quarters of child sex workers had no clear knowledge about HIV/AIDS and sexually transmitted diseases, though other studies have found widespread knowledge among sex workers as a whole (including adults).

III.B.2 (h) Access to safe water and adequate sanitation

Lack of access to safe water and adequate sanitation contributes to respiratory and gastro-intestinal illnesses, which in turn contribute to both malnutrition and mortality. In addition, reproductive health problems can arise from improper menstrual hygiene practices when women and adolescent girls lack access to adequate water and sanitation facilities. These issues are discussed in detail in Chapter V on water and sanitation.

III.C. ROLE AND CAPACITY ANALYSIS

III.C.1 Families

Families are the duty-bearers with the most immediate impact on maternal and child health and nutrition. They have the duty to maintain proper family care practices, such as infant and young child feeding, good hygiene, and the care and treatment of sick children. Their knowledge and skills for appropriate family care practices, however, are often lacking. Prevailing gender norms prevent many mothers from seeking appropriate care for themselves or their children, and many families lack the financial resources...
to meet the costs involved. Many people hold inappropriate beliefs and practices regarding pregnant women’s mobility, dietary consumption, and need for rest. Families are often insufficiently aware of danger signs during pregnancy and delivery and the signs of infection in infants. Fear of modern health care is common, both because of traditional beliefs and because of negative experiences with formal health care providers.

III.C.2 Communities

Community health and nutrition programmes can be effective, as shown in the 20 per cent of the country served by the National Nutrition Project, but most communities in Bangladesh still lack awareness of their right to health and nutrition and the importance of community demand for related services. They also lack linkages with health service providers and the organizational capacity to mobilize. The National Health Policy Update of 2008 envisions that community-based organizations will be involved in monitoring the quality and coverage of services.

III.C.3 Local Government Institutions

The districts, upazilas, union parishads, city corporations, and municipalities have responsibility for the delivery of primary and preventive health care services under the Ministry of Health and Family Welfare (MoHFW) and the Ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C). They have the potential to serve as vital links with communities. At present, however, they tend to play a passive role. The centralized system of governance and inadequate funding often leave them without the effective authority and the human and financial resources needed to carry out their responsibilities. The current top-down planning mechanisms are not able to allocate essential staff, medicines, equipment, and supplies in accordance with local needs.

Locally elected officials have the duty to ensure that health care providers are accountable for their performance. Substantial efforts are underway to strengthen locally elected bodies, but their current institutional, organizational, and resource capacities remain low.

III.C.4 Civil Society and the Private Sector

Civil society and the private sector play a large and vital role in the delivery of health care services, mobilizing community demand for services, training health workers, supporting national monitoring and evaluation of quality and access, research and development, and dialogue on policy development. They have duties to ensure that their activities serve to complement and strengthen national systems and to seek sustainability in their service delivery initiatives. At the community level especially, the complementary role of NGOs in service provision has a substantial and direct impact on health outcomes for large numbers of people who lack access to formal health services. (NGOs provide about two-thirds of the country’s community health workers.) Private traditional medical practitioners have the duty to ensure to the best of their ability that the services they provide benefit the people they serve. As mentioned above, comprehensive information on the role of NGOs and the private sector in the health sector is limited, leaving an incomplete picture of overall health services and capacities in the country.

"The government is committed to ensure quality health, nutrition and family welfare services, which are affordable, attainable and acceptable to its citizens. The government focus is on increasing health status, reducing health inequalities, expanding access to social safety net and encouraging affordable service delivery systems for everybody.” (Second National Strategy for Accelerated Poverty Reduction)
Like the Government and the local government institutions, the non-government sector is constrained in fulfilling its duties by shortages of infrastructure, equipment, supplies, and qualified staff. The lack of formal recognition by the Government (and accordingly the lack of a regulatory structure) also constrains the effectiveness of non-governmental health service providers. Moreover, civil society and the Government suffer from insufficient trust between them and, in many cases, the lack of a common understanding of their roles in the health and nutrition sector. The constraints facing traditional health care providers and informal practitioners of allopathic medicine include little formal training (often none) and the perpetuation of traditional beliefs and norms that influence their behavior and the behavior of their clients. Because of limited training, NGO-supported community health workers are sometimes unable to provide the full range of services needed—which include, for example, care and referral for newborns with signs of infection. The lack of functioning community clinics compromises the sustainability of NGO-supported community health workers. The complexities of working in urban slums have discouraged NGOs from working with slum communities, but this is starting to change. BRAC, for example, recently started providing community-based preventive and curative care through home visits and simple delivery centers in a project that envisions reaching 8 million slum dwellers in the country’s largest urban areas.

NGOs work closely with central and local government officials and the Government’s community health workers in a number of important projects, such as the urban primary health care projects, the National Nutrition Project, and the national HIV/AIDS response projects. In the case of nutrition, however, their work remains parallel to the mainstream Government health services. Sustainability will require full integration of nutrition and health programming. Civil society organizations have been active in HIV/AIDS prevention through research and advocacy, but very few of them have the technical capacity to provide treatment, care, and support services.

III.C.5 Government of Bangladesh

The Government of Bangladesh holds the ultimate responsibility for ensuring the rights of all Bangladeshi citizens. The Second National Strategy for Accelerated Poverty Reduction (NSAPR II) and the National Health Policy Update 2008 acknowledge the health problems identified above and set forth the following vision: “The health sector seeks to support creation of an enabling environment whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. With a vision that recognizes health as a fundamental human right the need to promote health is imperative for social justice. This vision derives from a value framework that is based on the core values of access, equity, gender equality and ethical conduct.” The NSAPR II recognizes food security as a core issue in the struggle against poverty. The National Food Policy of 2006 aims to (a) ensure adequate and stable supply of safe and nutritious food; (b) enhance the purchasing power of the people for increased access to food; and (c) ensure adequate nutrition for all, especially women, children and persons with disabilities.

According to the National Health Policy Update 2008, MoHFW has the lead role in policy formulation, regulation, facilitation, monitoring and supervision, and coordination among the wide variety of actors engaged
Children’s Right to Health and Nutrition

MoHFW also has responsibility for the delivery of Government health services in rural areas and shares responsibility for health service provision in the urban areas with the Ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C). A number of other ministries have programmes that reinforce health outcomes as well.

With support from a range of development partners, the Government of Bangladesh leads a Health, Nutrition and Population Sector Program (HNPSP) covering the period 2003-2010. The Program aims to modernize the health sector so that it becomes more responsive to clients’ needs, more efficient in the delivery of services, and more effective in providing key services for poor people. It is aligned with the NSAPR II and is designed to accelerate progress toward the health-related MDGs. HNPSP addresses health and nutrition only through public-sector providers, who, as noted above, provide only a small share of the health care services in Bangladesh.

The political commitment to improving the realization of children’s and women’s right to health and nutrition exists. The allocation of public resources, however, has not kept pace with this commitment, as described in Chapter I above. The National Health Policy Update 2008 acknowledges that “current public and private sources of health finance combined are insufficient to achieve full coverage of health services.” It also states that about two-thirds of total health expenditures are privately financed through out-of-pocket household spending. It sets forth the imperative of raising the share of the national budgetary allocations to health, nutrition, and population to 12 per cent by 2015.

Problems with the availability of financial and human resources, institutional structure, and coordination impede the Government’s ability to fulfil its duty to ensure children’s right to health and nutrition. A mid-term review of HNPSP in 2008 found that progress had been made in strengthening the delivery of health care services but that weaknesses in information systems, financial management, procurement, and human resources continue to limit the Government’s capacity to implement the program effectively.

Many of the constraints to the Government’s performance in the health sector that arose during the preparation of this Situation Analysis relate to human resource management. Key government personnel are frequently transferred without effective systems of institutional memory (such as record keeping and proper use of fixed support staff). Many important posts are vacant for long periods of time, and the numbers of nurses and community health workers are inadequate. Training programmes are poorly coordinated. Unattractive work conditions and remuneration result in absenteeism and make retaining health workers in remote areas extremely difficult. The resulting propensity for doctors to provide private services compromises the integrity of the government services and complicates the monitoring and evaluation of public and private service provision. The Government has recently begun to address some of the recruitment needs in the health sector, but addressing the shortcomings in human resource development will take time.

Another major constraint to the effective provision of public health care is the centralized structure of governance. The Health Policy Update 2008...
acknowledges this issue and envisions a process of decentralization and increasing local autonomy. The present top-down planning process allocates staff, supplies, and medications to the local levels with limited local input on needs and capacities for service delivery. During the midterm review of HNPSP, the Government and donors agreed to a short-term action plan that includes providing greater authority to local-level health and hospital committees and to promoting decentralized approaches. The MoHFW intends to introduce a local-level planning process in the next fiscal year and has started local planning orientations accordingly. The new system is expected to enable planning processes to start at the upazila level, with the districts compiling plans for submittal to the Ministry. As stated in the independent Annual Programme Review of HNPSP in 2009, “A fully effective health system is not possible via a system in which management within the 64 districts and nearly 500 Upazilas is split between the two DGs [the Directorate General for Health Services and the Directorate General for Family Planning], and the smallest decisions are taken in Dhaka through a structure involving two budget systems, 38 line directors, numerous projects and programmes, and the involvement of several Ministries.”

Other areas of concern include the lack of official recognition of informal health care providers, which results in insufficient support for and regulation of their activities. Urban-rural disparities in service delivery are persistent, whereby secondary and tertiary facilities are concentrated in urban areas while the urban poor remain largely unreached. Resource constraints lead to irregular supplies, including power failures. The need to ration services and supplies at the local level creates an environment conducive to corruption. Monitoring and evaluation mechanisms for quality in the delivery of health care services in both the public and private sectors are extremely weak.

The remainder of this section will explore some particular areas of Government intervention and responsibility with special relevance for child rights: (a) immunization, (b) maternal and neonatal health care, (c) Integrated Management of Childhood Illness, (d) nutrition services, (d) child injury prevention, and (f) HIV/AIDS.

### III.C.5 (a) Government role in immunization

As a result of Bangladesh’s successful programme of routine and supplementary immunization, vaccine-preventable diseases are not major causes of child death. The immunization activities include social mobilization, training, cold chain management, vaccine procurement, and monitoring and evaluation. Capacity building for cold chain management is underway and still needed. A follow-up measles campaign is planned for 2010 to immunize 17 million children of ages 9-59 months (those born after the catch-up campaign of 2006). UNICEF and WHO are advocating for a joint campaign covering polio, hepatitis A, and de-worming in addition to measles. They are also advocating for the establishment of annual National Immunization Days until India is polio-free. The Government and the Global Alliance for Vaccines and Immunization (GAVI) are co-financing the roll-out of a combined vaccine for DPT, Hepatitis B, and HiB, which is expected to reach national coverage in 2009. Bangladesh procures 100 per cent of its own auto-disabled syringes for immunization and also produces these syringes domestically.
III.C.5 (b) Government role in maternal and neonatal health care

Neonatal mortality—a serious problem that jeopardizes Bangladesh’s prospects of achieving the MDG on reducing child mortality—has received little attention from the Government until recently. MoHFW, with support from UNICEF and other partners, is developing a National Neonatal Health Strategy with guidelines for addressing newborn care at home and facility levels. The strategy integrates maternal, neonatal, and child health interventions across different health programmes.

The Government has made substantial progress in improving emergency obstetric care. A programme that was initially supported by UNICEF and is now part of the Government’s regular budget provides capacity building of service providers, equipment, supplies, and information services. To address the shortage of obstetricians and anesthesiologists, the Government recently started a programme of mandatory six-month training for about one-quarter of the newly recruited doctors. The first batch of about 300 trained obstetricians and anesthesiologists is expected to complete training in mid-2009. Through this process, the Government expects to have enough pairs for all the Upazila Health Centers (and multiple pairs in health centers with high utilization rates) within three years’ time. The Government is considering an incentive scheme to encourage obstetricians and anesthesiologists to serve in remote areas. The local-level planning process is expected to enable allocation of the newly trained pairs on the basis of patient usage.

The Government is revising the National Maternal Health Strategy 2001, which focused mainly on emergency obstetric care. The new strategy will also address service delivery at the community level and newborn health. As described above, the Government is introducing demand-side financing...
through a maternal health voucher scheme that envisions addressing the cost constraints to maternal health care for the poor.

III.C.5 (c) Government’s introduction of Integrated Management of Childhood Illness

WHO and UNICEF developed Integrated Management of Childhood Illness (IMCI) in the early 1990s as a strategy to reduce child mortality and morbidity in developing countries. The Government of Bangladesh has been implementing IMCI since 2002 to reduce child deaths due to the major killers—neonatal infections, pneumonia, diarrhea, malaria, and malnutrition—by increasing the quality and coverage of treatment and counseling, especially at local levels (upazila and below). After successfully piloting the facility-based components of IMCI in three upazilas, the Government began rolling out IMCI in government health facilities in upazilas throughout the country. The facility-based IMCI interventions focus on improving the case management skills of health workers and improving the health system. Facility-based IMCI is currently provided in 275 health facilities at the upazila level in 41 districts. Facility utilization by sick under-five children has increased substantially in the participating upazilas. The Government and partners are working to expand the programme and establish IMCI at the community level. The aim is to achieve national coverage by 2010.

As part of a multi-country evaluation of IMCI, a six-year study was conducted in one upazila of Bangladesh (Matlab). The study found that IMCI was associated with positive changes in all of the input, output, and outcome indicators that were expected to influence mortality and nutritional status, including improvements in infant and young child feeding practices and decreased stunting. The combination of improved facility care and community activities supporting care-seeking led to increased utilization of government health providers. Nonetheless, the study showed no measurable impact on mortality in the IMCI intervention area compared to the comparison area. A report on the study in 2009 (Arifeen et al.) provides a discussion of the possible reasons for this finding. Mortality rates were falling rapidly for the country as a whole during the period of the trial—most likely as a result of contextual factors, such as economic growth, increased maternal education, electricity, water and sanitation, housing, and communications. Bangladesh has a strong private sector and high availability of modern pharmaceuticals, creating alternatives to the government health system for those who can afford them. In addition, household counseling visits were introduced late in the trial and may have required more time to have an impact.

III.C.5 (d) Government role in nutrition

The Government has developed various policies, strategies, and organizational structures to address malnutrition among women and children, but the delivery of nutrition services remains inadequate. Nutrition programming is hampered by a lack of coordination among the many actors involved, limited institutional capacity, and, in most of the country, inadequate linkages between the Government’s health care structure and communities. There is presently no national body with full responsibility and authority for coordinating nutrition activities, and there is no overarching framework for the many different types of activities that are
underway. Discussions on the establishment of a Directorate for Nutrition have taken place, but the Government and donors have not reached agreement on this.

The main Government body addressing nutrition issues is the Institute for Public Health Nutrition (IPHN). IPHN is responsible for coordinating strategic issues within the Ministry of Health and Family Welfare. It implements programmes addressing micronutrient deficiencies, such as the Vitamin A campaigns and the promotion and quality assurance components of salt iodization. The Bangladesh National Nutrition Council, headed by the Prime Minister, was established to coordinate nutrition activities among Government ministries and non-governmental actors, but it has yet to become functional. A Nutrition Task Group is headed by the Joint Secretary of Public Health, but it lacks diversity and deals mainly with the National Nutrition Project.

In 2007 the Government launched a National Strategy for Infant and Young Child Feeding and a National Strategy for Anemia Prevention and Control, neither of which is nationally operational as of yet. Despite the magnitude and adverse consequences of iron deficiency, only a few small-scale, donor-supported interventions are in place to address childhood anemia. National Guidelines for the Management of Severe Acute Malnutrition were endorsed in May 2008. They have not yet become operational, though the Government is developing plans, with UNICEF support, for training health facility staff in their use. The numbers of acutely malnourished children underscore the imperative for community-based management of childhood nutrition, but the Government has not yet adopted a comprehensive, evidence-based approach to the management of under-nutrition in homes rather than facilities.

To address iodine deficiency disorder, a law was passed in 1989 requiring all edible salt to be iodized, and the drive for universal salt iodization started. A survey in 2004-2005 found that iodine deficiency disorder was still prevalent among children and that scarcely half of household salt was adequately iodized. The Government responded by arranging a review of the salt law. A committee established by the Government has developed a new law, which now awaits approval. If enacted and enforced, the new law will increase penalties on those who produce or sell salt that is not adequately iodized. It will also require both animal food industries and ready-made food industries to use iodized salt.

Food fortification can be an effective strategy for reducing micronutrient deficiencies. With technical support from the Global Alliance for Improved Nutrition (GAIN), UNICEF has developed a proposal for the fortification of refined edible oil (soybean oil, palm oil, and mustard oil) with Vitamin A. The project has Government support and is expected to cover the entire country and to be commercially viable and sustainable. Implementation has been delayed, though, because of frequent changes in management within the Ministry of Industry and the need for a stronger impetus from Government to push the project forward.

Thus, the Government health care system provides basic medical treatment for undernourished children but no other nutrition services, with the exception of Vitamin A supplementation. The NNP, which is part of HNPSP, implements nutrition activities at the community level in rural
areas through NGOs. Its core services include training, communication activities, birth weight recording, growth monitoring and promotion, food supplementation for under-nourished children and pregnant and lactating women, and micronutrient supplementation. The NNP is effective in reaching communities, but it is externally funded and lacks linkages with the relevant MoHFW directorates, raising questions of sustainability. The National Health Policy Update 2008 envisions the expansion of the NNP to cover the entire country, but it currently serves only about one-fifth of the country. Outside of the NNP, Government support to and monitoring of NGOs involved in nutrition is largely nonexistent.

III.C.5 (e) Government role in child injury prevention

The Bangladesh Health and Injury Survey of 2003 brought to light the importance of injury prevention in the overall process of reducing child mortality. In response, the Government incorporated injury prevention into the HNPSP and launched, with UNICEF support, a three-year child injury prevention project. The project was effective in reducing child injuries, especially drowning, in the three upazilas and one urban area where it was undertaken. It will continue for two more years with increasing attention to other types of injury, such as road accidents and burns. Based on findings from the project, the Government is developing a national strategy on child injury prevention. At present, the activities of different actors involved in injury prevention remain poorly coordinated.

III.C.5 (f) Government response to HIV/AIDS

Initiatives to respond to HIV began in Bangladesh even before the first AIDS case was identified in 1989. The Government adopted a National Policy on HIV/AIDS in 1996 and a multi-sectoral National Strategic Plan for STD/HIV/AIDS for 2004-2010. The Strategic Plan contains guidance on a range of HIV/AIDS issues, including testing, care, blood safety, and prevention among youth, women, migrant workers, and commercial sex workers. A wide range of additional national guidelines, manuals, and strategy documents related to HIV/AIDS have also been developed in recent years, though significant gaps exist in their implementation. A high-level National AIDS Committee, with representation from key ministries, NGOs, and Parliament, coordinates implementation of the Strategic Plan.

The National AIDS/STD Program under MoHFW is responsible for handling the HIV portfolio in Bangladesh, which involves various interventions to prevent the spread of HIV among most-at-risk populations. Three large programmes provide the main funding streams for these interventions: (1) a programme under the HNPSP managed by UNICEF during 2004-2009, (2) a programme of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) implemented by Save the Children USA, and (3) a USAID-funded programme implemented through Family Health International. The interventions focus on behavioral change communication, condom and lubricant distribution, needle and syringe exchange, voluntary counseling, testing, and referral, drop-in centers, and health care/promotion and management of sexually transmitted infections. A joint assessment of these programmes in January 2009 found little coordination among them beyond the programme planning stage. The assessment also found that no national bodies actively review the effectiveness of the overall response. The national M&E framework in place for 2006-2010 is not actively
implemented, and data gaps make measuring coverage nearly impossible. Based on the limited data available, the assessment team concluded that the sub-populations most under-served were men who have sex with men, male sex workers, and clients of sex workers.

Prevention of Parent to Child Transmission of HIV (PPTCT) remains in an early phase. The National Policy of 1996 envisioned care and support for pregnant women who are HIV positive, and PPTCT is part of the Strategic Plan. A PPTCT Strategy was developed in 2007 but is not yet operational. Bangladesh is among the few countries in the Asia-Pacific region with a harm reduction policy that links care and support on drug-related HIV infection, but the implementation of this policy and its impact are not documented. At present, less than 15 per cent of the estimated number of people who require antiretroviral (ARV) treatment receive it. The high cost of medicines is prohibitive for many people. Voluntary and confidential HIV counselling and testing facilities are also very limited.

III.C.6 International Development Partners

International development partners have duties to ensure that the technical and financial assistance they provide for the health sector are well coordinated, sustainable, and locally relevant. Donors have the potential to play a catalytic role in bringing about better trust and cooperation among national stakeholders. This requires deep understanding of the complexities of relationships in Bangladesh within and among the different Government bodies, political parties, and actors in the public sector and civil society. It also requires strong diplomacy to help bring about a culture of dialogue. Various views on the success of development partners in fulfilling their duties with regard to children’s rights were encountered during the consultations for this Situation Analysis. Some stakeholders felt that donors were excessively focused on PPTCT, which covers only the formal health care structure and lacks mechanisms for regular and sincere dialogue among the full range of stakeholders involved.

The main international development partners involved in health and nutrition in Bangladesh are the following:

- Asian Development Bank
- Canadian International Development Agency
- Global Alliance for Vaccines and Immunization
- Global Fund to Fight AIDS, Tuberculosis and Malaria
- Government of Australia/AusAID
- Government of Japan/Japanese International Cooperation Agency
- Government of Netherlands
- GTZ/KfW
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- U.K. Department for International Development
- United Nations Development Programme
- United Nations Population Fund (UNFPA)
- United States Agency for International Development
- World Bank
- World Health Organization.
III.D. RECOMMENDATIONS

The causality and role analyses indicate that policy advocacy, capacity building, communication for development, and expansion of the evidence base are key areas where UNICEF and other organizations promoting child rights can effectively support Bangladesh’s progress toward the realization of children’s right to health and nutrition.

Policy advocacy. The overall policy environment in Bangladesh could be strengthened in many ways that would contribute to the realization of children’s and women’s rights. Bangladesh has an urgent need for civil service reform and decentralization to enhance service delivery. Civil service reforms could address the current problems of human resource management in the Government health system, help to integrate nutrition services into the mainstream health system, and improve coordination between health services and family planning. A decentralized system of planning and resource allocation could alleviate the problems of rationing and create an environment conducive to good management and the delivery of services meeting local demand. Improving equity in the delivery of health and nutrition services will require policies to address the costs of health care, the incentives for health professionals to serve in remote areas, and the specific needs of currently under-served populations. Given that most people—especially among the poor—rely on private health care providers, policies to recognize, regulate, and collect information about these providers are essential. The Government’s commitment to operationalizing the community clinics could provide important opportunities to enhance community-based services. The current level of public expenditure for health and nutrition is inadequate to address the current challenges. Organizations involved in child rights can play important roles in advocating for policy development in all of these directions.

Development of national capacity and policies in key programmatic areas. The following are suggested directions in which support for capacity and policy development in key programmatic areas could be particularly fruitful:

• Maternal and neonatal health and survival: Actions should be prioritized at all levels to reduce maternal and neonatal mortality. Effective demand-side financing is likely to be particularly important in this regard, involving private clinics and NGOs in addition to government facilities. The scaling up of home visits by community-based skilled birth attendants and by community health workers who have the skills and supplies to identify, treat, and refer severe cases of neonatal infection is warranted. Rapid progress is also needed in incorporating emergency neonatal care services into the country’s emergency obstetric care programmes and strengthening Integrated Management of Childhood Illness (IMCI) to include neonatal care. Interventions for maternal, neonatal, and child health will be most effective when they are well integrated.

• Nutrition: Actions should be prioritized to address under-nutrition among children and women—both stunting and wasting. Implementing the National Strategy for Infant and Young Child Feeding is especially important, with a focus on reaching caregivers at the home and community level. Micronutrient deficiencies deserve greater attention through, for example, food fortification, identifying and addressing the reasons for inadequate salt iodization in households, expanding...
programmes to address anemia, and recognizing and addressing calcium-deficiency rickets.

- **Child injury prevention:** The development of a national injury prevention strategy and guidelines based on evidence from the Bangladesh Health and Injury Survey and the ongoing pilot child injury prevention project is underway with UNICEF support. Support for the development of national capacity to implement the policy will be needed in a variety of areas. Priorities are likely to include improving the practices of supervising toddlers, teaching children to swim, teaching road safety, public awareness-raising, the installation of barriers between children and hazards such as water bodies and traffic, technical innovations, legislative changes, and the management of injury cases.

- **Maintaining low HIV prevalence:** The current HIV/AIDS situation calls for a continuing focus on most-at-risk populations, with increased attention to reaching children within them, and the expansion of national capacity to provide appropriate treatment, care, and support services to ensure universal access. The recent joint assessment of targeted interventions for HIV in Bangladesh recommended setting up new and stronger mechanisms for coordination among programmes. In view of the overlaps between most-at-risk populations and the general population, a nationwide HIV/AIDS awareness campaign should be considered.

- **Immunization:** Capacity development for immunization merits continuing support, especially among under-served populations such as urban slum dwellers and street dwellers.

A number of capacity development initiatives could be undertaken that would have benefits across programmatic areas. Efforts to make the experience of visiting formal health facilities more comfortable for all people—especially the poor—could contribute to the utilization of qualified health care providers. Improvements in the collection and analysis of data would strengthen the delivery of services. For example, data are needed...
on the quality and quantity of private and NGO health services, progress in the implementation of IMCI, and the coverage of HIV/AIDS programmes. Improved trust and cooperation between the Government and civil society—and progress toward a common understanding of roles—would help to ensure quality and equity in all aspects of health care.

**Communication for development.** Communication for development (C4D) is an essential component for the success of all health and nutrition programmes. Bangladesh’s family planning and immunization programmes have been successful largely because of their components for behavioral change communication. C4D methods have not yet been adequately implemented for improving neonatal and postnatal care, infant and young child feeding, or care-seeking from qualified health care providers. Initiatives to improve the image of formal health care facilities will need to coincide with actual improvements in the quality of care those facilities provide. Attitudes and practices reflecting an understanding that children and women have the right to health and nutrition services, not just the need for them, and that service providers have the duty to fulfill that right are important among both service providers and those seeking care. C4D processes require deep understanding of beliefs, practices, and social and cultural norms, and they may take a longer timeframe to yield results than other interventions.

**Potential areas of research.** The findings of this Situation Assessment and Analysis point to a number of areas where expanding the evidence base could enhance initiatives for children’s and women’s right to health and nutrition. Research could help to explain why progress in promoting appropriate care practices related to childbirth, neonatal care, and postnatal care has been sluggish. Qualitative research would be particularly useful in uncovering the nature and extent of social and cultural barriers to improving these practices and the most effective ways to promote change. Research could also explore cost-effective ways to scale up community-based services, including home visits for neonatal and postnatal care, in the local context. Assessment of the quality and quantity of health and nutrition services provided by the private sector and NGOs—including the doctors who provide both public and private services—would provide a first step toward creating a comprehensive overall health system that fulfills the health and nutrition right of all children and women.
IV. Children’s Right to Protection

The Convention on the Rights of the Child commits States Parties to protecting children from “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.” This chapter explores the extent to which the children of Bangladesh realize their right to protection, the causes of violations of their right to protection, and the roles of the duty bearers who are responsible for child protection. The chapter considers (a) children’s exposure to abuse and negative behavior, (b) the exploitation of children through child labor, commercial sexual exploitation, and trafficking, and (c) the living conditions of street children and children without parental care.
IV.A. OVERVIEW OF THE SITUATION

IV.A.1 Children’s Exposure to Violence and Abuse

As in many countries, child abuse is rarely reported in Bangladesh. Official data and media accounts therefore provide little information on the nature and extent of the abuse that children experience. Several research initiatives in recent years, however, shed light on this issue by exploring children’s and adults’ perceptions of the way children are treated. These studies support the Government of Bangladesh in responding to the UN General Assembly’s call for States “to actively engage with children and respect their views in all aspects of prevention, response and monitoring of violence against them.”

The findings show that the behaviors Bangladeshi children like and dislike are largely consistent with those that adults perceive them to like and dislike. Liked behaviors include various ways of showing affection and respect for children’s feelings. Physical, verbal, humiliating, and threatening forms of discipline or punishment are the adult behaviors that children most dislike. In Bangladesh, unfortunately, most children are subjected to these behaviors, and many forms of child abuse are accepted in society, even by children themselves.

“No violence against children is justifiable; all violence against children is preventable.”
(UN Study on Violence against Children, 2006)
**IV.A.1 (a) Where are children exposed to violence and abuse?**

Child abuse takes place in homes, schools, workplaces, institutions, and public areas. Many kinds of child abuse—especially sexual abuse—are difficult to assess because of the sense of shame they create and the risks children face in reporting them. The prevalence of physical punishment, however, was revealed in the Children’s Opinion Poll of 2008.¹ Three-quarters of child respondents reported that physical punishment takes place in their homes. Among school-going children, 91 per cent said it takes place at their schools. Among those who were working, one-quarter reported that physical punishment occurs in their workplaces.

**Box 4.1**

**Children’s exposure to violence:**

**A view from adolescents in a village**

The prevalence of violence in children’s lives was evident in a focus group discussion held with adolescents in a poor village during the preparation of this Situation Analysis. Twenty-seven girls between the ages of 11 and 19 years, all members of an NGO-supported adolescent club, participated in the discussion. In response to a question about their exposure to violence, all of them said they had experienced or witnessed violence and that they were familiar with cases of extreme violence against children and women. These are some of their stories and comments:

- A relative of one of the participants was beating his wife. Their two small sons were afraid and started crying. The man picked up one of the boys, carried him to the river, and threw him in, where he drowned.

- A former member of the adolescent club had a romantic relationship with a boy. Her mother beat her and tried to arrange her marriage to another boy. She committed suicide by poison.

- One man in the village (or a nearby community) beat his wife to death and then hung her body so it would look like suicide; another beat his wife to death when she was pregnant and nearly full term.

- Some of the participants said they had relatives who were sexually assaulted. If this became known, usually the family of the victim would try to arrange her marriage to the man who assaulted her. This situation enabled the husband’s family to demand high and continuous dowry payments, and the girl’s life became one of constant abuse.

- On the way to school, the girls were exposed to “eve teasing” from boys. They consider this violence, though it does not usually include physical contact. Sometimes these boys give them inappropriate notes, make inappropriate comments, and try to get the girls to talk to them. The girls said they do not tell their parents about this because they believe their parents would immediately withdraw them from school.

Among those reporting physical punishment at school, one-quarter said it happens almost every day and 86 per cent said it happens at least once a week. More than half of the school-going children said that many to most of the students in their classes received physical punishment. About two-thirds of teachers—both male and female—punish children physically. **CAMPE’s Education Watch 2007** suggests that physical punishment by

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¹ The Children’s Opinion Poll 2008, conducted by Pathways Consulting Services Ltd. for UNICEF, used quantitative and qualitative methods to gather information in 31 districts from children in the later years of childhood (ages 9-18 years), including children in urban areas (slum and non-slum dwellers and street children), rural areas, char lands, and adivasi populations.
secondary school teachers is less common, though still prevalent, with 23 per cent of secondary-school teachers practicing it. Some of the girls who participated in a recent study of Abuse in Children’s Lives mentioned that they experienced—and disliked—sexual behavior from their male teachers. The Alternative Report on Child Rights in Bangladesh 2007, prepared by a group of children’s organizations for the Committee on the Rights of the Child, reported that “teachers beat students and in many cases teachers touch girl students with bad intentions or make vulgar gestures.” A group of primary-school-age children who were met in a village during the preparation of this Situation Analysis said their teachers physically punished all of them except a girl who was physically disabled and whose mother accompanied her to the school. The children said their teachers hit them with a stick on their hands and backsides and twisted their ears. They said they were afraid of their teachers.

Although physical punishment of children appears to be less common in the workplace than at home or in schools, many children are abused at work. The children who contributed to the Alternative Report 2007 noted that employers physically and sexually abuse child workers. In the study of Abuse in Children’s Lives, some employers acknowledged that they have sexually abused child workers. Children engaged in hazardous labor are abused by the very nature of their employment. Child domestic workers and sexually exploited children are particularly vulnerable to abuse, as described in the relevant sections below.

Children in contact with the law and those residing in institutions often experience violence. According to a recent UNICEF report, “corporal and other degrading punishments are used in all the institutions, including beatings, hanging by tying hands with a rope and handcuffing.” Children sometimes experience physical abuse during arrest and interrogation, and children accused or convicted of crimes are often held with adult prisoners from whom they are vulnerable to abuse. Child victims and witnesses are treated similarly to those in conflict with the law.

In public areas, some children—especially street children, child sex workers, and the children of sex workers—are subjected to verbal, physical, and sexual abuse from police, mastaans (hoodlums), and the general public. A form of mistreatment that adolescent girls often experience in public areas is “eve teasing,” which occurs when boys approach them inappropriately. Eve teasing can involve throwing notes or flowers to girls, singing songs, proposing sexual activity and/or marriage, whistling, making inappropriate or vulgar comments, threatening them, touching them, or trying to come close to them on public transportation. This behavior is so offensive and harmful in the Bangladeshi context that many girls consider it a form of sexual violence even when it does not involve physical contact.

Many Bangladeshi children are exposed to violence against the women in their families and communities. More than half of the ever-married girls and women of ages 15-49 responding to the BDHS 2007 reported that they had experienced some form of physical and/or sexual violence by their husbands in their current or most recent marriage. One-quarter

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2The study Abuse in Children’s Lives, supported by the Government of Bangladesh, UNICEF, and Save the Children Alliance, explored the ways that adults and children in the middle childhood and young adolescent stages (6-14 years of age) experience and perceive the treatment of children in one rural and two urban areas of Bangladesh in 2003-04.

had experienced physical and/or sexual violence in the past 12 months. In addition to the fear, insecurity, and stress that violence against women creates in children’s lives, it has important implications for the future. Physical violence is perpetuated from one generation to the next. The BDHS 2007 finds that women who saw their fathers beat their mothers are more likely to report that they have experienced physical violence by their husbands. Similarly, men who saw violence against women in their childhood homes were more likely to report that they recently committed violence against their wives.

Children who live and work on the street are offered informal education at a UNICEF-supported open school in Dhaka.

Children have definite views on the ways that adult behaviors affect them. In the study on *Abuse in Children’s Lives*, some children reported physical problems resulting from punishment, but they spoke mainly about the emotional impacts of adult behaviors. Children said that when an adult behaves in a positive way with them, they feel good about themselves and the adult, they feel happy, they are inclined to be obedient and helpful, and their performance in their work and studies improves. When an adult behaves negatively with them, they feel sadness, anger, fear, and shame. They develop negative feelings about themselves and the adult, and they often want to leave the place where the negative behavior occurred. In exceptional cases, they even want to die.

IV.A.1 (b) Which children are treated better than others?

All children in Bangladesh are vulnerable to abuse. There is no group of children for whom abuse—especially in the form of physical punishment—is uncommon. The only group of children for whom less than half receive physical punishment at home is older children who have secondary school certificates or higher levels of education, and even among them, 41 per cent are physically punished. Children and adults do, however, report variations in the ways children are treated depending on their characteristics, such as household wealth, parents’ levels of education, the type of school children attend, where they live, their age, and their gender. While studies on physical and sexual abuse of people with disabilities are not available in Bangladesh, international experience indicates that they are especially vulnerable to such abuse.

*Children’s Right to Protection*
Box 4.2
Child rights and society’s perceptions of childhood

The way a society perceives the stages of childhood has important implications for the realization of children’s rights. In Bangladesh, different stages of childhood are recognized, but they are generally not clearly distinguished by age. An anthropologist, Thérèse Blanchet, has observed that the notion of “the child” in the CRC—a person in the life stage from birth to 18 years of age—does not translate easily into language or consciousness. The Bangla word *shishu*, which is often used for “the child” of the CRC, evokes a small, innocent, protected, and dependent child. *Shishu* does not evoke a knowing and responsible child capable of forming independent opinions or participating in decisions. The commitment to fulfilling the rights of the child—translated as *shishu*—can therefore be interpreted as an imperative to meet the needs of small children. This is a concept that all members of society can readily agree upon.

Raising awareness that children and adolescents are entitled to claim their rights with an increasing sense of autonomy—not just to receive care—is more complicated. Adolescence itself is an unfamiliar concept to many people. The Bangla words for adolescents—kishor and kishori—are not widely known or used and are often considered to be an academic construct rather than a stage in the lives of ordinary people. The transition between childhood and the time when a person should adopt adult behavior and responsibilities is often perceived as a relatively abrupt event rather than a stage lasting for a number of years.

Many perceive this transition to take place at different ages depending on a child’s circumstances. Blanchet observes that “quantitative representation of age is not important or is easily manipulated … but everywhere reference is made to a threshold which separates a stage of innocence and ignorance from a stage of knowledge, responsible behavior, and the possibility of guilt and punishment.” For example, this threshold—in the eyes of society—can occur quite early for an elder sibling charged with the care of younger siblings, a child bride, an orphan, a child who works outside the home or lives on the street, or a child who is sexually abused or exploited. A recent study supported by Save the Children Sweden Denmark similarly finds that perceptions of when childhood ends vary according to social class and culture.

The perception of the end of childhood as an abrupt event whose timing depends on circumstances may help to explain some of the obstacles to children’s rights in Bangladesh. These include the reluctance to raise the minimum age of criminal responsibility, the treatment of children as adults in the judicial system, and the tendency to expect hard work and/or study from children.

**Socioeconomic status.** Both at home and at school, higher levels of household wealth and better-educated parents are associated with better treatment, including less vulnerability to physical punishment. In schools, teachers tend to treat the children of non-poor households better than those of poor households because they wish to maintain favorable relations with influential parents or because they perceive that non-poor parents are more likely to complain about mistreatment of their children. Socioeconomic status is also a factor in eve teasing: the worst forms occur when boys of wealthy or influential families prey upon girls from poor or middle-class families. In regard to the type of school attended, physical punishment is slightly more common in primary schools than in madrasas and less common in NGO schools. In the homes, schools, and workplaces
of adivasi children, physical punishment is consistently less common than in any other areas studied. Violence against women is also less common in households with higher levels of wealth and parental education.

**Age of the child.** Children’s ages—or more accurately their stages of development as perceived by adults— influence the quality of treatment they receive. Toward young children, adults in Bangladesh tend to take a permissive approach to childcare and to exhibit more positive than negative behaviors. At some point before puberty, children are typically expected to begin to work and/or study hard, and punishment is often viewed as necessary to keep them on the right path. Parents or guardians are generally believed to know what is best for children. Accordingly, they often make key decisions affecting their children—including what they study, whether/where they work, and who/when they marry—without consulting them. Rebellion against authority is not considered a normal part of adolescence. Children in the later years of childhood (roughly ages 14-18 years) experience less punishment—but by then many of them are already leading adult lives, and indeed many girls are already mothers themselves. (As Box 4.2 explains, the perceptions of the stages of childhood in Bangladesh often depend more on children’s circumstances than on their ages, and they profoundly influence the realization of child rights.)

**Gender.** Gender is a profoundly important factor in how children are treated. The Bengali word for a small child— *shishu*—is gender neutral, but the words used to describe children in later stages are gender-specific. This reflects the sharp differences in the ways that girls and boys are viewed after the start of puberty. The study on *Abuse in Children’s Lives* found that girls received more overall positive behavior from adults than did boys, but giving a child freedom of action occurred more with boys than with girls. Adults felt that restricting girls’ activities and movements was necessary to protect girls from harm and to maintain the reputations of the girls and their families. Fathers described the social disapproval of girls playing too much or learning to sing or dance. In the preparation of this Situation Analysis, the adolescent girls we met at a secondary school said they could not play sports because they did not have a concealed place to play and “people do not like to see girls playing outdoors.”

The situation was different for the girls we met at an NGO-supported adolescent club. These clubs are now creating recreation opportunities for girls in many communities throughout the country. They also provide opportunities for adolescent girls to socialize, read books, play games, learn life skills, and raise their social awareness. These clubs give many adolescent girls their only opportunities to expand their horizons beyond their homes (and schools, if they attend them)—they empower them simply by enabling some mobility.

Thoughts about their daughters’ marriages influence the way parents perceive and behave with their daughters. Many parents who participated in the study on *Abuse in Children’s Lives* considered their roles to include preparing their daughters for marriage and arranging their marriages. Preparing them for marriage means bringing them up in such a way that families of potential grooms will find them attractive, for example by having a modest demeanor, a good job (e.g., in a garment factory), and/or a good education. It also means providing them with social and religious training to prepare them to behave in their in-laws’ homes in a way that enhances the
reputation of their natal families. Some parents said the anticipation that their daughters would marry and leave their homes at a young age caused them to show greater affection for their daughters. Thoughts of boys’ future roles as the heads of their families with responsibility for caring for their parents also affected the behavior of parents. Some mothers said this caused them to favor their sons in various ways, and some fathers said it caused them to discipline their sons more.

As mentioned above, eve teasing is a form of abuse experienced only by girls. Teachers deal with it seriously, so it often remains within acceptable limits among students of the same or a neighboring school. Parents and teachers feel powerless to stop this practice, however, when boys of wealthy or influential families prey upon girls from poor or middle-class families. Because of the shame it can create for the girl and her family, the experience of eve teasing—or the fear of it—leads some families to prohibit girls from attending school. In a focus group discussion during the preparation of this Situation Analysis, adolescent girls said they do not tell their parents about the eve teasing they experience because they believe their parents would react by taking them out of school immediately.

**IV.A.2 Exploitation of Children**

**IV.A.2 (a) Child labor**

**Nature and prevalence of child labor.** Bangladeshi society is widely accepting of child labor, and national legislation on child labor is rarely enforced. Employers who wish to hire children therefore face few constraints. They rely on child labor for a number of reasons. Child workers are less expensive than adult workers. Many employers consider children capable of hard work while also being obedient, easy to control, and less demanding (or less likely to claim their rights). Some reserve dirty or low-status tasks for children because adults are unwilling to perform them. Children’s small, agile bodies are sometimes assets to their employers; for example, they are able to move around more easily in busy workplaces.

National surveys indicate that 13 per cent of the country’s children between the ages of 5 and 14 years are working, amounting to nearly 5 million child laborers. The rates of child labor are higher among boys than girls (17.5 per cent versus 8.1 per cent) and slightly higher among children living in rural areas relative to those in urban areas. The overall child labor rate in urban areas, however, masks the high prevalence of child labor in the urban slums, which, at 19 per cent, is the highest rate in all the areas of residence studied. Child labor is also exceptionally high in the tribal areas, at nearly 18 per cent. Of Bangladesh’s six administrative divisions, Chittagong had the lowest incidence of child labor (9 per cent) and Rajshahi had the highest (17 per cent). Forty-five percent of child laborers do not attend school, and children in the poorest quintile of households are twice as likely to be involved in child labor as those in the richest quintile. The agricultural sector accounts for most child labor (62 per cent), while the service and industrial sectors account for 23 per cent and 15 per cent respectively.

*“States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child’s education, or to be harmful to the child’s health or physical, mental, spiritual, moral or social development.” (CRC Article 32(1))*

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*The MICS 2006 and the National Child Labor Survey 2002-03 found the proportion of children who were working to be 12.8 per cent and 13.4 per cent respectively. The MICS 2006 defines child labor as “children aged 5-14 years who are working in unacceptable forms of employment.” This definition includes children aged 5-11 who are engaged in at least one hour of economic work or 28 hours of domestic work and children aged 12-14 who are engaged in at least 14 hours of economic work or 28 hours of domestic work.*
A large proportion of children’s work in Bangladesh is hidden and therefore unlikely to be captured in the official figures. For example, many children are engaged in domestic work, commercial sex work, and smuggling. Girls often perform work at home to support the economic activities of other family members. Children also provide services that are unlikely to be defined as work, such as housework, caring for younger children, running household errands, collecting water and fuel wood, looking after livestock, and contributing to household crop production. Some teachers ask children to carry out personal tasks for them. In addition, children have been drawn into political activities.

The National Child Labor Survey estimated that about 1.3 million children were engaged in hazardous labor. The worst forms of child labor in Bangladesh include child domestic work, commercial sexual exploitation, waste picking, and rickshaw pulling. They also include employment in construction, bidi (cigarettes) and match factories, hotels, restaurants, brickyards, and workshops for welding, match making, automobile repair, lathe operations, and the repair of electrical appliances. A recent NGO-supported study found that the ship-breaking industry, where labor is extremely hazardous, also employs some children. The children who contributed to the Alternative Report 2007 mentioned that many employers do not provide needed safety gear to working children or take responsibility when they are injured at work. Nearly one-fifth of the working children who

Source: MICS 2006

"The Committee is concerned at the continuing high incidence of child workers in five selected worst forms of child labour- namely, welding, auto workshops, road transport, battery recharging and recycling, and work in tobacco factories." (Committee on the Rights of the Child, 2009)
Children’s Right to Protection

responded to the Children’s Opinion Poll of 2008 felt that their working environments were unsafe.

Trends in child labor are difficult to assess through the national surveys because of changes in their methodologies over time, but a study of employers’ perceptions gives some insights into the ways that child labor may have changed since the early 1990s. The study suggests that employment opportunities have increased for both adults and children and that more children are working overall but younger children (age 10 years or under) are more likely to attend school and less likely to work. Whereas in the early 1990s children mainly worked as farm hands or domestic workers, employers observed that children now work in a wider variety of sectors. Some of the newer employment opportunities for children, such as those in the garment factories, provide higher status in society and better working conditions (even if those conditions are considered poor by international standards). More families are now engaged in home-based production where they employ their children themselves rather than arranging outside employment for them.

Many child workers are not paid regular wages. Girls, in particular, are often denied the right to work for a wage. For example, 58 per cent of the girls who participated in a nationwide ILO survey of child domestic workers in 2005-06 received no monetary wages, and the children who contributed to the Alternative Report 2007 observed that even when employers agree to pay wages, they often do not pay the agreed amount. When children do earn wages, they rarely have control over them. More than two-thirds of the wage-earning child domestic workers who participated in the ILO survey reported that their parents collected their wages, and only 14 per cent collected their wages themselves. The children who contributed to the Alternative Report said that the police sometimes take money from working children and threaten to take them into custody if they refuse to comply.

Typical non-wage compensation for child labor includes the provision of food, shelter, clothing, toiletries, and limited medical care, help with arranging marriages and paying for dowries, and support for the children’s families in the event of a crisis. Employers of children rarely consider the compensation they provide to child workers or their families as the fulfillment of duties to the children, nor do they see the children as rights holders entitled to claim their right to fair treatment and compensation. In some cases, children’s employers even regard themselves as providers of charity.

The study of employers’ perceptions, however, indicates that parents and even children are in better positions to negotiate the terms of children’s employment than they were in the early 1990s. As new employment opportunities have arisen for older children and more young children have enrolled in school, employers have faced increasing difficulty in recruiting and retaining child workers. Better communication infrastructure has enabled some child workers to develop networks among peers, customers, and other employers, further strengthening their bargaining power. As a result, employers perceive that contractual arrangements between employers and child workers or their families have become clearer, firmer, and more likely to involve cash payments. Employers claimed that, relative to the early 1990s, they were less abusive toward child workers, paid them

Using qualitative and quantitative methods, a study by Tariquzzaman and Kaiser (2007) covered 565 households and 600 workplaces in one rural poor area and one urban slum in Dhaka.

“The Committee notes with concern that girls engaged as child domestic workers are more vulnerable to violence and exploitation....” (Committee on the Rights of the Child, 2009)
more, gave them more leisure time, and were more inclined to support their health needs and education. Some employers also acknowledged that they engaged in negative strategies to retain child workers, including preventing them from leaving the house and threatening them with legal cases (e.g., with false allegations of theft).

While conditions may have improved overall, child labor continues to expose children to multiple risks. It detracts from their opportunities for schooling and recreation, which are essential for their development. Many types of child labor are hazardous to children’s physical and mental health. Child labor often exposes children to abuse and exploitation. A recent UNICEF/INCIDIN assessment of commercial sexual exploitation of children found that half of the children surveyed were initially involved in other forms of child labor. Often living a life on the move, working children also become more vulnerable to trafficking. Most of the children who contributed to the Alternative Report 2007 said that employers beat child workers. One-quarter of the working children who participated in the Children’s Opinion Poll of 2008 reported that they experienced physical punishment at their workplaces. In the study on Abuse in Children’s Lives, one of the behaviors of employers that children reported liking is “not making them do heavy or excessive work.” Rather than recognizing this as a right, they consider this a positive adult behavior that they appreciate.

**Child domestic work.** Child domestic work is a sector of particular concern because of the large numbers of children involved and the hazardous nature of the work. Child domestic work can be defined as the engagement of a child under 18 years of age in performing domestic chores in another’s household, regardless of the amount or type of remuneration. According to surveys supported by ILO and UNICEF in 2005-2006, Bangladesh has more than 420,000 child domestic workers, and more than three-quarters of them are girls. This work is concentrated in the urban areas, with Dhaka city alone having an estimated 148,000 child domestic workers. The most common tasks for girls are washing dishes, cooking, serving food, washing clothes, babysitting for their employers’ children, and mopping floors. Among boys, the most common tasks include purchasing daily essentials, mopping floors, raising cattle, and gardening. Almost all child domestic workers live at their employers’ homes and work seven days a week. Employers reported that the children working in their homes worked seven hours a day on average, but the child workers themselves reported an average of 9-12 hours a day.

Nearly half of the girls who participated in the ILO survey of child domestic workers were expecting their employers to help them get married and pay their dowries. Most of the surveyed children slept at their employers’ homes and considered their sleeping accommodations to be as good or better than those at their own home. Almost all of them received three meals a day. More than 90 per cent said they received some kind of medical treatment when they were sick, though one-third reported that they had to work while they were ill and only 37.5 per cent of employers said they had given them time off due to illness.

Four-fifths of the surveyed child domestic workers said they would like to attend school if given the opportunity, but only 11 per cent were currently attending school and half of them had never attended school at all. The parents of 80 per cent of these children had no formal education, and the parents of only 6 per cent had primary level education or above. The

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“Each Member which ratifies this Convention shall take immediate and effective measures to secure the prohibition and elimination of the worst forms of child labour as a matter of urgency…. The term the worst forms of child labour comprises: (a) all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict; (b) the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances; (c) the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties; (d) work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.”

(ILO Convention 182, ratified by Bangladesh in 2001)
illiteracy of these children and their families contrasts sharply with the relatively well educated status of their employers and the priority that their employers typically place on the school performance of their own children.

Child domestic workers are highly vulnerable to abuse. The children who participated in the *Alternative Report 2007* noted that employers sometimes touch girls inappropriately while calling them “younger sister” and sometimes beat them while calling them “thieves.” A qualitative study of 80 child domestic workers in Dhaka found that half of the girls and one-third of the boys considered themselves to be physically abused by their employers (Blanchet 1996). Ten percent of the girls said they had been raped in the homes of their employers, and the average age of girls at the first sexual abuse was 11. In the ILO-supported survey, 19 per cent of child domestic workers said they were slapped or beaten, and 0.8 per cent of the girls reported that they experienced sexual abuse. Given the prevalence of child domestic work in Bangladesh, even the findings in a quantitative survey like this suggest that large numbers of children are abused in the homes of employers.

The vulnerability of child domestic workers to sexual abuse is widely recognized in Bangladeshi society. It creates a stigma that can damage girls’ reputations and marriage prospects. The study of employers’ perceptions showed that greater access to education for girls has made families less willing to risk their daughters’ reputations by placing them in domestic work. For those who are sexually abused, the stigma makes the experience doubly harmful. It also encourages silence among girls who are sexually abused and therefore works in the interests of the abuser.

In addition to physical and sexual abuse, child domestic workers endure a variety of demeaning practices. Many employers have their own children, who have myriad advantages over the child workers and sometimes even punish them and order them around. In the ILO-supported survey, 60 per cent of child domestic workers reported that their employers scolded them. Some employers rename their servants, calling them by short and common names against the children’s wishes.

Child domestic workers also face restrictions on their mobility and freedom of association. Living at their employers’ residence, they are typically far from their own families and communities, and employers often restrict or forbid them from interacting with the servants of other families. Blanchet (1996) found that many employers locked their domestic servants inside their homes because of fears that they would steal from them, reveal private household matters, and develop networks that would empower them to challenge their employers’ authority. One-fifth of the child domestic workers who participated in the ILO survey said they did not have the freedom to leave their jobs. Almost all of them said they were allowed to visit their own families, but 11 per cent of the girls did not do so. Ten percent of girls said their employers prohibited them from meeting friends, and 19 per cent said they do not seek such permission because they do not have any friends in the neighborhood. Whether domestic workers are forcibly confined or simply lack access to external contacts, their seclusion in private homes makes them especially vulnerable to abuse.

Child domestic workers who are not in contact with their families have no external protection and are highly exposed to abuse. Nine percent of the
child domestic workers who participated in the ILO study said they became
domestic workers because they had no one to look after them. Children
are not able to enter orphanages without adults to apply on their behalf.
Domestic work is therefore a logical destination for children without parental
care. Also, parents who agree to place their children in domestic work often
leave their opportunities for contact with their children entirely in the hands
of the employers. Some parents do not even know the addresses of the
households where their children work or how to contact them.

IV.A.2 (b) Commercial sexual exploitation of children

Many children are drawn into commercial sexual exploitation, sometimes
when they are well below the age of puberty. Some of these children are
based in large registered brothels, which are scattered throughout the
country. Some work on the streets, in parks, or at bus or train stations.
Some are used for the production of child pornography, and some consume
pornographic products for the satisfaction of customers. The closure of
some brothels in recent years is widely believed to have served only to make
the sex trade in other areas more competitive. Reliable, disaggregated data
are not available on the numbers of women, men, and children—especially
boys—who are involved in commercial sex work, but estimates for women
and girls alone range as high as 150,000. Their backgrounds, circumstances,
and the problems they face depend largely upon where they work.

Box 4.3
Commercial sex work creates a stigma for sex workers … but not
for those who procure commercial sex

Children and women involved in commercial sex work—and the children of
commercial sex workers—face intense social disapproval and marginalization.
The children of sex workers are commonly denied access to schools. If the
occupations of sexually exploited children become known in their places of
origin, their families are often also scorned, and many families reject their
children as a result. Brothel workers are denied proper burial, and some
communities require them to be marked when in public, for example by
wearing burqas or remaining barefoot. People verbally assault sex workers,
threaten them with blades and acid, and spit at them. Police, mastãans
(hoodlums), and customers physically and sexually abuse street-based sex
workers—and extort money from them or deny them payment—with impunity.
Sometimes shopkeepers charge them discriminatory, extortionate prices.

This contrasts sharply with society’s views of those who procure commercial
sex. The demand side of the sex trade—including the procurement of
children—is largely ignored. Men who patronize sex workers are often fully
integrated and accepted in society. In a recent opinion survey of highly
educated and influential adults, CARE Bangladesh found that almost 40 per
cent knew a man who had visited a sex worker. An older woman, scarred with
a blade, said to researchers: “We believed for the longest time that we have
committed unpardonable sins and we must live our lives as social outcasts.
It never occurred to us to question why the men who come to us can have
normal family lives and live without social stigma.”

Within brothels, girls who are bonded sex workers, or chukri, are the most
deprived of their rights. They are typically bought by an older sex worker
in the brothel. They are not allowed outside of the brothel, they cannot
choose their customers, and they are under strict surveillance to prevent
them from running away. They are beaten and/or deprived of food when they are perceived to have broken rules of the brothel. Some of them keep contact with their families, who believe they work at garment factories or in other jobs, and some send money to their families. According to a study supported by CARE Bangladesh, water and sanitation problems are even more severe in the brothels than they are in urban slums. Little is known about the trends in sex work over time, but a researcher familiar with the country’s largest brothel has observed a deterioration in the conditions of chukri since the early 1990s, especially in terms of their addiction to drugs and the duration of the time period in which they remain in this status.7

Children of brothel-based sex workers who are brought up inside the brothel represent an extremely disadvantaged group because they are stigmatized from birth. Many people in mainstream society perceive that the children of sex workers were conceived in sin and that sinfulness is inherent to a person. This view makes their acceptance into society virtually impossible, so they often start working in the brothel themselves. Popular sympathy is more common with regard to children who are brought up in villages and then trafficked or otherwise forced into brothels. According to the CARE Bangladesh study, brothel-based sex workers perceive that a change in the attitudes of school authorities toward their children—enabling their children to attend school and expanding their children’s opportunities in life—would bring the most significant qualitative change to their own lives.

Street-based sex workers have greater independence and agency. Some girls whose brothels were closed have found working on the streets preferable to the slavery they experienced in the brothel. They are, however, more vulnerable in many respects. They have no protection from physical and sexual violence by mastaans (hoodlums) and police officers. They also have no protection from customers’ refusal to pay. They are vulnerable to arrest and maltreatment in the criminal justice system (described further below in regard to street children and children without parental care). Whereas brothel-based sex workers have some collective bargaining power, a recent study by UNICEF/INCIDIN found that street-based sex workers are less inclined to suggest or insist on condom use for fear of losing a customer, and they are substantially more likely to report that they “always comply with clients’ say-so.” They are frequently subjected to verbal abuse from the general public and threatened with acid and other weapons, and they often have to pay bribes to the police. They are typically alienated from their parents who face social recriminations if they allow them to come home. According to the CARE Bangladesh study, street-based sex workers feel that a change in the attitudes of their parents would bring the most significant qualitative change to their lives. Many of them feel that their parents’ rejection prevents them from leaving sex work.

Little is known about the lives of sex workers in the expensive hotels and guesthouses of Bangladesh. Upper-class brothels are also reported to exist. The women and children working in these environments may be better integrated into society and less vulnerable to stigmatization than are brothel- and street-based sex workers.

The life experiences of sexually exploited children often involve dislocation from their homes and families, child labor, and sexual abuse. While none of these experiences make commercial sexual exploitation inevitable, they are all risk factors. Eighty percent of the sexually exploited children in the

7 Interview with Thérèse Blanchet, 10 April 2009.
UNICEF/INCIDIN study were living apart from their parents. They usually left home in anticipation of better opportunities in work or marriage, and many left to escape domestic abuse. Many of them had migrated from rural to urban areas, sometimes alone and sometimes with families that did not—or were not able to—ensure their safety in the city. Only a small proportion of the children became involved in sex work immediately after leaving home for the first time. Most of the boys and nearly half of the girls first became involved in child labor, especially domestic work, petty trade, and employment in garment factories. As described above, child labor often exposes children to physical and/or sexual abuse. Whether in the workplace or elsewhere, almost half of the girls and 94 per cent of the boys in the UNICEF/INCIDIN study experienced sexual abuse before they became involved in commercial sex. Some adolescents are drawn to sex work because of the income it provides, which gives them a degree of autonomy and security, however limited, that they find inaccessible to them elsewhere.

Most sexually exploited children are individually recruited. For half of the children surveyed in the UNICEF/INCIDIN study, cash transactions took place at the time of their initial departure from home or at the time they entered commercial sex work. Some were forcibly abducted, and many were lured with promises of good jobs or marriage. Recruiters of children for sex work are most active among street children and children living in urban slums. In some cases children are recruited from shelter homes—the very institutions intended for their protection.

Children involved in commercial sexual exploitation are regularly denied their rights to education and health. Although the great majority of the children who participated in the UNICEF/INCIDIN study consider education important for achieving a better life, less than 1 per cent of the girls and 15 per cent of the boys were currently attending an educational institution. Nearly two-fifths had never attended school. The children identified financial constraints, involvement in work, and the absence or lack of awareness of caregivers as the main factors hindering their education.

Sexually exploited children are highly vulnerable to general and reproductive health problems and have low access to health care services. Within the three months preceding the UNICEF/INCIDIN study, three-quarters of the surveyed children were sick (for 16 days on average) and one-third were injured (causing suffering for 12 days on average). More than half of them had suffered from sexually transmitted diseases. Among those who were sick or injured, 18 per cent and 43 per cent received no treatment, respectively, and many of those who did seek treatment went to informal health service providers. Violence, abuse, and deprivation of emotional and social support from reliable caregivers take a toll on the children’s mental health as well. The study found that they suffer extensively from depression (68 per cent) and regular nightmares (83 per cent), and one-quarter of them reported that they “do not trust anybody.” Substance abuse is also a problem. Nearly half of the children (more boys than girls) reported that they use addictive substances, including cigarettes, marijuana/ganja, alcohol, and betel leaf. Some of the girls reported using addictive substances at the demand of their customers.

Sexually exploited children are also deprived of their rights to participation. They have almost no access to organizations that support children’s physical, mental, and social development. Although half of the children

"States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse...."  
(CRC Article 19(1))
surveyed in the UNICEF/INCIDIN study consider having access to child/adolescent-focused organizations important for enhancing their welfare, only 2 per cent of them reported any such access.

**IV.A.2 (c) Trafficking and labor migration affecting children**

Traffic in women, men, girls, and boys—internal and international—takes place in Bangladesh for commercial sexual exploitation and forced labor. Some trafficked persons are physically coerced, while others are lured by promises of jobs or marriage. Some parents willingly send their children away to escape poverty, and some sell their children into bondage. Forced and bonded labor are most evident in domestic labor situations, though they occur in other settings as well, such as the forcing of boys and young men into seasonal labor in the dry fish industry. Unwed mothers, children without parental care, and others outside of normal family structures are especially vulnerable to trafficking.

**Box 4.4 Social barriers to reintegrating trafficking victims**

In a study supported by CARE Bangladesh, a group of policy makers and other influential adults were asked for their views on what would happen if their daughter’s friend was trafficked and repatriated. Most of the participants felt that after repatriation, the girl’s parents would take her back. A significant proportion, however, thought the parents would then exclude their daughter from social events. Most of them indicated that they would not let their own daughters associate with a girl who had been trafficked. Their rationale was that the trafficking victim had been exposed to many things from which they would like to protect their daughters.

Traffic happens through legal and formal migration as well as through illegal, informal, and undocumented migration. The concept of trafficking is most meaningful when seen in the context of the harm done to a person, not the legal status of the migrant. Often Bangladeshis who emigrate legally find themselves in situations of forced labor once they arrive in their destination countries. This happens, for example, to women who emigrate for domestic work and then encounter restrictions on their movement, non-payment of wages, and physical or sexual abuse. Traffickers sometimes marry women in Bangladesh, exit the country with them through official channels, and then sell them into bonded labor or commercial sexual exploitation in the destination country. Conversely, some undocumented migrants—particularly women and children suffering from poverty, abuse, and/or social marginalization in their homes and communities—find greater access to their rights after they migrate. (See Blanchet 2009.)

For women and children who are rescued and repatriated, reintegration is difficult and sometimes impossible, even when the Government and NGOs offer them services. Recent research has sought to explain the reluctance of victims to come forward and accept services. Accessing specialized services requires a victim to register a complaint with the police, but sometimes the traffickers are members of victims’ families or communities, making prosecution complicated and potentially harmful to the victim. Many victims fear damage to their reputation if their experience is exposed. Some do not believe that justice will be served by involving the police, and some...
anticipate that NGO projects are of limited duration and therefore provide only limited protection. The training and rehabilitation packages proposed by NGOs are not always sufficiently attractive, and some victims fear that accepting rehabilitation services will jeopardize their ability to migrate again if they so choose. This may be a particular concern for older girls because national legislation denies the right to legal and formal labor migration to women under 25 years of age.

When trafficking victims do come forward, their court cases tend to be lengthy, which often gives traffickers the time they need to reach illegal out-of-court settlements with victims or their families. These settlements may serve the interests of family members and traffickers more than those of the victims. In addition, shelter homes for trafficking victims are poorly prepared to provide psychosocial services to highly traumatized victims, and some have been criticized for failing to recognize residents’ dignity, privacy, and right to mobility.

Legal and procedural restrictions on Bangladeshi women seeking overseas employment and the social stigma associated with women who work abroad have encouraged clandestine arrangements for migration. Anti-trafficking messages have tended to address the risks of trafficking without acknowledging the benefits of migration. They have also sometimes appeared to equate legal migration with safe migration, which is inconsistent with the experiences of many female migrants. When anti-trafficking messages are construed as anti-migration messages, they antagonize individuals and communities that depend on female migration for their livelihoods—and push migration further underground.

The victims of bonded labor and forced child labor constitute a large proportion of Bangladesh’s trafficking victims, but their plight is largely overlooked in the public conscience. The selling of girls into prostitution is reviled—reflecting a high social value on female purity and honor—but once they are absorbed into sexual exploitation, public opinion generally turns against them. Other types of in-country trafficking—such as enslaving child domestic workers—appear to be regarded as less serious. This may reflect the social acceptance of child labor.

IV.A.3 Street Children and Children without Parental Care

IV.A.3 (a) Children living and/or working on the streets

Many children live and/or work on the streets in urban areas. Some of them are separated from their families and have no one to care for them, some have parents who also live on the street, and some work on the street but live with their families in slum areas. According to a study by the Government and the Bangladesh Institute of Development Studies, Bangladesh had about 674,000 street children in 2005, and Dhaka alone had about 250,000. Nearly half were age 10 or under, and nearly 80 per cent were boys. Street children are especially vulnerable to violence, sexual abuse, hazardous work, conflict with the law, and trafficking. They also suffer from abysmal sanitation and hygiene conditions, poor health, and limited access to any kind of education. The children who contributed to the *Alternative Report 2007* said that most street children are not receiving...
education; some of them commented that street children are not allowed to attend school because they wear dirty clothes.

Box 4.5
Child beggars in Dhaka: A profile

The streets, footpaths, markets, transportation terminals, and other public areas of urban Bangladesh are the workplaces of many child beggars. A survey of child beggars in Dhaka City in 2008 by Aparajeyo, a national NGO, provides some insights into the profiles and living conditions of these children.

Four-fifths of the 751 child beggars who participated in the survey had been engaged in begging for more than one year, and nearly half of them had lived in Dhaka for more than six years. About half were involved in other income-earning activities, such as rag-picking and selling various goods, and some were drawn into smuggling or political activities. Local hoodlums often stole their money. One-quarter of them said they experienced torture or harassment from the police, and only 2 per cent said they had positive experiences with the police. Child beggars working at traffic signals reported that they have to pay bribes to traffic police. Many girls said they were victims of sexual abuse and exploitation by rickshaw pullers, mastaaens (hoodlums), and the police.

Half of the surveyed child beggars were introduced to begging by their parents. In some cases they worked alongside their parents, and in some cases their parents accepted payments from “syndicates” for the children’s begging services. Aparajeyo reports that the commercial use of children for begging has become common. Some of the infants and children used in this way are given drugs to keep them lethargic or sleeping.

The Children’s Opinion Poll of 2008 found that the problems facing street children, as the children perceive them, depend largely on where they sleep and work. The main problems mentioned by the children who sleep in open areas are exposure to cold weather in the winter, wetness during the rains, sleep deprivation, exposure to mosquitoes, theft while they sleep, and sexual abuse. The boys who carry goods for passengers complained of the heavy loads they carry and the behavior of the registered kulies (porters), who often beat them and take the money they earn. Street children in all areas of work said that police abuse them and try to drive them away. The rag pickers, the children who work in shops and restaurants, and those who sell goods on the street complained of various types of abuse from mastaaens (hoodlums), shopkeepers, restaurant owners, and the general public. The children contributing to the Alternative Report 2007 mentioned similar concerns and also highlighted the use of street children for political activity and illegal trade.

The abuse that is prevalent throughout the homes and schools of Bangladesh—combined with the specific hardships in street children’s backgrounds—lead many of them to experience a strong sense of freedom in the street life. One study found that many children living on the street “describe the freedom of the street as an intoxicating experience, and once a child has known it, he or she cannot go back to the constraints of family life. These children live in a heroic world where the ability to survive is attributed to their own wits and nobody else’s.” (Blanchet 1996) The qualitative part of the Children’s Opinion Poll of 2008 similarly found that although street children generally wanted more security and stability, they had become accustomed to their way of life and enjoyed their freedom.
The Government and NGOs support drop-in centers for street children that respect their desire for the freedom to come and go. Open 24 hours a day, these centers provide street children with a safe place to rest or sleep, toilets, bath facilities, food, and health support. The centers serve as an entry point for further services, such as counseling, recreation opportunities, life skills training, non-formal education, vocational training, job placement support, and legal assistance. Often the personnel of the centers attempt to establish contact between the children and their families, arrange family visits, and help children prepare to return to their families in the event that they and their families become ready and willing. When reintegration is not possible or desirable, they help children find ways to live in mainstream society, for example by supporting their negotiations with landlords. NGOs provide other facilities for street children as well, such as day care centers, community-based education centers, and savings schemes. The proportion of street children reached through these programmes, however, remains very small.

**IV.A.3 (b) Children without parental care**

As described above, many children without parental care resort to informal alternatives, such as living on the street or becoming child domestic workers who live with their employers, and they are vulnerable to trafficking. Formal alternatives for children without parental care are limited and almost exclusively institutional rather than family-based. The Government maintains a reservation to the Article on adoption in the Convention on the Rights of the Child on the grounds that adoption contradicts Islamic law—an assertion that is widely contested. The commonly held belief that moral character is inherited from one’s biological parents makes adoption—especially in cases of children whose parents are unknown or are socially marginalized—difficult to address.

**Box 4.6  
Rights of children in residential institutions**

The child residents and personnel of children’s residential institutions in Bangladesh often lack knowledge about the rights of these children. Internalizing the concept of children’s rights requires acceptance that all children—including those who reside in institutions—are entitled to claim their rights and that the adults who deal with them, directly or indirectly, have duties to ensure that those rights are fulfilled. In contrast, the prevailing attitude is that these children are beneficiaries of the goodwill of the state.

In general, the basic material needs of these children are met, and they have access to education, but their rights are denied. They lack the emotional support and stability that a family and community should provide. Many of them have insufficient contact with their living relatives. Violence against them is common and extreme. Children in official orphanages are poorly prepared to live independently when they are released at the age of 18. The Government and NGOs provide various non-formal education, vocational training, and life skills programmes for children in juvenile detention and vagrant homes, but these programmes are not provided consistently and are poorly monitored and recorded. The Government is currently developing minimum standards of care for all residential institutions for children. These standards and a comprehensive monitoring system are badly needed.

The number of children residing in government, private, and NGO institutions has been estimated at about 50,000. The actual number is
probably higher but still small relative to the number of children without parental care who live in informal arrangements or without care entirely. The main Government-run facilities where children reside are orphanages, vagrant homes, juvenile detention facilities, and adult prisons. The Government also has some “safe homes” and three centers for disabled children. Bangladesh has many madrasas that house and educate orphans as well as children whose parents enroll them. (See Chapter II for further information on madrasas.) NGOs and private organizations also operate some orphanages and shelter homes for repatriated trafficking victims and children in contact with the law.

The Government has 84 orphanages in locations around the country, housing about 9,200 children of ages 6-18 years. These are called shishu paribar, which means “children’s families.” Orphans under the age of 6 years are housed in “baby homes.” Bangladesh has three baby homes providing care for about 225 infants and young children. The term orphan in Bangladesh does not necessarily imply that both parents are dead or of unknown whereabouts. In fact, for a child to enter an orphanage, an adult must apply on his or her behalf (and reportedly also often pay an informal fee). This system closes the doors of the shishu paribar to many children without parental care.

Table 4.1 Status of Government-run shishu paribar/orphanages in Bangladesh

<table>
<thead>
<tr>
<th>Division</th>
<th>Total</th>
<th>Shishu Paribar</th>
<th>Shishu Paribar for Girls</th>
<th>Shishu Paribar for Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of SPs</td>
<td>Capacity (No. of children)</td>
<td>No. of children residing</td>
<td>No. of SPs</td>
</tr>
<tr>
<td>Dhaka</td>
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<td>2650</td>
<td>2380</td>
<td>10</td>
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<tr>
<td>Chittagong</td>
<td>14</td>
<td>1775</td>
<td>1579</td>
<td>8</td>
</tr>
<tr>
<td>Rajshahi</td>
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<td>2350</td>
<td>2188</td>
<td>8</td>
</tr>
<tr>
<td>Khulna</td>
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<td>1800</td>
<td>1543</td>
<td>9</td>
</tr>
<tr>
<td>Barisal</td>
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<td>1050</td>
<td>950</td>
<td>5</td>
</tr>
<tr>
<td>Sylhet</td>
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<td>575</td>
<td>556</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>84</td>
<td>10200</td>
<td>9196</td>
<td>42</td>
</tr>
</tbody>
</table>


The Government has special facilities for the detention of children in contact or conflict with the law. These facilities reflect an extremely weak system of justice for children. The minimum age of criminal responsibility was raised from 7 to 9 years in 2004, but it still falls far short of the CRC Committee’s recommended age of 12, and the death penalty can be imposed on children who are 16 years of age or older. The most fundamental principles of due process are routinely violated. Police officers have wide discretionary powers to arrest children in need of protection on the grounds of vagrancy, begging, truancy, smoking, alcohol abuse, or prostitution. Arrest, detention and sentencing are often arbitrary and sometimes illegal. Physical abuse and torture have been applied during arrest and interrogation. The law requires separate detention facilities for children and adults, but many children—including those detained while awaiting trial—are incarcerated with adult prisoners. This further increases their vulnerability to abuse and negative social learning. In addition, children who are witnesses or victims

“The Committee appreciates the efforts of the State party to address the previous concluding observations, including the removal of some children from adult jails, the establishment of juvenile development centres and the increased training for judges, magistrates and law enforcement officers concerned with juvenile justice. However, the Committee expresses great concern over information indicating that children younger than 15 years old had been condemned to life sentences and children younger than 18 years old to the death penalty. The Committee also notes with concern that the legal age of criminal responsibility has been raised to only 9 years old. Furthermore, the Committee is concerned at the remaining number of children in adult jails and ill-treatment of children in custody by police, the length of police detention and the absence of juvenile courts.”

(Committee on the Rights of the Child, 2009)
of crime are often held under the pretext of “safe custody” and treated like children in conflict with the law.

Bangladesh has three specialized Juvenile Courts. The Juvenile Courts have limited jurisdiction and cannot hear the cases of children who are accused of serious offences. The Children Act 1974 requires Courts at all levels to follow special juvenile court procedures when hearing cases involving a child under the age of 16. Nonetheless, the cases of most children in conflict with the law are handled in the regular criminal courts, where child defendants are often tried jointly with adults and have no legal representation. Like adults, children arrested for vagrancy are taken before a special magistrate. Police officers are known to exaggerate children’s ages in court documents to avoid the procedural safeguards granted to children by law. The low level of birth registration in Bangladesh has contributed to this problem.

For children in conflict with the law, Bangladesh has three “child development centers” or Kishore Unnayan Kendra (KUK)—two for boys and one for girls, with the capacity to accommodate 700 children (550 boys and 150 girls). Formerly known as juvenile correction centers, the KUKs were established to provide long-term treatment, training, and rehabilitation for children in conflict with the law. In practice, however, they have been criticized for being simply places of confinement. Children in pre-detention, child offenders, children in “safe custody,” and children whose parents have voluntary admitted them are mixed together in the KUKs. Each KUK has a minimum of two social workers, but they do not have the requisite skills, resources, or motivation to provide proper case management. Although their families are usually known, the children in KUKs have limited contact with them; the rules of the institution restrict the children’s correspondence and prevent them from visiting their families. In recent years, a UNICEF-supported project has facilitated the visits of some family members to children in the KUKs.

The 1974 Children Act entitles parents to voluntarily commit their children to KUKs on the grounds that they are “uncontrollable.” Some families believe that the KUKs will provide better care for their children than they can. This belief is held particularly among the poor. Once children are placed in a KUK, it becomes difficult for families to arrange their release.

In line with the 1943 Vagrancy Act, which was designed to enable homeless people to seek help, the Government operates six vagrant homes. Children and adults are placed together in the vagrant homes. Vagrancy is considered a legal offense, and the police are authorized to arrest people they suspect of vagrancy. The absence of consistent criteria for declaring someone a vagrant gives the police substantial discretionary authority. As a result, street dwellers, including street children, are subject to arbitrary arrest and detention in these facilities. Conditions for children in the vagrancy homes are reportedly worse than those in the KUKs, partly because they are housed with adults. Children in need of “safe custody” are also placed in the vagrant homes. The Vagrancy Act does not limit the period of detention, and children are often detained in vagrant homes for long periods of time, particularly when they are unable to give names and addresses of their families.

Qualified social workers are not available to provide individual case management for the residents of vagrant homes, and most children and personnel in these institutions lack awareness of the children’s right to be
Children’s Right to Protection

reunified with their families and communities when safe and feasible. The social workers do make efforts to contact family members or guardians by telephone or letter, and in 2008 they supported the reintegration of about 60 children into their families or communities. The process is not systematically recorded, however, and the social workers have limited capacity, resources, systems, and incentives to follow up. The widespread disempowerment of women and children in their families and communities—and the abuse they experience—create the likelihood that large numbers of children will be unable to safely reintegrate. This is especially true for girls, who have more difficulty reintegrating when their communities know that they have been—or may have been—exposed to sexual abuse and exploitation.

IV.B. CAUSALITY ANALYSIS

As described above, the key areas where children’s access to their right to protection is challenged in Bangladesh are abuse, exploitation, and the lack of a comprehensive system for protecting the rights of children without parental care. This section outlines the immediate and underlying factors determining children’s access to their right to protection. (Basic factors, which are largely common across all children’s rights, are discussed in Chapter I above.) This structure is intended only to highlight some of the key patterns and issues that arose during the consultations and literature review for this Situation Analysis. Causality is not always linear, and it does not always follow any specific pattern from one child to another. Abuse, exploitation, and the quality of care arrangements are often linked to one another, and they have multiple causes that are also often linked.

IV.B.1 Immediate Factors

The immediate factors influencing children’s right to protection include (a) social acceptance of physical punishment of children and violence against women, (b) the levels of personal stress and social or family-related pressures that caregivers experience, (c) the practices of child marriage and dowry, (d) social acceptance of child labor, and (e) the extent to which laws and policies on child protection are enforced.

Box 4.7
Child marriage: Views from adolescent girls in a village

The team preparing this Situation Analysis asked a group of adolescent girls in a poor village to describe the fears and concerns in their lives. They mentioned two concerns above all others: the fear that their parents will arrange early marriages for them, and the fear that they will be unable to continue their education. These fears are related, since child marriage is one of the reasons girls drop out of school. These girls said they object to early marriage because they have seen its consequences. One girl explained that her cousin died in childbirth. Another explained that early marriage and pregnancy diminish girls’ health, make their husbands not want to look at them, and result in violence against them.

“States and civil society should strive to transform attitudes that condone or normalize violence against children, including … acceptance of corporal punishment.”
(UN Study on Violence against Children, 2006)
Social acceptance of physical punishment of children and violence against women. Physical punishment of children is commonly accepted as a teaching and disciplinary aid in homes, schools, and institutions. Most people—both adults and children—are unfamiliar with the concept of positive discipline and believe punishment is in children’s best interest. All of the adult groups that participated in the study on Abuse in Children’s Lives (and also the village women who were met in preparation for this Situation Analysis) indicated that they consider physical punishment of children to be normal and acceptable. They argued that wrongdoing by children—such as not studying, not going to school, or quarrelling—requires a disciplinary response. Rural teachers expressed the view that creating fear in children is effective in maintaining classroom discipline. In focus group discussions for the abuse study, children presented similar arguments as justifications for physical punishment. Relative to urban children, rural children were more likely to view negative behaviors of adults as justified.

Violence against women is most common in households where husbands consider wife-beating acceptable. A recent study using BDHS data found that men with this view were more than four times as likely to report that they have recently physically abused their wives (Johnson and Das 2008). In the BDHS 2007, nearly one-third of women and 7 per cent of men reported that physical abuse took place for no reason at all.

Personal stress and family/social tensions. In the study on Abuse in Children’s Lives, correcting children’s wrongdoing was not the only reason adults gave for engaging in negative behaviors that children dislike. More than one-third of these reasons were unrelated to the behavior of the child. Negative behavior on the part of adults often stemmed from their own negative mental state—being in a bad mood, angry, or worried as a result of financial pressures and other family or personal problems. Mothers, especially urban poor mothers, mentioned family problems—such as domestic discord or violence, a husband leaving his wife or taking a second wife, and a mother having to shoulder all the family responsibilities—more frequently than did fathers. In the BDHS 2007, financial crisis was among the reasons given by women and men for spousal violence.

Many street children and child domestic workers have come to their current ways of life because of broken or dysfunctional families. Parental divorce or separation, domestic disputes and violence, the death of a parent, polygamy, and unsupportive stepparents are important parts of the personal histories of many of these children.

Child marriage and dowry. While the practice of child marriage has decreased in Bangladesh over the last 30 years, it remains common in rural areas and urban slums, especially among the poor. Many families consider girls ready for marriage at the onset of menstruation. As mentioned above, the MICS 2006 found that one-third of women of ages 15-49 were married before their fifteenth birthday and nearly three-quarters of women of ages 20-49 were married before their eighteenth birthday. Of the women of ages 15-19 at the time of the survey, 42 per cent were already married. Arranging early marriage for a girl is often financially beneficial for her family—she is no longer a financial burden, and the marriage of a younger daughter often requires a smaller dowry than the marriage of an older daughter. Some poor families would like their daughters to marry early but cannot afford the dowry demands of the families of potential grooms.
For women and girls, the practices of early marriage and dowry contribute to disempowerment, poor health, and vulnerability to violence, sexual exploitation, and trafficking. Girls are often placed in domestic employment situations with the anticipation that their employers will arrange their marriages and/or pay their dowries. A child bride usually drops out of school (if she was attending school) and begins full-time work in the home of her husband’s parents, where she often lacks status and bargaining power and can effectively become a bonded laborer or slave. Because they cannot abstain from sex or insist on condom use, child brides are often exposed to serious health risks such as premature pregnancy, sexually transmitted infections, and HIV/AIDS. The BDHS 2004 found that one-third of adolescent girls of ages 15-19 had begun childbearing, with early childbearing more prominent in rural than urban areas. Many poor families are unable to fulfill the dowry demand after the marriage has taken place, and in some cases grooms’ families demand continual payments. In such cases, the husband and other family members may abuse the girl as a means to bring pressure on her family. The reasons given by women and men for spousal violence invariably include dowry-related issues.

If a girl in these circumstances becomes separated from her husband, a lack of survival options may leave her vulnerable to commercial sexual exploitation and trafficking. Another link between trafficking and the practices of early marriage and dowry occurs when traffickers use promises of dowry-free marriages as a ploy to attract girls from poor families. Finally, the notion that a girl as young as 12 years of age is eligible for marriage—and is therefore an acceptable sex partner—contributes to the social acceptance of men who patronize child sex workers.

Social acceptance of child labor. Child labor is widely accepted as normal in Bangladesh. Children’s contributions to household survival are often praised. Many employers who worked as children themselves consider child labor necessary or inevitable. In some cases the work children perform is seen as valuable experience for their adult lives. When children work in obedience to their parents or guardians—for example, in family enterprises or in domestic labor situations arranged by their parents—the work they perform is generally not seen as exploitative, even when, as is usually the case, the children have no control over the compensation provided in exchange for their labor. A study of employers’ perceptions of child labor since the early 1990s found that NGO and Government advocacy campaigns had not led to any general decline in employers’ preferences for hiring child workers.

Extent to which laws and policies on child protection are enforced. The laws and policies regarding child labor, physical punishment, violence against women, sexual exploitation, imprisonment of children with adults, trafficking, child marriage, and other aspects of child protection are routinely violated. In some cases, people are not aware of the laws, but more commonly they are simply ignored—by both those in violation of them and those who are responsible for enforcing them—because they conflict with social norms and established practices. Regardless of how well laws and policies are designed, their implementation depends ultimately on attitudes, awareness, and willingness. The level of national ownership of laws and policies is essential. Some positive changes are anticipated from the ongoing nationwide consultations—including consultations with children—for the development of policies such as a national strategy to combat violence against children and a national action plan for combating sexual exploitation of children.
The lack of birth registration for most children has been an enabling factor in the violation of laws and policies to protect children. The Government is actively addressing this issue. The Birth and Death Registration Act, adopted in 2006, requires birth certificates as proof of age for a number of essential services, including marriage registration, and a campaign for universal registration is underway. The expansion of birth registration in Bangladesh is expected to provide an important step in meeting child rights. Birth registration provides the child with a name, identity, and nationality, which are rights in themselves, and it enables access to other child rights, including the prevention of child marriage, and the right to age-appropriate treatment for children in contact with the law. Birth registration also makes protection against child labor, sexual exploitation of children, and child trafficking easier and can facilitate the recovery and reintegration of children who become separated from their parents or guardians (including through trafficking) and who become victims of crime.

### IV.B.2 Underlying Factors

The underlying factors influencing children’s right to protection include (a) knowledge and awareness to motivate social change, (b) the legal and policy framework for child protection (and gaps in their harmonization with the CRC), and (c) institutional capacity for child protection. This section focuses on knowledge and awareness; the legal, policy, and institutional structures for child protection are discussed in the role and capacity analysis (section IV.C.) below.

Knowledge and awareness of children’s rights—and the rights and responsibilities of duty bearers—have important links with all of the immediate factors discussed above. Children’s access to their right to protection depends on the ways people perceive matters such as the effects of positive and negative forms of discipline, the developmental stages of childhood and adolescence, alternatives to institutionalization for children without parental care, and the risks associated with early marriage, child labor, and trafficking. It also depends on awareness of related laws and policies and their purposes. As elaborated in Chapter I above, children have the right to participate in social change and to have their voices heard in the process. Child rights advocates are supporting numerous awareness-raising initiatives, including public information campaigns, child rights training, and the expansion of mental health capacities in academia and the health care system. Some encouraging steps are underway in Bangladesh to promote child participation and the projection of children’s voices, though they remain small steps facing resistance from those with traditional views on the role of children.

One area where knowledge and awareness have motivated change in recent years is primary education. The strong public policy emphasis on primary education has helped to increase the priority that parents place on schooling relative to work for primary-school-aged children. The study on employers’ perceptions of changes in child labor since the early 1990s reached this conclusion, though it also found that attitudes toward child labor itself had not changed much. Another area where increasing knowledge and awareness appears to be having an impact is child marriage, which is declining gradually in Bangladesh, though it remains a serious problem.

Knowledge about sexually transmitted diseases, including HIV/AIDS, is important for children’s right to protection. NGO programmes are actively...
raising awareness among adolescent groups throughout the country. This is a particular concern for sexually exploited children. Three-quarters of the child sex workers who participated in the UNICEF/INCIDIN study had no clear knowledge about these issues.

IV.C. ROLE AND CAPACITY ANALYSIS

IV.C.1 Families

Families are the duty-bearers with the most immediate responsibilities for ensuring children’s right to protection. A number of factors challenge their capacities to fulfill their duties. 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. 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. Many girls are uninformed about their rights and about issues of reproductive health and gender equality. Restrictions on the mobility of adolescent girls, which are rooted in social norms and values, limit their opportunities to meet and exchange ideas among their peers.

IV.C.2 Communities

Communities have duties to mobilize for child protection within the community and to demand accountability when these rights are violated. They have a particularly important role to play in supporting the reintegration of orphans, trafficking victims, and other children who are separated from their natural families. Teachers have the duty to abstain from physical punishment of children, to pursue child-friendly teaching methods, and to ensure, to the best of their ability, that children are free from abuse and exploitation. 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. One of the encouraging signs about the positive role that communities can play is that neighbors sometimes provide assistance to women during domestic violence incidents.

IV.C.3 Non-Government Organizations

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, provide services to street children and those in residential institutions, provide legal aid to vulnerable women and children, rescue children from pre-trial detention in police stations, trace the families of children without parental care and support their reunion, conduct training on the legal rights of women and children, support legal reform, investigate cases of violence against women and children, and operate shelter homes for children in contact with the law and repatriated trafficking victims. They also support adolescent clubs throughout the

“The Committee expresses deep concern that no durable solution has yet been found to comprehensively address the rights of refugee children. The Committee reiterates its recommendation to the State party to ... address the concerns of approximately 100,000 – 200,000 Rohingya, including children, not registered as refugees by the State party but who reside in the country for similar reasons as the registered refugees in official camps and to provide them with, at a minimum, legal status, birth registration, security and access to education and health care services.” (Committee on the Rights of the Child, 2009)
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). The growing commitment to programmatic approaches rather than projects is likely to help ameliorate this problem.

IV.C.4 Employers

Employers of children have the responsibility to adhere to all laws and policies relevant to child labor. They are further responsible for treating child workers with dignity and respect, providing them with adequate compensation, honoring all contractual arrangements (formal or informal) with them, ensuring that their work is safe and suitable to their ages and abilities, ensuring their access to education, and providing vocational skills that will help them in their future lives. Research shows that many employers abuse children, require heavy or excessive work from them, restrict their mobility, prevent them from attending school, and neglect their health needs. Their main constraints in fulfilling their duties to children are lack of awareness and the low level of enforcement of child labor laws, which encourages them to view harmful child labor practices as normal.

IV.C.5 Local Government Institutions

Social workers, administrators, 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 are responsible for monitoring and evaluating service delivery. The 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, and coordination difficulties. Concerns about abuses by the police and their lack of responsiveness arose repeatedly during the preparation of this Situation Analysis.

IV.C.6 Government of Bangladesh

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. This section will review the policy and institutional aspects of the Government’s role in ensuring children’s right to protection.

Policies regarding children’s right to protection are weak in Bangladesh, but the political will to bring about change is growing. The recent separation of the judiciary from the executive provides a long awaited opportunity for legal reform in favour of children. The judiciary, particularly the higher judiciary, has become proactive in promoting and protecting the rights of children in contact with the law and has requested legislative changes in
accordance with international standards. The Second National Strategy for Accelerated Poverty Reduction (NSAPR II) acknowledges children’s right to protection from abuse, exploitation, and violence. It places a priority on the social protection and education of street children, working children, children who are refugees or internally displaced, children in conflict with the law, children in orphanages and other institutions, and children in sex work, disaster situations, broken families, and urban slums. The NSAPR II also sets forth targets for reducing the prevalence of child marriage.

Birth registration is vital for children’s rights, and registering births is a duty of the Government. The low rate of birth registration in Bangladesh has obstructed the enforcement of all age-related protections, such as those regarding justice for children, child marriage, child labor, and commercial sex work. It has also made the reunification of children who have become separated from their parents or guardians more difficult. The Birth and Death Registration Act, which came into effect in 2006, marks a turning point for children’s rights in Bangladesh. The new law has created demand for birth registration by requiring it for many public services, including marriage registration and school enrollment. It also established a national Birth Registration Day, which was observed for the first time in 2007, and it provided for free birth registration for two years. The Government has extended free registration for children until July 2010, by which time universal birth registration for children might be attainable, and UNICEF is advocating for the birth registration of children to be designated free of charge into the indefinite future. Since 2006, the proportion of the population with birth registration has increased from 7 per cent to 52 per cent, largely through harmonization of the birth and voter registration processes. The proportion of children who are registered, however, is not currently known.

**Government role in regard to violence and commercial sexual exploitation of children.** The Suppression of Violence Against Women and Children Act 2000 (amended in 2003) allows for the prosecution of the perpetrators of some specific and severe kinds of violence against children—such as kidnapping, abduction, rape, sexual harassment, and trafficking—but it excludes some important forms of sexual abuse and exploitation. It does not provide a comprehensive definition of violence against children. Although the Government has issued a circular prohibiting physical punishment in primary schools, this practice is legally sanctioned and commonly occurs, as described above, in homes, schools, and children’s institutions. Bangladesh has no legal recognition of male-to-male rape, leaving male rape victims and sexually exploited boys with little opportunity to seek justice. Legal protections are not provided for children used in pornography. A UNICEF-supported review of child-related legislation in Bangladesh concludes that a consolidated legal package on violence against children is needed.

In 2001, the Second World Congress Against Commercial Sexual Exploitation of Children gave local child rights activists an opening to engage the Government on this issue. A national action plan was subsequently developed but has not been implemented. New momentum for progress in this area has emerged following the Third World Congress, which convened in late 2008 with the participation of the Government of Bangladesh. A new, more practical national action plan is under preparation.

The police have responsibilities to provide protection, but they are known to abuse children themselves and have not generated trust among

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse....”
(CRC, Article 34)
communities. The BDHS 2007 found that very few women who experienced violence by their husbands received help from the police or the court system. Participants in focus group discussions for this Situation Analysis said that the police and the court system rarely intervened in domestic violence except in cases of murder, and even then the families of the perpetrators were able to arrange for the cases to be dropped.

**Government role in child labor.** Bangladesh has ratified ILO Convention 182 on the Worst Forms of Child Labour. It has not, however, ratified ILO Convention 138 on minimum ages of employment. The Labor Act 2006 defines minimum ages for light, regular, and hazardous work (ages 12, 14, and 18 respectively), but these types of work are not clearly defined. The Government does not have enough monitors or monitoring capacity to enforce the law, and corruption has been a problem in the monitoring process. The monitoring system addresses only the formal sectors, whereas the vast majority of child labor is in the informal sector. Domestic work—and child domestic work in particular—currently has no legal status or recognition in Bangladesh. The lack of regulation in this sector leaves many children, especially girls, extremely vulnerable to violence and exploitation. Children raised an objection to the use of children in political activities during the 2008 meeting of the Child Parliament, which Save the Children Australia supports. This led to the inclusion of a pledge to combat this practice in the election manifestos of the lead political parties in the 2008 election.

The Government has prepared a Child Labor Eradication Policy. If approved, the proposed policy is a step forward, but continuing support for policy development will be needed. The proposed policy makes some references to child domestic work, including a limit of five hours of work per day and a requirement that employers give child domestic workers opportunities for education and recreation. It acknowledges that child labor in the informal sector should be brought under legislation.

**Government role in counter-trafficking.** The Government is undertaking serious measures to combat trafficking in women and children. As a result, Bangladesh is now classified as a “Tier 2” country in the U.S. State Department’s ranking of countries on trafficking issues, meaning the U.S. Government recognizes that Bangladesh is making significant efforts to eliminate trafficking in persons. Nonetheless, the Government’s capacity to address trafficking violations remains limited, especially in regard to victim protection and prevention of internal trafficking.

Bangladesh has not yet ratified the Palermo Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children. Regional cooperation in anti-trafficking is essential and remains in an early stage. The Convention on Prevention and Control of Trafficking in Women and Children for Prostitution of the South Asian Association for Regional Cooperation (SAARC), for example, currently addresses only trafficking for commercial sex work—it ignores trafficking for other purposes. Further, it addresses trafficking of women and trafficking of girls as though they were identical issues, and it does not address trafficking of men and boys. It also lacks a compliance mechanism. Bangladesh’s Suppression of Violence against Women and Children Act, amended in 2003, prohibits trafficking for both commercial sexual exploitation and involuntary servitude, and it provides for severe punishment of traffickers. It includes young boys but excludes those over the age of 16. Bangladesh’s penal code prohibits forced labor but provides insufficient penalties to deter the offense. Restrictive policies on female labor migration have pushed this process underground.

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“States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.”

(CRC, Article 35)

“The Committee reiterates, with urgency, its previous recommendation that the State party concentrate its efforts to combat the sale of children and trafficking.”

(Committee on the Rights of the Child, 2009)
The Government’s counter-trafficking measures include the establishment of an inter-ministerial cell at police headquarters, monitoring committees at district, upazila, municipality, and union levels, and anti-trafficking police units in all 64 districts. Traffickers have been regularly arrested, prosecuted, and convicted. With support from UNICEF and the International Organization for Migration (IOM), the Government recently rescued 199 Bangladeshi boys who were trafficked to the United Arab Emirates to work in camel racing. Bangladesh and India have developed bilateral arrangements for the rescue, recovery, repatriation and reintegration of trafficking victims and are engaged in dialogue on a comprehensive and uniform system. Bangladeshi embassies have opened safe houses for trafficking victims in key destination countries. The Government’s steps to raise public awareness about trafficking include a campaign of television and radio public service announcements.

The Government and NGOs have initiated various programmes to support the rescue, repatriation, and reintegration of trafficking victims, which have had limited success. To date, the victims of bonded labor and forced child labor have not factored significantly into policies and programmes. Actions to reduce the demand for commercial sex have not been taken. The Government rarely (if ever) prosecutes those responsible for holding people in involuntary servitude or those who procure child sex workers.

The Ministry of Home Affairs is the nodal ministry for counter-trafficking, including activities for rescue, repatriation, recovery and reintegration. This ministry has expertise in the procedures for rescue, repatriation, and recovery, but the Ministry of Social Welfare would be better suited for the provision of specialized services for rescued trafficking victims and their families and communities.

Government role in protecting children without parental care. The Ministry of Social Welfare and its Directorate of Social Services (DSS) are responsible for identifying and supporting socially disadvantaged and at-risk people in Bangladesh, including children. Their strength lies in their comprehensive network of social workers at the union level. They are constrained, however, by limited managerial and technical capacity, limited financial and human resources, and the sheer magnitude of their task. At present most of their activities are reactive and curative, with a strong focus on institutionalization and little attention to preventive measures or the reintegration and rehabilitation of children at risk. The existing approach to training is segmented, with three different entities providing training. Planning and resource allocation follows a top-down approach, whereby policies and programmes are developed in Dhaka with little input from the field level. DSS implements a large number of programmes and has separate management arrangements for the various programme components, many of which have overlapping mandates or target groups. Committees at various levels are the only monitoring tools, and they also have overlapping mandates and are poorly linked with one another.

DSS operates the various institutions for children, including the orphanages (shishu paribar), baby homes, KUKs, and vagrant homes. Many of these institutions suffer from poor infrastructure, vacant posts, untrained staff, and poor quality of care. DSS is developing minimum standards of care to replace the disparate and inadequate sets of rules and regulations that now apply to them. NGOs provide some specialized services in the institutions, but DSS maintains full responsibility for service delivery.

“A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.”
(CRC Article 20(1))
World Bank study has recommended that DSS maintain overall control over these institutions but hand over their day-to-day management to voluntary organizations under a co-management agreement.

The Government has developed a draft street children policy and is undertaking initiatives to provide services for street children—through drop-in centers and other facilities—with support from UNICEF, the World Bank, and NGOs. Police officers are duty bearers with regard to children’s rights, but, as described above, they rarely fulfill their responsibilities in this regard. Rather than providing protection, the police reportedly often abuse street children and subject them to arbitrary arrest and detention.

**Government role in regard to justice for children.** The Children Act 1974 and the Children Rules make an implicit link between children without parental care and criminality, referring to these children as “potential offenders” rather than citizens with rights. The treatment afforded to children in conflict with the law and those without parental care is essentially the same—they are brought before the juvenile court, which can order them to be placed in an institution. This is inconsistent with international standards.

Where laws and policies are in place to protect children, they are rarely enforced. The National Strategy for Accelerated Poverty Reduction states that “children in difficulty with the law should be treated with the objective of reintegrating them with their families/communities rather than to ‘punish’ them.” The Children Act 1974 requires that children in conflict with the law be tried in juvenile courts and that children in prison must be separated from adults. The Suppression of Violence Against Women and Children Act prohibits the placement of children who are victims or witnesses of crime in prison for “safe custody.” In practice, however, the system of justice is largely punitive, crimes involving children are processed through ordinary criminal courts, and children are often imprisoned with adults.

In 2004 the minimum age of criminal responsibility was raised from 7 to 9, which marks a substantial improvement but still falls far short of the international standard of age 12. Similarly, the minimum age at which children are treated as adults in the criminal justice system is 16, whereas the international standard is 18. Even the death sentence is permitted for children aged 16 or older. The country’s low birth registration rate makes verifying a child’s age difficult in most cases, which means children in conflict with the law are often deprived of age-related protections even as they are defined in Bangladesh.

**Government role in regard to child marriage.** The Child Marriage Restraint Act fixes the minimum ages of marriage for men and women at 21 and 18 years respectively. This law is routinely ignored, and enforcement is virtually nonexistent. In addition, the differentiation between the minimum ages for women and men is contrary to international standards. If the campaign for universal birth registration is successful, this will provide an important tool for preventing child marriages.

**Government role in protecting children at times of emergency.** Current policies on emergency situations involve care for children only when they are orphaned. With support from UNICEF and other partners, however, the Government has taken a more holistic approach in response to Cyclone Sidr in 2007. This approach targets all vulnerable children, not just orphans, and involves basic care and psychological, recreational, and learning.
support. A regular coordination body has been established. The Ministry of Women and Children Affairs has the mandate for protecting children during emergencies, but the Ministry of Social Welfare has greater capacity to provide the long-term support that orphaned and vulnerable children need for recovery and reintegration. UNICEF and other development partners are advocating for the involvement of the Ministry of Social Welfare and for the adoption of policies that incorporate broader child protection coverage for children affected by natural disasters and other emergencies.

IV.C.7 International Development Partners

International 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. Three areas where substantial multi-donor support is provided are justice for children, services for street children, and counter-trafficking. With representation from the Government, UN agencies, donors, and NGOs, a Juvenile Justice Roundtable has strengthened coordination and policy dialogue, developed a plan of action for creating a child-friendly system of justice, and successfully advocated for the development of a separate law on justice for children. The services provided for street children are expected to expand with substantial new World Bank funding, following the approach and lessons learned under UNICEF-supported interventions. Support for counter-trafficking has enabled Bangladesh to develop substantial capacity for bringing international traffickers to justice and is now needed particularly in the areas of victim support and internal trafficking.

IV.D. RECOMMENDATIONS

The causality and role analyses indicate that policy development, communication for development (C4D), and capacity building are key areas where UNICEF and other organizations promoting child rights can effectively support Bangladesh’s progress toward the realization of children’s right to protection. These areas of intervention are linked to one another. For example, the ability of a strong legislative and policy foundation to improve children’s lives depends on the extent to which duty bearers are aware of relevant laws and policies, accept their rationale, and respect the rule of law—and on their capacity to implement laws and policies.

Policy development. Genuinely consultative processes, involving children and adults, can lead to the development of laws and policies for child protection that are nationally owned and relevant in the national context. Such processes are underway for policies on violence against children and commercial sexual exploitation of children. Consultative policy development can be expected to benefit child protection in other areas as well, such as child labor, treatment of street children, justice for children, alternatives for children without parental care, and child marriage. The extension of birth registration to all children merits continuing support, as does the potential establishment of an independent, child-sensitive, and accessible system for receiving and processing complaints from children. The design of a package of essential services for child protection would be an important first step toward the development of comprehensive child protection policy.
Communication for development (C4D). Children’s access to their right to protection depends largely on the ways people perceive childhood. This includes their knowledge and perspectives on the effects of positive and negative forms of discipline, the developmental stages of childhood and adolescence, alternatives to institutionalization for children without parental care, the participation of children in decisions affecting them, and the risks associated with early marriage, child labor, and trafficking. It also includes the prevalence of discriminatory attitudes toward women and girls, children with disabilities, street children, children without parental care, and victims of abuse, neglect, and exploitation. Attitudes toward those who procure the services of child domestic workers and sexually exploited children are as important as attitudes toward the children themselves. Knowledge about sexually transmitted diseases, including HIV/AIDS, is also important. The potential for progress in C4D is evident in the changes that have already taken place in Bangladesh as increasing numbers of people have chosen primary education over other alternatives and the average age of girls’ marriage has increased.

Raising social awareness on child protection issues is important within all child rights programming. Targeted awareness-raising campaigns are also needed. As recommended by the Committee on the Rights of the Child, an education campaign for boys and men on gender issues and sex discrimination would be particularly beneficial. In addition to conveying messages on health care, education, nutrition, and hygiene, the media can serve to raise awareness about the harsh conditions of life facing many children in Bangladesh. To avert the possibility of backlashes from those with traditional views on the roles of children and women in society, these efforts must be designed with sensitivity to cultural realities. They can usefully acknowledge the role of poverty in causality while also conveying the message that poverty is not an excuse for anyone to look the other way—many violations of children’s right to protection can be addressed before poverty is eradicated.

Capacity building. The role analysis shows the potential for capacity building among all duty bearers to improve conditions for children’s rights. A first step in all cases is ensuring that duty bearers recognize children as rights holders entitled to claim their rights, not just to receive benevolence. The following are suggested areas where capacity building could be particularly fruitful:

- Parenting skills and the knowledge and awareness of caregivers.
- The organizational capacity of communities, especially their ability to create demand for effective policing and other public services.
- Development of proactive social work skills within the Government, NGOs, and academia to support vulnerable children and their families.
- Capacity of the Government and NGOs to provide appropriate alternative care opportunities for children deprived of family environments. The development and implementation of minimum standards of care and monitoring systems for all forms of alternative care are essential. Services for street children—designed to enable their full development while recognizing the realities of their lives and respecting their views—are expanding already. Support for the reunification of children with their families and communities should be
strengthened along with understanding of the obstacles to reunification and the potential harm that can result from reunification when conditions are not appropriate.

- Clarification and greater understanding of the delineation between Government and civil society responsibilities and the mechanisms available for them to work together. This will help to strengthen trust and partnership between the Government and civil society while ensuring that the full range of national capabilities is utilized.

- Capacity to develop and implement programme-based approaches that enhance partnerships and the use of resources.

- Introduction of mechanisms for the participation of children in all matters affecting them within families, communities, schools, the justice system, and national policy-making processes.

- Child protection services for children and families who migrate to the cities, especially to the urban slums.

- Government, NGO, and community mechanisms for the protection of trafficking victims and prevention of internal trafficking, with attention to the distinctions between migration (which can be formal or informal) and trafficking (which causes harm to a person, whether it takes place through formal or informal channels).

- Holistic Government, NGO, and community mechanisms for children affected by natural disaster.

Potential areas of research. Designing policies and programmes that successfully address violations of children’s right to protection requires understanding the full social and economic context in which children in different circumstances live—how society perceives and treats them, and how they perceive their environment and options. This requires careful research. The findings of the Situation Analysis point to a number of areas where additional research could enhance initiatives for policy development, C4D, and capacity building:

- Regular monitoring of children’s and adults’ perspectives on the ways children are treated.

- Comprehensive study of sexual abuse, including sexual abuse of disabled children, to support the development of a national strategy. Sexual abuse is a difficult subject to study in any country, and in Bangladesh it has been largely neglected.

- Best practices for reducing the demand for child sex work and for investigating, prosecuting, and sentencing the perpetrators of sexual offences against children.

- Study of the effectiveness of initiatives to change the image of child labor and the adults who employ (or exploit) children in hazardous areas of work.
V. Children’s Right to Water, Sanitation, and Hygiene

Safe water, adequate sanitation, and good hygiene practices are critical to the realization of all children’s rights in Bangladesh. Their use reduces the risks of respiratory and gastrointestinal diseases, which disproportionately affect children, contributing to their under-nutrition, morbidity, and mortality. Menstrual hygiene is important for reproductive health, and access to adequate facilities for menstrual hygiene at schools can make the difference between going to school and not going to school for adolescent girls. Avoiding the consumption of excessive levels of arsenic—which contaminates much of Bangladesh’s drinking water—is necessary to prevent the debilitating and sometimes deadly effects of arsenicosis and other arsenic-related diseases. Safe water, sanitation, and hygiene also have potentially life-changing social impacts, as cleanliness and avoidance of disease can raise the social standing of the poor and influence the security of girls and women in marriage.

This chapter provides an overview of the situation regarding women’s and children’s right to safe water, sanitation, and hygiene in Bangladesh. It then analyzes the factors influencing the realization of this right and the roles and capacities of relevant duty bearers. It closes with recommendations for support in the water and sanitation sector from UNICEF and other organizations involved in child rights.
V.A. OVERVIEW OF THE SITUATION

In the early 1990s, about 98 per cent of households in both urban and rural areas were believed to have access to safe drinking water. Most households were using “improved” water sources, which were mainly shallow tube wells purchased privately by households and developers. The picture of water safety changed dramatically after confirmation in 1996 that many of the country’s groundwater sources are contaminated with arsenic. The most recent WHO-UNICEF estimate of safe drinking water coverage is 80 per cent in 2006, up only slightly from the current estimate for coverage in 1990 (78 per cent). The intrusion of saline water and the presence of high levels of iron also compromise water quality in large parts of the country. About 29 per cent of shallow tube wells in Bangladesh are contaminated with bacteria due to poor maintenance of their surroundings. The country does not yet have mechanisms in place for systematic water quality monitoring and surveillance.

Access to safe water varies seasonally and across regions. Almost 90 per cent of the country’s tube wells are shallow, and these wells become nonfunctional in about 35 per cent of the country’s territory during the dry season, which lasts for three to four months each year. Access to water is particularly problematic in the coastal belt (saline zones) and the hilly, stony districts of the Chittagong Hill Tracts. Water scarcity results from naturally occurring droughts, from water management practices in India (affecting the flow of water into Bangladesh), and from over-extraction of water for irrigation purposes, which is lowering the groundwater table.

MDG 7: Ensure environmental sustainability

Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Carrying a pot of drinking water after Cyclone Sidr in 2007, Rozina crosses fallen trees on her way home in the district of Borguna. Her family’s source of drinking water is about one kilometer from her home. The cyclone destroyed many sources of safe water.
Since the 1970s, households have invested substantially in improved sanitation facilities, usually relying on private sector providers, and the Government has stepped up its role in providing sanitation facilities to households in recent years. According to data from the Multiple Indicator Cluster Surveys (MICS), the practice of open defecation has declined markedly—from more than 30 per cent in 1994 to less than 10 per cent in 2006. Estimates of sanitation coverage vary widely—from 39 per cent to 87 per cent. The WHO/UNICEF Joint Monitoring Programme (JMP) classifies a pit latrine with slab as an “improved” facility. In the MICS 2006, the Bangladesh Bureau of Statistics (BBS) used a more stringent definition by classifying latrines without functioning water seals as unimproved, even if they had slabs. The result was the low estimate of 39 per cent sanitation coverage. In 2008, another Government body, the Department of Public Health Engineering (DPHE), gave the much higher figure of 87 per cent. This estimate was based mainly on financial data rather than on actual access, use, or quality of latrines. UNICEF and WHO subsequently initiated intensive dialogue with the Government and stakeholders on the sanitation data, leading to an understanding that the reality lies somewhere between the two figures. The ongoing MICS 2009 survey is expected to clarify this issue.

Figure 5.1 Proportion of population using an improved sanitation facility, 2006

Despite remarkable progress in sanitation, many challenges remain. Latrines are often not designed for hygienic emptying and sludge disposal. To prevent contamination of water sources, latrines must be located at
sufficient distances from them, but this has become increasingly difficult as more and more latrines are installed in densely populated areas. In addition, seasonal water scarcity reduces the suitability of the widely promoted and used pour-flush latrines. During floods there is a high risk of latrine pit contents spilling into the environment and causing serious health hazards. The availability of latrines in public areas is minimal, and the country lacks accessible sanitation facilities for people with disabilities.

The proportion of households with sanitary latrines is higher in urban areas, even in urban slums, than in rural areas, and it is highly correlated with wealth and the education of the household head. Those in the poorest wealth quintile and those living in tribal areas are the least likely to have access to hygienic sanitation facilities.

Natural disasters compound Bangladesh’s water and sanitation problems. Extreme weather events affect the quality and quantity of water supply and sanitation facilities and consequently children’s health and nutrition. In 2007, for example, Cyclone Sidr flooded many water points with saline water and contaminated surface water sources, placing the affected people at risk of disease. An estimated 400,000 children under the age of five were among those affected. Bangladesh has always been disaster-prone, and natural disasters—including floods, cyclones, storm surges, and droughts—could become more frequent and intense as a consequence of global climate change. Indeed, Bangladesh’s location, low elevation, poverty, high population density, poor infrastructure, and high dependence on natural resources make it one of the most vulnerable countries in the world to climate change. The Government has built substantial disaster management capacity, but emergencies continue to pose a serious obstacle to children’s rights and to programming efforts to address them.

A child washes her hands with soap using a hand-washing device in her school.
Urbanization, growing slum populations, and poor provision of water and sanitation in the slums and public areas of cities and towns increase the vulnerability of many of the poor. The share of the population living in urban areas is currently about one-quarter and is projected to rise to one-third by 2020 and to one-half by 2035—while the country’s total population grows from about 148 million (in 2009) to nearly 200 million, according to Government projections. Due to this rapid urbanization with growth mainly in the urban slums, urban water and sanitation coverage in Bangladesh is showing a negative trend.

Only about one-third of the hundreds of pourashavas (secondary towns) in Bangladesh have piped water networks, and they usually cover only a small part of the population. Where piped water is available, it is often contaminated due to intermittent supply and leakages in the water mains. Most “improved” water sources in the towns are tube wells. The tube wells lower local groundwater tables and can expose families to arsenic and bacteriological or other contamination in crowded areas where sufficient spacing from pollution sources (such as latrines, drains, and industrial waste disposal sites) cannot be maintained. The lack of sewerage systems, limited coverage of household septic tanks, and the absence of solid waste management also create unhygienic living conditions for the urban poor. Hygiene awareness and knowledge of the links between poor hygiene and disease are lowest among slum dwellers, most of whom have low levels of education. Moreover, inadequate recognition of the rights of slum dwellers and the poor to safe water and sanitation leave many people unreached. The urban poor without security of tenure have little incentive to invest privately in water and sanitation improvements and face high costs if they choose to arrange private service provision.

V.B. CAUSALITY ANALYSIS

The key factors influencing the realization of the right to safe water, sanitation, and hygiene in Bangladesh include the following: (a) water, sanitation, and hygiene practices, (b) water quality threats and mitigation measures, (c) expansion of access to sanitation facilities, (d) disaster management, and (e) coordination among partners in the water and sanitation sector. (Basic factors, which are largely common across all children’s rights, are discussed in Chapter I above.)

V.B.1 Water, Sanitation, and Hygiene Practices

The practices of hand washing, latrine use, water use, and menstrual hygiene are essential for preventing disease and other problems related to water and sanitation. Hand washing practices directly affect the risks of contracting gastro-intestinal diseases. Nearly three-quarters of the household heads surveyed for MICS 2006 reported hand washing with water and soap or ash after defecation. Good hand-washing practices were more common in urban areas, even in the urban slums, than in rural areas. The survey also found a strong positive correlation between hand washing and both the educational level of the household head and the socioeconomic status of the household. Reported and actual behavior, however, may differ markedly. This is evident in the findings of a UNICEF/ICDDR,B survey undertaken in the rural areas of 22 districts in 2007, as
shown in Table 5.1. This survey also shows that the very poor are less likely to have effective hand-washing practices.

**Table 5.1 Hand-washing practices, reported and observed, selected rural areas, 2007**

<table>
<thead>
<tr>
<th></th>
<th>% practicing hand washing with both hands and soap before preparing food</th>
<th>% practicing hand washing with both hands and soap before eating</th>
<th>% care takers of children who are still being fed who practice hand washing with both hands and soap or ash after defecation</th>
<th>% care takers of children who are not yet using latrine who practice hand washing with both hands and soap or ash after cleaning child’s bottom</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>Reported 27</td>
<td>14</td>
<td>56</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Observed 1</td>
<td>0</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Hardcore poor</td>
<td>Reported 21</td>
<td>9</td>
<td>45</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Observed 1</td>
<td>0</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

*Source: UNICEF/ICDDR,B, SHEWA-B Health Impact Study 2007*

Even when latrines are available, they are often not used, or not used consistently by all household members. When they are shared among multiple households, using them is generally inconvenient at times of the day, such as early morning, when many people would like to use them. Some latrine designs are ill-suited for children and the elderly, and they are almost never suitable for people with disabilities. If arrangements are not made to ensure that latrines are regularly cleaned and maintained, they often become unusable. Routine flooding and droughts also make many of them unusable for significant parts of the year. The security and privacy that latrines provide make them appealing for women and children, but the health benefits are less well understood, with the result that in some cases only (or mainly) women and children use them.

Some households continue to use contaminated water sources because alternative sources are not available at reasonable distances from their homes. In some cases, however, households use safe water sources but do not maintain proper water handling and storage practices. This can lead to contamination of drinking water between the time it is collected and the time it is consumed.

Menstrual hygiene is important for the reproductive health of women and girls and for school attendance and retention among girls. In addition to the health- and education-related benefits, when sanitation facilities are appropriately hygienic and private, they provide women and girls with greater convenience and dignity. Limited access to appropriate facilities—combined with a prevailing culture of shame and embarrassment surrounding menstruation—can lead to poor menstrual hygiene and, in turn, to illness and infection. Latrines meeting requirements for menstrual hygiene are rarely available in secondary schools. A UNICEF study in 2007 found that one-third of the adolescent girls in the rural areas of 22 districts were not practicing proper menstrual hygiene.

*“The Committee recommends that the State party ... provide separate and appropriate sanitary facilities for adolescent girls and boys.” (Committee on the Rights of the Child, 2009)*

Children’s Right to Water, Sanitation, and Hygiene
V.B.2 Water Quality Threats and Mitigation Measures

The main threats to water quality in Bangladesh arise from arsenic contamination, bacteriological contamination, iron content, and saline intrusion. In many areas of the country, arsenic enters water supplies from natural deposits in the ground. As a contaminant, arsenic is particularly insidious because it is odorless and tasteless, and its health impacts are severe but not immediate. Regular consumption of arsenic-contaminated water can damage children’s cognitive development and cause cancer, heart disease, and skin problems (mostly in adults after long periods of exposure). The impacts on children are sometimes not manifested until they become adults—sustained, early consumption of arsenic elevates their risks of early-adult cancers. Malnourished people are twice as likely to develop arsenicosis as well-nourished people. People suffering from arsenicosis can recover more rapidly from skin lesions when they eat nutritious food or take multi-vitamin supplements. Social stigma makes it harder, in some cases impossible, for single women suffering from arsenic poisoning to marry. Once married, women face the risk of divorce if they develop arsenicosis skin lesions. Unmarried women are more vulnerable to poverty and social exclusion. Women are also less likely to receive early diagnosis or treatment.

About 20 per cent of the shallow tube wells in Bangladesh are contaminated with arsenic, and the problem is widespread throughout the country. Arsenic has been detected in 61 of the country’s 64 districts. Some districts are more heavily affected than others. Arsenic contamination is not limited to rural areas, but it is more common there. In urban areas, tube wells are often deep enough to avoid arsenic contamination. Also, some urban areas have piped water supplies with iron-removal processes that reduce the arsenic content of the water.

At least 20 million people in Bangladesh are at risk from arsenic levels exceeding the national standard in their nearby water sources. The number of arsenic-related deaths is not known, but more than 1 million people are estimated to be at risk of death from exposure to arsenic for 20 years or longer. Over the past decade, the number of people showing the effects of drinking arsenic-contaminated water has increased, and about 15,000 people have been diagnosed with arsenicosis. The incidence of cancer has been rising, though isolating arsenic as the cause of cancer is difficult.

The Government and partners tested about half of approximately 10 million tube wells between 2000 and 2005, targeting areas most likely to have arsenic contamination. The water from about 20 per cent of the tested wells was found to exceed the national standard for arsenic concentration (50 parts per billion). The arsenic-contaminated tube wells were painted red while those that were found safe were painted green. A wide communication campaign informed the population about the significance of the markings. Most tube wells installed after the testing campaign remain untested. Projects that support tube well installation generally test for arsenic, but the Government’s testing programme has stopped. The arsenic content of groundwater changes over time, so periodic monitoring of water quality, particularly of water from tube wells found to have moderate arsenic contamination, is important.

UNICEF and other development partners are supporting the installation of arsenic-free water points and helping the Government to raise awareness.
about the dangers of arsenic in groundwater and about measures to avoid arsenic. The Government’s programme of testing and marking tube wells, combined with awareness raising campaigns, had the most significant impact on human exposure to arsenic of any measures taken so far. Four-fifths of the population is now aware that arsenic can be a problem in water from tube wells, and about 70 per cent of households who have heard of arsenic report that they are taking some action to avoid arsenic, most commonly by collecting water from a tube well known to be safe. The likelihood of switching to a safe well depends largely upon the availability of safe wells within walking distance. Another intervention with a large impact on human exposure is the installation of deep wells by the Government and NGOs. Deep wells are usually shared among households, so their location is critical to ensure that women, whose mobility is often constrained for social and cultural reasons, have access to them. The greatest challenges are in the highly affected areas where deep tube wells are not viable.

Source: NAMIC
The Government has provisionally approved four commercial arsenic removal filters for use in Bangladesh (one for communal use, three for household use). UNICEF has supported the distribution of these filters to communities through a participatory process and is monitoring their technical performance and social acceptability.

In some parts of the country, high iron content in tube well water motivates households to use unprotected surface water sources instead. Bacteriological contamination is a problem in areas where safe distances from latrines and other pollution sources are not maintained. Saline intrusion into drinking water sources is an increasing problem in the coastal belt. Addressing these issues will require continuing development of technologies that are suited to local preferences and the different geohydrological environments of Bangladesh.

Since Bangladesh does not have a reliable nationwide water quality surveillance programme or database, information on progress in arsenic mitigation and other measures to improve water quality is not yet available. During the testing of tube wells for arsenic, the Government had a National Arsenic Mitigation Information Center that maintained a database on the test results. The information center was externally funded and is no longer operational, but the database exists, and UNICEF is supporting the Government in resuming its use. The ongoing 2009 MICS survey has a household water-quality-testing component that will shed some light on this issue.

A woman and child wash hands with soap and water from community tube well in a village of Gaibandha district.

V.B.3 Expansion of Access to Sanitation Facilities

In 2005 the Government adopted a National Sanitation Strategy that set forth the target of 100 per cent access to improved sanitation by 2010. The Government recently extended the target date to 2013. In connection with the National Sanitation Strategy, the Government earmarked 20 per cent of the allocations to upazilas from the Annual Development Programme.
(ADP) for sanitation. These funds are intended to enable the locally elected bodies to provide free materials for the substructure of latrines (75 per cent of the funds) and hygiene education (25 per cent of the funds) to the hardcore poor. The Strategy was pursued vigorously for the first two years, leading to substantial improvements in sanitation coverage in Bangladesh, though progress slowed during 2007-2008. In a UNICEF-supported study of the sanitation programme’s performance during 2004-2006, almost four-fifths of the latrine recipients reported that the ADP latrines had significant impacts on their environments by reducing foul smells and ensuring cleanliness surrounding their residences. About 30 per cent said that the latrines enhanced the security of women and children in their communities, and one-fifth said use of the latrines had raised their social status.

Despite its successes, the programme is not without its limitations. The UNICEF-supported study found substantial weaknesses in its implementation, particularly in regard to monitoring and supervision. Many of the intended beneficiaries did not actually receive the latrine materials, and some of the households that received them were non-poor. Some of the upazilas were allocated more—and some less—than the 20 per cent of the ADP intended for the sanitation programme. Very few upazilas strictly followed the utilization ratio for hardware and software activities. Nearly two-thirds of the study population was unaware of the Government’s programme of distributing latrine materials to the hardcore poor. Sustainability of the initiative will require stronger support for hygiene promotion. WaterAid also conducted a study of the ADP allocations for sanitation in 2006-2008 and identified similar implementation weaknesses. During preparation for this Situation Analysis, consultations at the local level indicated that these problems are continuing.

Another problem is over-reporting of sanitation coverage. Upazilas that achieved 100 per cent coverage were entitled to additional budgetary support. This created an incentive for over-reporting. Our consultations at the local level indicated that some of the upazilas that are recognized as having 100 per cent sanitation actually have less coverage during the rainy season, and many of the existing latrines are unhygienic.

The National Sanitation Strategy addresses sanitation at the household level only. Enabling full sanitation for the whole population—at all times—will require the introduction of sustainable sanitation facilities and mechanisms in schools, markets, transportation terminals, and other public places. Some projects have undertaken water and sanitation initiatives in public areas. These have shown that sustainability is possible with private enterprises charging user fees and providing maintenance, repair, and cleaning services.

V.B.4 Disaster Management in the Water and Sanitation Sector

As described above, natural disasters cause continual setbacks to Bangladesh’s progress in water, sanitation, and hygiene, and climate change is expected to increase the frequency and severity of weather events in the years to come. The Government has developed substantial capacity in disaster management and risk reduction, which mitigates the impact of disasters when they occur. For example, a highly effective early warning system is in place for cyclones, whereby trained volunteers in
vulnerable districts disseminate warnings throughout their communities, enabling rapid evacuation to cyclone shelters. The early warning system for flooding is less effective because of the difficulty of forecasting inundation. Preparedness for an earthquake is also inadequate, especially in the densely populated and rapidly expanding urban areas. Most water and sanitation projects fail to adequately address the need for enhanced community-level capacity for disaster preparedness and response.

The Water, Sanitation and Hygiene (WASH) cluster for emergency response was activated after Cyclone Sidr in 2007 and has helped to improve overall coordination of response activities in the sector. With the Government in the lead and UNICEF as the lead international agency, the WASH partners have developed emergency standard operating procedures, assessment and monitoring tools, and technical guidelines, which have been submitted for Government approval. A union-level analysis of emergency WASH vulnerability was carried out to enable locally specific preparedness and response interventions, and contingency planning is underway. Further efforts will be needed to ensure that the WASH functions are fully integrated into Government systems and procedures.

V.B.5 Coordination among Partners in the Water and Sanitation Sector

With support from Danida, the Government prepared a Sector Development Programme (SDP), which was adopted in 2006. The SDP outlines a vision for the water and sanitation sector in Bangladesh. It assembles all the relevant national and international policies, strategies, and targets and sets forth a 10-year framework for development and cooperation in the sector. It identifies gaps in the sector and estimates financial costs of improvements. The degree of consensus reached among the key partners involved in the sector, however, was insufficient for the SDP’s effective implementation. It also does not address climate change, contain an emergency preparedness or response strategy, or adequately recognize the special water and sanitation conditions of the Chittagong Hill Tracts. Consequently, it has failed to induce many of the actions needed to revitalize the sector. Instead, attention has focused on the challenges to operationalizing the programme and the need for its revision.

A Policy Support Unit (PSU) within the MoLGRD&C is the anchor for SDP revision. The role of the PSU is to support the Government in the development, review, implementation, and monitoring of sector policies and to assist with donor harmonization and the development of a sector-wide approach. The PSU officially opened in early 2007, but frequent transfers and other bureaucratic obstacles have hindered its progress. Weak institutional capacity and the absence of collaboration within an overall framework have led development partners to rely on separate project implementation units and ad hoc capacity development projects. These have considerable transaction costs and cannot address systemic issues such as civil service reform and decentralization. Nonetheless, within the Local Consultative Group (LCG), development partners have begun to coordinate their activities and to prepare joint responses to the Government rather than pursuing entirely separate agendas. The LCG’s sub-group on water supply and sanitation provides an active forum for coordination.

In recent months, the Government has shown a renewed interest and

"The Committee recommends that the State party … better equip schools with … adequate sanitation facilities for girls and boys. “
(Committee on the Rights of the Child, 2009)
momentum for progress in developing the water and sanitation sector. A full-time Project Director was assigned to the PSU in early 2009, and Government representation in the Sub-group and leadership in other related forums have increased. More rapid progress toward aid harmonization is possible if the Government takes an increasingly active lead in organizing the process.

Globally, UNICEF has been designated as the lead international agency to cooperate with the Government in the Water, Sanitation and Hygiene (WASH) cluster for emergency response. As described above, the WASH cluster substantially improved emergency coordination among national and international agencies in the aftermath of Cyclone Sidr in 2007. The Government has decided to continue monitoring and flood preparedness through the cluster’s Strategic Advisory Group, which will re-activate the cluster during the early warning phase of any future disaster. The WASH cluster is expected to enable a coherent response among all key humanitarian actors when future emergencies occur.

V.C. ROLE AND CAPACITY ANALYSIS

V.C.1 Families

Families are the duty-bearers with the most immediate impact on children’s right to safe water, sanitation, and hygiene. They have the duty to maintain proper hygiene practices and to teach them to their children. They also have the duty to participate in community efforts to mobilize improvements in water supply and sanitation. Adequate skills and supportive attitudes regarding proper hygiene practices, however, are often lacking. Age-old habits and beliefs are hard to change. In addition, poor access to safe water and sanitation facilities constrain the ability of many families to maintain good hygiene practices. Many families are unaware of the role they can play in supporting community sanitation initiatives, and many are not sufficiently
empowered within their communities to play such a role. In addition, participation in community initiatives may seem like a distant priority for poor families that must concentrate their energies on daily survival.

V.C.2 Schools

Schools have a vital role to play in fulfilling children’s right to safe water, sanitation, and hygiene. When schools provide water and sanitation facilities that are functional, clean, and safe, they contribute to the health of students and teachers—and therefore to students’ enrollment, attendance, retention, and learning achievement. Facilities suitable for menstrual hygiene—including separate facilities for males and females and adequate privacy—are needed in both primary and secondary schools. Schools can instill good hygiene practices in children, which will benefit them throughout their lives. Schools also serve as models for hygiene behavior, which can be replicated throughout communities. By assigning cleaning duties to boys and girls alike, schools can promote both hygienic conditions and gender equality. Moreover, schools can encourage children’s participation in many ways. They can engage children in selecting sites for water and sanitation facilities, in social movements for better water and sanitation services, in initiatives to raise awareness about hygiene, and in measures for climate change adaptation.

Unfortunately, many schools are constrained in fulfilling these roles because their resources are limited and teachers and administrators are insufficiently motivated to prioritize water, sanitation, and hygiene in their work. The Second Primary Education Development Programme (PEDP-II) has introduced Primary School Quality Level Indicators that include the provision of water and sanitation facilities in schools, but the school infrastructure development plans do not specify the quality of facilities, the convenience of their location, or the ratios between the number of students and the capacities of the facilities. Resources have not been allocated for the maintenance of water and sanitation facilities in schools.

UNICEF’s external monitoring agency reported in 2007 that only 13 per cent of primary schools and 43 per cent of secondary schools in the rural areas of 22 districts had separate latrines for girls and boys. Less than half of them met all the criteria of being open, functional, clean, maintained, and used. Only 7 per cent of the latrines for girls in secondary schools met requirements for menstrual hygiene. The 2009 Annual Sector Performance Report for PEDP-II found that when primary schools have latrines at all, 150 students, on average, share a single toilet. The rolling out of School Level Improvement Plans and the new Better Health, Better Education component of PEDP-II present opportunities to incorporate school sanitation and hygiene education initiatives. Encouragingly, during consultations in preparation for this Situation Analysis, children and adolescents said that they had learned about proper hand washing and menstrual hygiene from their teachers.

V.C.3 Communities

Communities have the duty to build coherent, organized, and well-informed demand for the installation and maintenance of adequate water and sanitation facilities. They also have a vital role to play in planning and monitoring water and sanitation initiatives—especially in ensuring
that women and children have adequate, safe, and convenient facilities. Children have a right to participate in these community functions and need encouragement from communities to raise their voices. In some communities, Water and Sanitation Committees provide a forum for local leaders to mobilize communities and act as agents for change, but in most cases they have remained weak. Often communities do not recognize the benefits of community-owned water and sanitation initiatives and/or lack the organizational capacity to motivate effective demand. Social and cultural perceptions of the roles of children obstruct their participation. In addition, local government bodies are often not well attuned to providing the level and type of support and responsiveness to communities that is required of them.

V.C.4 Local Government Institutions

The districts, upazilas, union parishads, city corporations, and municipalities have duties to ensure that local populations receive adequate water and sanitation services. They are responsible for establishing Water and Sanitation (WatSan) Committees and ensuring that the committees coordinate service provision and actively promote hygiene and environmental sanitation. The LGIs have the potential to link communities with the central Government; they are in the best position to serve communities while informing policy makers about community realities. Locally elected officials are responsible for ensuring the accountability of water and sanitation service providers.

At present, however, LGIs tend to play a passive role, and the WatSan Committees function poorly if at all. As is the case in other sectors, the Government retains a highly centralized, supply-driven approach to service delivery in the water and sanitation sector. This limits the authority of local officials and elected representatives to fulfill their responsibilities. LGIs lack the flexibility they need for the allocation of staff and other resources. The culture of top-down administration drains authority and initiative away from the locally elected bodies, which are most in touch with community needs and perspectives. Technology is usually centrally planned, specified, and allocated, often using a “one size fits all” approach. This approach tends to preclude the development of low-cost, alternative technologies to mitigate the effects of climate change and to suit the different geo-hydrological environments in Bangladesh, especially the coastal belt, where the water table is low, and the hilly, stony districts of the Chittagong Hill Tracts.

In addition, LGIs have severely limited human and financial resources. Their institutional and management capacities for planning and monitoring are generally weak. Ill-defined roles and lack of both vertical and horizontal coordination create confusion and obscure accountability. This further constrains local government institutions from providing communities with adequate services and from supporting community-based planning and monitoring. Lasting impacts on children’s lives will require more effective efforts to encourage behavioral and social change in families and communities. Public sector staffing and capacity at the local level is insufficient to implement the advocacy and community mobilization needed to bring about such change.

In recent years, however, small local governance projects have demonstrated that locally elected bodies have the potential for fiscal
responsibility, effective service delivery, and collaboration with communities in planning, implementation, and monitoring when a sound performance-monitoring framework is in place. The Government is now moving toward replicating and institutionalizing these lessons on a countrywide basis. The World Bank and other donors are supporting a project that will finance development activities at the union level in phases throughout the country. If water and sanitation initiatives are given high local priority, this mechanism will provide resources for implementing them.

The Sector Development Programme envisions a process of decentralization, whereby the local government institutions play a critical role in service delivery while the central Government serves as facilitator rather than service provider. Concrete measures to bring about decentralization—such as new institutional arrangements, funding mechanisms, and formal allocations of responsibility—have yet to be announced. Development partners have taken different approaches to water and sanitation initiatives in an environment where local government institutions remain largely ineffective. The challenge is to balance capacity building of local government institutions (which have the advantage of permanence and sustainability) with the use of NGOs (which often have more managerial and organizational capacity) while ensuring that communities are mobilized and community demand is realized.

V.C.5 Civil Society and the Private Sector

Civil society’s role in the water and sanitation sector includes advocacy for policy development, supporting technological innovation, strengthening service delivery, and helping communities to hold local government bodies and service providers accountable. Civil society organizations have successfully raised awareness of water, sanitation, and hygiene issues and motivated policy development. The social movement leading to the National Sanitation Strategy, for example, was driven by civil society. Under existing programmes and projects in the water and sanitation sector, NGOs lead most of the components to raise awareness and promote positive behavior change; whereas the Government and the private sector can provide hardware, the NGO sector is best suited and most productive in providing “software” services. Civil society is also important for motivating climate change adaptation and building the capacity of communities for emergency preparedness and response. Civil society organizations have the duty to ensure that their activities are effective and sustainable and that they complement and strengthen national systems, including the roles of locally elected bodies. Many of them are constrained in their human and financial resource capacities.

The private sector has played the leading role in the provision of water and sanitation facilities throughout the country. Private enterprises have installed roughly 80 per cent of the hand-pump tube wells in the country and have responded well to the demand for spare parts and repair services. In terms of sanitary ware, the private sector leads the provision of rings and slabs and has the potential to expand into related items and services.

V.C.6 Government of Bangladesh

As mentioned in the previous chapters, the Government of Bangladesh holds the ultimate responsibility for ensuring the rights of all Bangladeshi
citizens. In the water and sanitation sector, reaching the poor is particularly challenging, especially the urban poor and the poor in tribal areas. The central government bodies responsible for water and sanitation are the MOLGRD&C (for overall systems) and the Ministry of Primary and Mass Education (MoPME) and the Ministry of Education (MoE) (for facilities in schools). These ministries have duties to provide clear and rational definitions of the roles of all actors in the sector and to ensure coordination among them. Ideally, they should serve as facilitators and technical assistance providers to the locally elected bodies, rather than as direct service providers. Accordingly, they have a duty to delegate sufficient authority to local officials for them to function optimally. The specific roles and capacities of the Government in ensuring water quality, sanitation, disaster management, and sector coordination are described in the causality analysis above. The main constraints that the Government faces in fulfilling its duties include limited human and financial resources, institutional weaknesses, and gaps in implementation capacity, especially in regard to community mobilization and promotion of children’s and women’s rights. Complaints of political influence and corruption are common, and vacant posts and transfers of key personnel without sufficient mechanisms for institutional memory compromise effectiveness.

The Government has a number of policies in place to ensure the realization of the right to water and sanitation. Internationally, Bangladesh is committed to ensuring environmental sustainability (MDG 7) with the target of halving by 2015 the proportion of people without sustainable access to safe drinking water and sanitation. Nationally, Bangladesh has established more stringent targets for water and sanitation than those for the MDGs. For sanitation, the national target is 100 per cent access to improved sanitation for all of the population—rural and urban—by 2013. For water, the national target is safe water for all by 2011.

In regard to climate change, the Government adopted a National Adaptation Programme of Action in 2005 and the Bangladesh Climate Change Strategy and Action Plan in 2008. The Climate Change Strategy is a ten-year programme prioritizing adaptation and disaster risk reduction. It addresses food security, social protection, health, disaster management, infrastructure development, research and knowledge management, capacity building, and institutional strengthening—with many references to reaching vulnerable people, including women and children. A high-level National Environment Committee will provide overall guidance for implementation of the Climate Change Action Plan, and the Ministry of Environment and Forests will coordinate implementation.

The Government has not yet adopted a comprehensive urban sector policy, though proposals have been developed. This leaves water and sanitation service provision in the rapidly growing cities and towns without appropriate planning or monitoring. In addition, the rights of the urban poor, especially slum dwellers, to water and sanitation services are constantly challenged by problems with security of tenure, which could be addressed in a national urban policy or in the revision to the Sector Development Programme (or both).

The Government developed an Arsenic Mitigation Policy and Implementation Plan in 2004, but full consensus among the actors in the sector was not achieved, and implementation has been weak. The Implementation Plan is currently under revision.
V.C.7 International Development Partners

International development partners are responsible for ensuring that the programmes and projects they support have local leadership and ownership, are well coordinated with other initiatives, and are effective and sustainable. They are also responsible for encouraging child participation. In many cases, the interventions they support are not well harmonized with each other or with Government programmes, and often children are not consulted in meaningful ways. The efforts to improve coordination in the sector among national and international partners through the Sector Development Programme and the WASH cluster for emergency response are described above.

Development partners are constrained by their own institutional procedures and by the Government's limited motivation and capacity to organize and lead a genuine sector-wide programme. In the absence of a comprehensive programme for the water and sanitation sector, interventions need to be carefully targeted and designed for mainstreaming into the practices and procedures of local and national government institutions.

The main international partners involved in the water and sanitation sector in Bangladesh are the following:

- Asian Development Bank
- AusAID
- Canadian International Development Agency
- Danida
- Japan International Cooperation Agency
- Netherlands
- U.K. Department for International Development
- World Bank
- World Health Organization.

V.D. RECOMMENDATIONS

The causality and role analyses suggest the following avenues would be productive areas for investment in promoting children’s right to safe water, sanitation, and hygiene in Bangladesh. They involve policy advocacy, capacity building, research and development, and communication for development. In all initiatives, attention should be drawn to the perspectives, circumstances, and rights of children and women.

Reaching the poor and underserved. Surveys have consistently shown that the poor and those with low levels of education are the most severely deprived of their right to safe water, sanitation, and hygiene. Residents of urban slums and tribal areas are also highly vulnerable in this respect. Promotion of access to safe water, sanitation, and hygiene services among the poor and underserved should continue. This can take many forms. UNICEF and other organizations involved with child rights could contribute to the development of an overall urban policy that provides for the rights of the urban poor, including slum dwellers. Qualitative and quantitative research will be needed to identify the constraints to providing water, sanitation, and hygiene services to underserved groups and opportunities to overcome them. This will be particularly important for developing
strategies that target the urban poor, for whom violations of the right to water, sanitation, and hygiene are closely linked with violations of the right to housing and security of tenure. Promotion of more effective utilization of the Government’s sanitation subsidy for the hardcore poor is clearly needed. Technical support could be provided to local governments for needs assessments and the design of innovative approaches for reaching the poor and underserved. Support may be needed in negotiations with local governments and service providers for the provision of services to poor communities. Raising awareness, promoting positive behavior change, and supporting community-level disaster preparedness among poor and underserved communities will also continue to be important.

Improving water, sanitation, and hygiene conditions at schools. The health of students and teachers depends on schools having safe, convenient sources of water in sufficient quantity and safe, clean, and functional toilets that provide adequate privacy. The availability and quality of water and sanitation facilities also influence school enrollment, attendance, retention, and achievement. In addition, schools provide opportunities for the development of student leaders who can promote proper hygiene behavior throughout their communities. Organizations involved in child rights could build upon UNICEF’s substantial experience in school sanitation and hygiene education by scaling up school-level interventions, promoting their replication, helping to build the capacity of School Management Committees to ensure adequate water and sanitation provisioning, promoting the participation of children in school water and sanitation decisions, and advocating for the inclusion of water, sanitation, and hygiene in the planning and budgeting for school infrastructure and maintenance.

Increasing the focus on quality and sustainable sanitation. Bangladesh has made enormous progress in the expansion of sanitation coverage among households in recent decades, and particularly during the past few years. Nonetheless, many people still lack access to sanitation, and the quality and sustainability of sanitation facilities require much greater attention. Many toilets are unsanitary, easily damaged by flooding, or dependent on
pour-flush systems that are not viable during the dry season. Many are insufficiently spaced from water sources, are shared by too many people to ensure availability for everyone, and lack systems for hygienic emptying and sludge disposal once they reach capacity. They are almost never designed to ensure that the elderly and people with disabilities will find them accessible and convenient for use. In addition, systems are often not in place to ensure that the toilets are maintained, repaired, and kept clean, which leads to their disuse. UNICEF and other organizations can support technological innovations to address these issues, advocate for policies that take them into account, and promote the introduction of appropriate systems for maintenance and cleaning of sanitation facilities in consultation with households and communities at the time of installation.

Technological innovations that treat human waste as a resource—for fertilizer, compost, and biofuel—may be especially promising. They would require substantial social mobilization to build acceptance, and scaling them up would require strong collaboration across sectors (agriculture, health, environment, local governance).

**Expanding sanitation in public areas.** Public policy has focused mainly on household sanitation and has largely neglected the need for sanitation facilities in markets, transportation terminals, and other public places. This is especially problematic in heavily congested urban areas, affecting the health of the public in general and leaving street dwellers with a complete lack of access to sanitation. UNICEF and other organizations could support the scaling up of sustainable mechanisms involving the private sector in the installation, maintenance, and cleaning of hygienic sanitation facilities in public areas. They could also advocate for policy development, especially urban policy development, to address these issues.

**Recognizing and promoting the roles of the private sector, civil society, and local government.** The private sector plays a central role in the provision of water and sanitation facilities and services in Bangladesh. UNICEF and other organizations can advocate for water, sanitation, and hygiene policies that recognize this role and enable the private sector to flourish wherever it can most effectively serve the population. They can also support private sector development and livelihood opportunities in the water and sanitation sector. This could include, for example, the installation, maintenance, and repair of toilets and safe water points for households and public areas, the development and marketing of alternative technologies suitable for local conditions, the production and marketing of sanitary ware (including items for hand washing), and the provision of hygienic pit emptying and sludge disposal services. Expanded private sector involvement could improve sustainability and enable the Government to allocate public resources more selectively where they are most needed, such as serving the extreme poor and the installation of deep tube wells and other interventions that are too costly for most households.

Civil society has a critical role in mobilizing community demand for water and sanitation services, promoting positive behavior change, ensuring accountability of the local government and service providers, and promoting policy development. UNICEF and other organizations could explore opportunities to strengthen the sustainability and impact of civil society organizations in the water and sanitation sector, including their capacity for independent monitoring and evaluation of progress in the sector.
Alongside continuing advocacy at the policy level for decentralization, UNICEF and other organizations could contribute to improvements in the delivery of water and sanitation services by supporting the development of local government capacity for decentralized planning and implementation of water and sanitation interventions.

**Raising children’s voices.** Age-appropriate participation of children should be encouraged in policy advocacy and in all aspects of programme and project planning, implementation, and monitoring and evaluation. Children could participate, for example, in the WatSan Committees at all levels, in communication campaigns, and in outreach from schools. Children should be consulted—and their views taken into account—before any activities related to their right to water, sanitation, and hygiene are undertaken.

**Sector coordination.** International development partners should continue supporting the Government’s progress toward a comprehensive, well-coordinated programme for the water and sanitation sector. UNICEF has a critical role in the coordination of disaster preparedness, response, and risk reduction and in ensuring that children’s rights are fully respected in climate change adaptation.

**Strengthening information management.** Information management is extremely weak in the water and sanitation sector. Technical support would be useful for the establishment of systematic water quality surveillance and monitoring, the collection of more reliable data on water and sanitation conditions in the urban slums, and the creation of a comprehensive national database on drinking water and sanitation. UNICEF and other organizations could also help to build national capacity to analyze the data and ensure their use in the development of policies and programmes to promote the right of all children to water, sanitation, and hygiene.

**Research and development.** New research could identify the barriers to behavior change, ways to ensure replication of successful models, and the types of intervention that have the highest returns to water and sanitation investments in terms of health and other rights. UNICEF and other organizations could also support the development of alternative technologies to address the many vexing water and sanitation issues in Bangladesh. Examples include studying locally suitable options for the following:

- Arsenic and iron removal
- Sanitation during droughts and floods
- Facilities meeting the needs of specific population groups (including people with disabilities)
- Withdrawing water from deep levels
- Recharging aquifers with rainwater
- Isolating water sources from sources of pollution
- Waste management
- Climate change adaptation.

Wherever pilot testing of innovations shows effectiveness, investments in scaling up their introduction and promoting their social acceptance will be needed.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADP</td>
<td>Annual Development Programme</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>AusAid</td>
<td>Australian Government Overseas Aid Program</td>
</tr>
<tr>
<td>BANBEIS</td>
<td>Bangladesh Bureau of Educational Information and Statistics</td>
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<tr>
<td>BBS</td>
<td>Bangladesh Bureau of Statistics</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacille Calmette-Guerin (vaccine for tuberculosis)</td>
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<tr>
<td>BDHS</td>
<td>Bangladesh Demographic and Health Survey</td>
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<tr>
<td>BEHTRUWC</td>
<td>Basic Education for Hard-to-Reach Urban Working Children</td>
</tr>
<tr>
<td>BNFE</td>
<td>Bureau of Non-Formal Education</td>
</tr>
<tr>
<td>C4D</td>
<td>Communication for development</td>
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<tr>
<td>CAMPE</td>
<td>Campaign for Popular Education</td>
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<tr>
<td>CEmOC</td>
<td>Comprehensive emergency obstetric care</td>
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<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CMNS</td>
<td>Child and Mother Nutrition Survey</td>
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<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSBA</td>
<td>Community-based skilled birth assistants</td>
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<tr>
<td>DFID</td>
<td>U.K. Department for International Development</td>
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<tr>
<td>DPE</td>
<td>Department of Primary Education</td>
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<tr>
<td>DPHE</td>
<td>Department of Public Health Engineering</td>
</tr>
<tr>
<td>DPT</td>
<td>Diphtheria, pertussis, and tetanus</td>
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<tr>
<td>DSS</td>
<td>Directorate of Social Services (of the Ministry of Social Welfare)</td>
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<tr>
<td>ECD</td>
<td>Early childhood development</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
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<tr>
<td>FIDH</td>
<td>International Federation for Human Rights</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<tr>
<td>GDP</td>
<td>Gross domestic product</td>
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<tr>
<td>GPS</td>
<td>Government primary school</td>
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<tr>
<td>HFSNA</td>
<td>Household Food Security and Nutrition Assessment</td>
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<tr>
<td>HiB</td>
<td>Haemophilus Influenzae Type B</td>
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<tr>
<td>HIES</td>
<td>Household Income and Expenditure Survey</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus / acquired immune deficiency syndrome</td>
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<tr>
<td>HNPSP</td>
<td>Health, Nutrition and Population Sector Programme</td>
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<tr>
<td>ICDDR,B</td>
<td>International Centre for Diarrhoeal Disease Research, Bangladesh</td>
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<tr>
<td>ICT</td>
<td>Information and communication technology</td>
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<tr>
<td>IDD</td>
<td>Iodine deficiency disorder</td>
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<tr>
<td>IDEAL</td>
<td>Intensive District Approach to Education for All Project</td>
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<tr>
<td>ILO</td>
<td>International Labour Organization</td>
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<tr>
<td>ILO-IPEC</td>
<td>International Labour Organization – International Programme on the Elimination of Child Labor</td>
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<tr>
<td>MCI</td>
<td>Integrated management of childhood illness</td>
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<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
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<tr>
<td>IPHN</td>
<td>Institute for Public Health Nutrition</td>
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<tr>
<td>IYCF</td>
<td>Infant and young child feeding</td>
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<tr>
<td>KUK</td>
<td>Kishore Unnayan Kendra (child development center)</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<td>---------------------------------------------</td>
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<tr>
<td>LGI</td>
<td>Local government institution</td>
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<tr>
<td>LSBE</td>
<td>Life skills based education</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicators Cluster Survey</td>
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<tr>
<td>MoE</td>
<td>Ministry of Education</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MoLRD&amp;CC</td>
<td>Ministry of Local Government, Rural Development and Cooperatives</td>
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<tr>
<td>MoPE</td>
<td>Ministry of Primary and Mass Education</td>
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<tr>
<td>MoWCA</td>
<td>Ministry of Women and Children Affairs</td>
</tr>
<tr>
<td>NAMIC</td>
<td>National Arsenic Mitigation Information Centre</td>
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<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
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<tr>
<td>NCTF</td>
<td>National Children's Task Force</td>
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<tr>
<td>NFOWD</td>
<td>National Forum of Organizations Working with the Disabled</td>
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<tr>
<td>NGO</td>
<td>Non-government organization</td>
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<tr>
<td>NNP</td>
<td>National Nutrition Project</td>
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<tr>
<td>NSAPR</td>
<td>National Strategy for Accelerated Poverty Reduction</td>
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<tr>
<td>ORS</td>
<td>Oral rehydration solution</td>
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<tr>
<td>PEDP</td>
<td>Primary Education Development Programme</td>
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<tr>
<td>PEDP-II</td>
<td>Second Primary Education Development Programme</td>
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<tr>
<td>PPTCT</td>
<td>Parent-to-child transmission of HIV/AIDS</td>
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<tr>
<td>PSU</td>
<td>Policy Support Unit (water and sanitation)</td>
</tr>
<tr>
<td>RED</td>
<td>Reach Every District (immunization strategy)</td>
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<tr>
<td>RNGPS</td>
<td>Registered non-government primary school</td>
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<tr>
<td>ROSA</td>
<td>Regional Office for South Asia (UNICEF)</td>
</tr>
<tr>
<td>ROSC</td>
<td>Reaching Out-of-School Children Project</td>
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<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
</tr>
<tr>
<td>SDP</td>
<td>Sector Development Programme (water and sanitation)</td>
</tr>
<tr>
<td>SHEWA-B</td>
<td>Sanitation, Hygiene Education and Water Supply in Bangladesh Project</td>
</tr>
<tr>
<td>Sida</td>
<td>Swedish International Development Cooperation Agency</td>
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<tr>
<td>SitAn</td>
<td>Situation Assessment and Analysis</td>
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<tr>
<td>SLIP</td>
<td>School Level Improvement Plan</td>
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<tr>
<td>SMC</td>
<td>School Management Committee</td>
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<tr>
<td>SSC</td>
<td>Secondary School Certificate</td>
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<tr>
<td>STD</td>
<td>Sexually transmitted disease</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>UPEP</td>
<td>Upazila Primary Education Plan</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WatSan</td>
<td>Water and sanitation</td>
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<tr>
<td>WFP</td>
<td>World Food Programme</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td>YPSA</td>
<td>Young Power in Social Action (NGO)</td>
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</table>

**Acronyms**
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