“Plus 5” Review of the 2002 Special Session on Children and World Fit For Children Plan of Action

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1. Introduction

This document embodies the Bangladesh review of the 2002 Special Session on Children and World Fit for Children Plan of Action. Bangladesh attended the Special Session on Children held in May 2002 with the Hon. Prime Minister of Bangladesh as the head of the delegation. Bangladesh, an early signatory to the Convention on the Rights of the Child (CRC), also made its commitment in May 2002 at the United Nations Special Session on Children where world leaders met to review the progress since 1990 and endorsed the *World Fit for Children* document, which contains a declaration of objectives and a global plan of action, explicitly linked to the MDGs.

Bangladesh strongly believes that poverty alleviation starts with interventions for children and thus most of the MDGs relate to children. The Poverty Reduction Strategy Paper (PRSP) (2004-2007) and the National Plan of Action for Children (2005-2010) are commitments of the government to alleviate poverty. Both documents were prepared at the same time and gave equal emphasis on establishment of child rights. The government has continued to invest increased amount of budgetary resources for children and women for the last three decades. The presence of a strong and vibrant NGO sector has helped to strengthen girl's education, literacy, and improve health and nutrition status of the people. Despite remarkable successes, much more remain to be achieved.

The government is sincerely committed to the realization of the WFFC goals and targets and recognises that it is essential to periodically review the achievements. Five years from the adoption of the WFFC document, it is an opportunity to review the achievements, gaps and ways and means to fulfil the commitments.

The review report was prepared with the leadership of the Ministry of Women and Children Affairs (MOWCA), concerned line ministries, UNICEF and NGOs during August-December 2006. The line ministries are: Health and Family Welfare, Social Welfare, Education, Local Government, Rural Development and Cooperatives, Home Affairs, Law, Finance, Planning, Information, Youth and Sports, Labour, Cultural Affairs, Chittagong Hill Tracts Affairs and the Primary and Mass Education. The report preparation process was documented initially in a concept paper agreed between all partners.

The review report was drafted by a core committee and discussed in MOWCA and UNICEF before wider circulation for review and feedback. It was also discussed in inter-ministerial meetings. Many basic documents were consulted and data and information were collected from recent surveys and those provided by the Ministries, Bangladesh Bureau of Statistics (BBS), UNICEF and others. Successive drafts were shared with line ministries, NGO coalitions and international organizations like Save the Children Alliance and Plan International and concerned UN agency, UNICEF, for comments.

2. Major National Actions taken for Children and towards the WFFC Targets since 2002

The total population of Bangladesh is estimated to be around 140 million projected from the census count of 130 million in 2001 (BBS, 2001). The population is young, with about 12 percent under 5 years of age, 37 percent under 15 and 47 percent under 18 years. The rural population

comprises 74 percent and the urban population 26 percent of the total. The children below 18 years total about 67 million.

The government's focus of development in the new millennium has been reduction of poverty and ensuring basic social services for the poor in the spirit of the Millennium Declaration and the MDGs. Progress has been made in the area of poverty reduction over the last two decades and in the Human Development Report 2003, Bangladesh was included in the medium human development group. Bangladesh was ranked 145th out of 173 countries in the Human Development Report 2002 and 137th out of 177 countries in the Human Development Report 2006.

The PRSP considers the achievement of MDGs. The PRSP puts forward a three-year (2004-2007) plan for reduction of poverty, employment generation, improvement of nutrition, maternal health, quality of education, sanitation and safe water supply. Under the leadership of the Ministry of Women and Children Affairs (MOWCA), the third National Plan of Action (NPA) for Children (2005-2010) was formulated, keeping the goals and objectives of the Millennium Declaration, MDGs and WFFC in view. The NPA has included five thematic areas which are, Food and Nutrition, Health, Education and Empowerment of the Girl Child, Protection against Abuse, Exploitation and Violence, and Environmental Sustainability.

There has been positive development in the legal and policy environment for children such as the formulation of the 2002 National Plan of Action to Combat Sexual Abuse and Exploitation, including Trafficking as a follow-up to the Yokohama Commitment 2001. The government is presently preparing the State Party report for the Committee on the Convention on the Rights of the Child (CRC) which is due in September 2007. Bangladesh signed the Optional Protocols to the Convention on the Rights of the Child on (i) Sale of Children, Child Prostitution and Child Pornography (ii) Involvement of Children in Armed Conflict, and also reported on both of these Optional Protocols.

The UN agencies and the government jointly identified six UNDAF (2006-2010) priorities in 2005. These are: Democratic Governance and Human Rights, Health, Nutrition and Sustainable Population, Education and Pro-poor Growth, Social Protection and Disaster Risk Reduction, Gender Equity and Advancement of Women, and Prevention and Protection against HIV/AIDS. The children's issues were articulated in these priorities which would contribute to the achievement of the PRSP, MDGs, WFFC and NPA for Children.

2.1 Promoting Healthy Lives

The second Health, Nutrition and Population Sector Programme (HNPSP) which started in 2004 has a big component on Essential Services Package (ESP) for improvement of health status of the women, children and mothers. Various programmes have been included under it like EPI, eradication of polio, malaria, phylaria, T.B., arsenicosis, diarrhoea, hepatitis, tetanus, measles and dengue in addition to mother's and adolescent health. Local level planning is undertaken in all the 472 Upazilas of 64 districts as part of a decentralization programme to promote quality and management of the health services.

The critical life-saving newborn care practices among the care-givers such as thermal protection to prevent hypothermia that leads to infection/sepsis, initiation and continuation of exclusive breastfeeding, and treating neonatal illness by trained providers are very low. Only 6% newborns received thermal protection (as reported by mothers) with drying and wrapping-up by dry cloths

and not given bath for 3 days, and only 23% of newborn with ARI were reported to be taken to a qualified provider (ICMH/UNICEF, 2005). The challenge is to increase awareness on sound neonatal practices for mothers, families, and primary care providers.

In four City Corporations and 21 Pourashavas, the Support for Basic Services in Urban areas Project (SBSUAP) and in six City Corporations, ADB-funded Primary Health Care Services Project are being implemented. These projects focus entirely on the poorest section of the community.

A total of 206 Urban Development Centres (UDCs) are functioning in 4 City Corporations since 2001, each serving approximately 2,000 population. UDC is a basic service delivery unit, established close to the low income group areas, to create provisions for primary health care, basic education to children, and women's empowerment training and social awareness building.

The Department of Public Health Engineering (DPHE) with UNICEF and other development partners are working to increase sanitation coverage through a set of activities. These include awareness building, social mobilization campaign, preparation of community action plans, revitalization and formation of WATSAN committees at the Union, Upazila and District levels, credit scheme for latrine producers, mobilization of school management committees, construction of latrines in primary and secondary schools, sanitation and hygiene education in schools, and carrying out studies and evaluation.

2.2 Providing Quality Education

A National Plan of Action for Education for All (EFA) for the period 2003-2015 was prepared in line with the Dakar Framework for Action. Bangladesh made primary education, i.e., up to class V, free and compulsory by enacting the Compulsory Primary Education Act, 1990. The government is committed to the EFA goals following Dakar Framework which aims at achieving the targets by the year 2015. To provide support and assistance to the eligible female students of secondary level (grades 6-10), education was made free for girls up to the 10th grade in 1994. This benefit was extended up to the 12th grade from July 2002.

Bangladesh has achieved the goal of gender parity in primary school enrolment. With a view to improve access of children of poorer households to primary education and reduce drop out rate, food for education programme for landless families sending their children to school was introduced in 1993-94 in 460 Unions out of 4,500 Unions selected on the basis of economic and educational backwardness criteria. By 1999-2000, the programme was expanded to 17,403 schools in 1,247 Unions benefiting 2.3 million students. In the remaining 3,208 Unions, a stipend scheme was introduced in April 2000. In 2000-2001, the programme benefited 3.2 million students. In order to promote further equity and access of underprivileged children to primary education, the government introduced a new five year country-wide Primary Education Stipend Project at a cost of Tk. 33,123 million in 2003.

In order to improve school management and ensure quality of teaching, the coverage of Intensive District Approach to Education for All (IDEAL) project was expanded in 2001 from 24 districts to 38 out of the country's 64 districts. Communities were involved in planning and monitoring of activities in nearly 40,000 schools, and more than 150,000 teachers were trained in interactive teaching-learning methods. A total of 10.3 million children benefited from this project between 2001 and 2005.

Through the five-year Basic Education for Hard to Reach Urban Children (BEHTRUC) project, 346,500 urban working children were given access to basic education, out of which over 60% were girls. The project has provided a good example to address child labour issues. Building on this experience, the second phase of the project has been launched in 2005 to enroll 200,000 urban working children (of which at least 60% will be girls) which will impart literacy and numeracy competencies equivalent to primary education as well as provide life skills and livelihood skills to a selected 20,000.

Starting from a very low base, the Early Childhood Development (ECD) project initiated effective pilot interventions in all 64 districts during 2001-2005. Continued advocacy on the value of early childhood care and support generated high level of consciousness among parents and other care givers. Center based group learning activities were provided to 20,600 children in urban poor communities and to 20,587 children in three districts of the Chittagong Hill Tracts (CHT) between 2001 and 2005. A new phase of the project has started in 2006.

The Primary Education Development Programme (PEDP-II), a $1.8 billion programme was launched in 2004 to bring quality alongside quantitative achievements in primary education and extend educational opportunity to the poorest. This is a continuation of large primary education programme being implemented since 1993 of which girl's scholarship has been an important component resulting in gender parity in primary and lower secondary education. Under PEDP-II, 30,000 additional classrooms will be constructed by 2009 of which about 50% have already been constructed. To improve capacity of teachers, 54 Primary Training Institutes are imparting teacher training to the primary school teachers. About 72% of teachers have already received the training. Textbooks are distributed to all primary level students free of cost and on time.

2.3 Protecting against abuse, exploitation and violence

The government enacted a new Birth and Death Registration Act in 2004, which came into force in July 2006 together with its corresponding rules: with the adoption of a universal birth registration strategy, printed and disseminated in an administrative circular, birth registration will be free for the following two years. Task Forces are being created and trained, from national to ward level for its implementation. Two anti-trafficking projects have contributed to raising awareness and also proposed various activities to prevent trafficking of children.

Bangladesh has ratified various conventions with the aim of protecting children from abuse and exploitation. Some of the main ratifications include: The ILO Convention 182 on the Worst Forms of Child Labour in 2001, SAARC Convention on Prevention and Combating Trafficking in Women and Children for Prostitution in 2002, and SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia in 2002.

An Action Programme (AP) was taken in the year 1999, to form a National Policy on Child Labour under the ILO-IPEC. But the AP was ended in December 2002 without finalization of the policy. Later on, a Letter of Agreement (LOA) was signed between MOLE and Save the Children Fund (Sweden-Denmark) in May 2006. According to the LOA, Save the Children Fund (Sweden-Denmark) will provide financial and technical assistance for the formulation of the Child Labour Policy. It is expected that the draft Child Labour Policy would be finalized within May2007.

As a first step towards reducing child labour, several programmes have been undertaken by the Ministry of Labour and Employment to eliminate and reduce hazardous and exploitative forms of

child labour since 1995. Support was extended to the private sector and NGOs for the elimination of child labour from garments industries by creating other viable opportunities for children. An estimated 4.9 million children aged 5-14 years (BBS, 2003) are working and many of them are exposed to hazardous and risky conditions. Between 2000 and 2006, 20,000 children benefited from another ILO and Dutch funded project on child labour. During the same time period, 40,000 children who were engaged in hazardous work in industries have been rehabilitated through life and livelihood skill development project. Another project is currently being implemented to rehabilitate 30,000 children from hazardous work and provide 20,000 parents micro-credit facilities to reduce dependency on their children. The National Timebound Programme Framework (TBP), aimed at reducing child labour, especially its worst forms, was developed for 2006-2015.

The government constituted an inter-ministerial committee on children in confinement and prison at the beginning of 2002. As a result, hundreds of children were freed from custody between 2002-2006. Three separate handbooks, one each for police, magistrates and judges on children in conflict with the law have been developed and training has been delivered to relevant officials. The minimum age of criminal responsibility for children was raised from 7 to 9 years in 2004.

The Ministry of Law has done a comprehensive review of all Bangladeshi laws from a child rights perspective. Abolition of death penalty for children between 16 and 18 years, prohibitions of the practice of 'safe custody' and consistency on the definition of children in different laws will be harmonized.

The Ministry of Social Welfare through the baby homes, street children drop-in centres and institutions for the disabled, is providing basic services to the vulnerable children. The ministry has involved NGOs and social organizations in these efforts. Under the ARISE project, street children receive support like shelter, health services and education. Under these initiatives, about 129,000 children receive support.

2.4 Combating HIV/AIDS

The government has formulated a National AIDS policy in 2005 to minimize the risk of HIV/AIDS in the country. Although HIV/AIDS prevalence is low, vulnerability and risk factors are considerable. Poverty and social and economic inequality force people to adopt survival strategies such as migration, which may put them at risk.

A population-based survey among adolescents and young people of 15-24 years of age indicates that only one out of three males in urban and one out of four in rural areas have correct knowledge of HIV and AIDS (Save the Children, USA and NASP 2005).

Bangladesh took the threat of HIV epidemic seriously and initiated a national response back in 1985 when, the National AIDS Committee (NAC) was established. The National Policy on HIV and AIDS endorsed by the Cabinet in 1997 guides the national HIV response. The government is committed to address HIV in partnership with national and international organizations. The Ministry of Health and Family Welfare (MOHFW) acts as the coordinating body and the Directorate General of Health Services (DGHS) is the Implementing Agency for AIDS/STD activities through the National AIDS/STD Programme (NASP). Other ministries, NGOs and the private sector participate in the national response.

To ensure a nationally coordinated, comprehensive, timely and expanded response to HIV/AIDS, a National Strategic Plan 2004-2010 was developed through an initiative by MOHFW-NASP and UNAIDS, with consultation and strategic review by all concerned development partners. The major component of the plan are: (a) provide support and services to the most vulnerable and high risk population, (b) prevent vulnerability to HIV infection, with special focus on youth (c) promote safe practices in the health care system (d) care, support for people living with HIV and e) minimize the impact of the HIV epidemic.

Under the HIV/AIDS Prevention Project (HAPP) with the World Bank and DFID funds, UNICEF has engaged in a unique experience of procuring services of 11 NGOs to work with priority groups such as drug users and women working as sex workers; and with 70 NGOs and CBOs working with local level initiatives in the HIV/AIDS area. The government also developed the National Communication Strategy on HIV/AIDS (2004-2010).

3. Resource Trends for Children

Bangladesh has been allocating more than 20% of the total government expenditure in social sectors since 1990, which is more than 3 percent of the GDP. The government has increased its investment in education sector by allocating about one-sixth of the national budget of which the share of primary and non-formal education sub-sector is nearly half.

Table 1: Budget Allocation under Annual Development Programme (ADP)

(Taka in million)

Year	Total Development Budget	Primary and Mass Education (part of Education budget)	Education	Health
2001-2002	160,000	14,053 (8.8%)	21,710 (13.6%)	14,430 (9.0%)
2002-2003	171,000	14,466 (8.5%)	25,520 (14.9%)	15,430 (9.0%)
2003-2004	203,000	11,058 (5.5%)	27,110 (13.4%)	16,120 (7.9%)
2004-2005	220,000	15,957 (7.3%)	31,410 (14.3%)	21,560 (9.8%)
2005-2006	245,000	16,660 (6.8%)	32,970 (13.5%)	22,690 (9.3%)
2006-2007	260,000	19,920 (7.7%)	38,650 (14.9%)	20,633 (7.9%)

Source: Annual Budget for 2001-02, 2002-03, 2003-04, 2004-05, 2005-06, 2006-07; Finance Division, Ministry of Finance; (Exchange rate of 1 US$= Taka 70.0)

The above table shows that there is an overall consistency in development budget (Annual Development Programme) allocation in two major social sectors, i.e., education and health sectors.

The education and health sectors together account for about one quarter of the total development budget. The increase in allocation has been substantial in the last six-year period. It is to mention that the development budget is composed of both internal resources and foreign aid and loan. In 2006-07, for example, total internal resources have been estimated to be 56% of total development allocation while 44% is coming from external resources.

Five sectors, education, health, social welfare, sports and culture, and labour and manpower are considered under the social sector. The following table gives sector-wide breakdown of allocation for last six years.

Table 2: Allocation in Social Sectors under Annual Development Programme (ADP)

(Taka in million)

Sector	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
1. Education and Religions Affairs	21,710	25,520	27,110	31,410	32,970	38,650
2. Health and Family Welfare	14,430	15,430	16,120	21,560	22,690	20,633
3. Social Welfare, Women Affairs & Youth Development	1,730	2,270	1,690	1,800	1,880	3,765
4. Sports and Culture	790	940	1,210	1,450	1,570	1,606
5. Labour and Manpower	180	270	570	690	710	837
6. Sub-total	38,840	44,420	45,179	55,290	58,128	65,491
7. As percent of ADP expenditure	24.3	26.0	22.3	25.1	23.7	25.19
8. Total ADP allocation	160,000	171,000	203,000	220,000	245,000	260,000

Source: Annual Budget for 2001-02, 2002-03, 2003-04, 2004-05, 2005-06, 2006-07
Finance Division, Ministry of Finance; (Exchange rate of 1 US$= Taka 70.0)

4. Development and Use of Monitoring Instruments to Track WFFC/MDG Targets

The government has decided to make the General Economic Division of the Planning Commission the coordinating body for tracking progress of national targets, as defined in the PRSP and MDG. The tracking of the progress of WFFC falls on the Ministry of Women and Children Affairs which it does in cooperation with other ministries having specific role in children's activities like education, health and protection. In each area, a set of indicators have been developed and data on each of those are being collected and published in different survey reports. Most of MDG and WFFC indicator data are available now. In most surveys, qualitative improvements in methodology and survey design have been brought in.

The progress of many child-related programmes are monitored regularly by Implementation, Monitoring and Evaluation Division (IMED) under the Ministry of Planning. IMED does it in addition to project officials who has monitoring staff in field locations. Every project steering committee is monitoring overall progress of implementation on a regular basis. All projects and programmes carry out mid-term and final evaluations besides conducting other studies and surveys.

Impact level data and information are provided by specific surveys. The last Demographic and Health Survey (DHS) was carried out in Bangladesh in 2004 and recent Multiple Indicator Cluster Survey (MICS) in 2003 and 2006. The MICS conducted jointly by Bangladesh Bureau of Statistics (BBS) and UNICEF, is a mechanism for systematic collection of data on the situation of children and women. The MICS produces disaggregated data for district, urban slum/non-slum, and sex since 1995. In 2006, through the adoption of a new sampling design, MICS produced data on a wider range of indicators through surveys in about 68,000 households. New data on early childhood development, immunization, child and women health, education, cooking fuel, dwelling type and ownership, protection of adolescents, injury and accidents have been collected in 2006.

The Sample Vital Registration System (SVRS) provides regular data on child mortality and Child Nutrition Survey generated comprehensive children data every four years. These surveys are carried out by Bangladesh Bureau of Statistics.

Bangladesh carried out the largest survey in the developing world to investigate the causes of under-five mortality and morbidity in 2003. This survey, conducted in 170,000 households revealed that injuries and accidents account for 29 per cent of all deaths among children 1-4 years (ICMH & UNIVEF, 2003). Based on the findings, a new project has been undertaken to prevent injuries and accidents. Another survey conducted in 2003-2004 established that 36% of infants are born with low birth weight (BBS & UNICEF, 2003-4). The anaemia survey of 2003 showed that anaemia is a severe public health problem in children aged 6-59 months and adolescents and pregnant women in Chittagong Hill Tracts (CHT).

5. Enhancing Partnerships, Alliances for Children and Participation

Collaboration between the government, development partners including the UN agencies, the World Bank, and the Asian Development Bank (ADB) in children's front has increased in recent years. The relationship with international and national NGOs and civil society organizations is also stronger than previously. In certain committees of MOWCA, to specify just one, the Inter-Ministerial Child Rights Committee has included UNICEF, Save the Children Alliance and Bangladesh Child Rights Forum as member in 2003. This made cooperation between the government and non-government agencies closer.

Several interventions such as for the elimination of child labour is being implemented by the Government jointly with UNICEF, ILO and ADB. Apart from joint programmes, joint initiatives are already there in health, education, water supply and emergency activities. The Government is actively working with the UN Theme Group on HIV/AIDS for the last three years to produce the national strategy on HIV/AIDS. Many development partners work with the government in planning, implementation and monitoring of two sector-wide programmes in health, nutrition and population (HNPSP) and primary education (PEDP-II).

Participation of non-governmental organizations and children is encouraged and ensured through different national programme of the government such as organising child rights week, child labour day, international children day and other programmes. Children were respondents in surveys such as in Children Abuse Study and Children Opinion Poll. Children participated in the formulation of the National Child Labour Policy, National Plan of Action (NPA) against Sexual Exploitation and Abuse of Children including Trafficking, and National Plan of Action for Children (2005-2010).

Coming to actual programme implementation, one prime example of partnership is mobilization of about 600,000 volunteers including teachers, NGO workers and women on National Immunization Days (NIDs) to cover 25 million children. NGOs are also involved in non-formal education, water supply and sanitation, awareness building and health service delivery. Child Rights Week, an annual event since 1992 is being jointly celebrated by the government and NGOs. From 2001, two NGOs have been involved in a UNICEF-supported project aiming at increasing the life choices of 50,000 adolescent girls through the creation and empowerment of the girls.

6. Achievement of WFFC Plan of Action and related MDG Targets

This report reviews achievements of WFFC Plan of Action and related MDG Targets related to children and women. The MDG 1, Target 2 covers aspects of nutrition achievement. In line with MDG 2, Target 3, the achievements in primary school enrolment and completion rates will be demonstrated. Two related indicators of MDG 3, Target 4 on the achievement of gender parity in primary enrolments and attendance have been shown. Data for achievement against MDG 4 concerning child mortality and corresponding Target 5, MDG 5 (improving maternal health), Target 6, as well as MDG 6 (combat HIV/AIDS, malaria and other diseases), Target 7, are given in this report. The achievements in water and sanitation are in line with MDG 7 and corresponding Target 10 (access to safe drinking water and sanitation) and Target 11 (slum dwellers). The indicators for child protection are drawn mainly from the Millennium Declaration but also from Goal 8, Target 16.

MDG Targets Relevant to Children and Women	
Goal 1:	**Eradicate extreme poverty and hunger**
Target 2:	Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Goal 2:	**Achieve universal primary education**
Target 3:	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education
Goal 3:	**Promote gender equality and empower women**
Target 4:	Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015
Goal 4:	**Reduce child mortality**
Target 5:	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
Goal 5:	**Improve maternal health**
Target 6:	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
Goal 6:	**Combat HIV/AIDS, malaria and other diseases**
Target 7:	Have halted by 2015, and begun to reverse, the spread of HIV/AIDS
Goal 7:	**Ensure environmental sustainability**
Target 10:	Halve, by 2015, the proportion of people without sustainable access to safe drinking water
Target 11:	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers
Goal 8:	**Develop a global partnership for development**
Target 16:	Develop and implement strategies for decent and productive work for youth

6.1 Goal 1: Eradicate extreme poverty and hunger

There has been considerable progress in child nutrition in the recent years especially in control of micronutrient deficiencies. The percentage of children aged 6-59 months with stunting decreased

from 64.2% in 1992 to 48.3% in 2000 and 42.4% in 2005; underweight decreased from 68.3% in 1992 to 51.0% in 2000 and 47.8% in 2005; and wasting decreased from 16.7% in 1992 to 12.0% in 2000 and remained at 12.7% in 2005 (BBS & UNICEF, 1992, 2000, 2005).

A national survey conducted by BBS/UNICEF in 2003-4 (BBS/UNICEF 2003-04) revealed that 36% of infants are born with low birth weight (LBW <2,500g), The prevalence of LBW is very high because adolescent girls and women are frequently malnourished when they become pregnant and do not consume adequate nutritious food during pregnancy. Maternal malnutrition (body mass index <18.5 kg/m^2) in non-pregnant rural women declined from 52% in 1996/7 to 38% in 2004, but is still high (NIPORT, 2004).

Iodised salt consumption increased from only 19% in 1993 to 70% in 2000 and rose to 84% in 2006 (BBS/UNICEF, 1993, 2000, 2006). Due to salt iodization, the total goiter prevalence in children has decreased from 50% in 1993 to 6% in 2004/5 and biological iodine deficiency among children decreased from 71% in 1993 to 34% in 2004/5 (IPHN/BSCIC/ICCIDD/UNICEF, 1993 and 2004/5).

Vitamin A supplementation of children aged 12-59 months rose from 41% in 1993 to 85% in 1995, and has been sustained at more than 85% throughout the last decade. Vitamin A deficiency in preschool-aged children continues to be successfully controlled through high coverage of vitamin A supplementation twice a year, with the prevalence of night blindness sustained well below the 1% threshold that signals a public health problem. Recent anaemia surveys conducted by BBS/UNICEF and HKI showed that 49% of children aged 6-59 months, 46% of pregnant women and 28% of adolescent girls are anaemic.

Bangladesh has a strong culture of breastfeeding. Almost all children (98%) are breastfed at some time in their lives and over 80% of children are still breastfed at 20-23 month of age (NIPORT, 2004). However, many aspects of infant and young child feeding are far from optimal. The initiation of breastfeeding is often delayed, with less than one in four infants (24%) put to the breast within an hour of birth (NIPORT, 2004). While colostrum feeding has improved in the past decade (87%), the traditional practice of giving pre-lacteal feeds (48%) to the newborn has not (BBF, 2005). Only 42% of infants aged less than six months are exclusively breastfed (NIPORT, 2004) because other liquids and complementary foods are given too early. Complementary feeding can also begin too late; almost one-third (29%) of children aged 6-9 months do not receive any solid or semi-solid foods (NIPORT, 2004). Over one in five (22%) of infants aged under 6 months and 27% of infants aged 6-9 months are bottle-fed (NIPORT, 2004).

6.2 Goal 2: Achieve universal primary education

Access to primary education has increased steadily over the last two decades. Net enrolment rate of children in the primary level has increased from 82.7% percent in 2003 to 87.2 percent in 2005 (MOPME, 2005). The girls' enrolment was 90.1% and boys 84.6% as per 2005 survey. The gross enrolment rate has increased from 73 percent in 1990 to 96.6 percent in 2000, and 97.5 percent in 2005. There are 80,446 primary level institutions, 124,992 teachers in primary schools and 16.2 million students enrolled in 2005.

Completion rate for five year primary education increased from 40.7% in 1991 to 67% in 2001, and to 67% in 2005. In primary level, repetition rate is 10.5, and attendance rate stands at 77% (MOPME, 2005).

The dropout rate has gone down for primary level (grade 1-5) from 38 percent in 1995 to 33 percent in 2001, and 22 percent in 2005. Though the average drop out rate in the entire secondary level cycle (grade 6-12) is 38 percent but the rate is higher in the upper grades (grade 9-10).

Pupil to teachers ratio was 63:1 in the primary level in 2002 which came down to 54:1 in 2005 (MOPME, 2005). The ratio of female/male teachers is also increasing due to implementation of teachers recruitment policy of appointing 60% female teachers in government primary schools. The percentage of female teachers was 21.09 in 1991, which went up to 39.47 in 2001 and 44% in 2005. At the secondary level the ratio of student to teacher is around 40:1 (BANBEIS 2002). The literacy rate for 7 years and above stands at 53% (SVRS 2003).

The concept of early childhood development (ECD) is new and thus there are deficiencies in the knowledge and practices of early childhood care and development for under-5 children, particularly for psycho-social development of the child. The practice of physical punishment as a means of upbringing children is common as the MICS 2003 shows that 40 percent of parents of children under five used physical punishment when children did something wrong (BBS/UNICEF, 2003). However, one positive feature is that about 47% of household members are engaged in activities that promote learning and school readiness for children upto five years of age (BBS/UNICEF 2006).

6.3 Goal 3: Promote gender equality and empower women

Gender gap in primary enrolment has reversed to a ratio of 49:51 between boys and girls. The girl's enrolment was 84.3% and boys 81.1% in 2003. The enrollment rate has improved due to increase in government's budgetary allocation for education, making primary education free, massive scholarship programme in primary level and girl's stipend programme up to the twelfth grade. Girls were found to have a slightly higher attendance rate compared to the boys: 59.7% for girls against 57.1% for boys. However, still geographic variation in net enrolment exists. With 90.9% net enrolment rate (88.5% for boys and 93.5% for girls), rural Khulna Division led while rural Sylhet Division lagged behind with 75.7% (76.4% for boys and 74.9% for girls) (CAMPE-UPL, 2002).

Net enrolment in secondary level were 45.87% for girls and 40.60% for boys in 2001 which went up to 52.11% and 44.05% respectively (MOE, 2006). Gross and net enrolment for female students are higher than male students in junior secondary level (grade 6-8) and secondary level (9-10). However, female enrolment reduces in the higher grades (grade 11-12). Retention rates in the secondary school for girls is 40.35% and boys 42.71%, in 2005.

6.4 Goal 4: Reduce child mortality

There has been a steady decline in the infant mortality rate from 92 per thousand live births in 1991 to 53 per thousand in 2003 (BBS, SVRS, 2003). Under-five child mortality rate has come down from 151 in 1990 to 78 per thousand in 2003 (BBS, SVRS, 2003).

There has been an epidemiological transition of mortality pattern in Bangladesh. Due to the relative decline in deaths caused by infectious diseases, non-infectious causes such as injuries and accidents now are considered to be important causes of deaths. The recent study (ICMH and UNICEF, 2003) shows that injuries and accidents contribute to 29% of total deaths among children aged 1-4 years.

As per the Coverage Evaluation Survey 2000, 2003 and 2006, the valid coverage of fully immunized children (all doses given at right intervals) increased from 52% in 2001 to 63% in 2003 and to 71% in 2006. Both hepatitis B vaccination and AD syringes have been introduced in

2003. Facility Based Integrated Management of Childhood Illnesses (IMCI) activities that began in 2002 cover over 140 of sub-districts (upazila) in 2006.

There have been various interventions that helped in reduction of mortality rates. Access to vaccination is foremost among them. The BCG coverage was as high as 96% in 2003 which went up to 98% in 2006. The access to immunization in Bangladesh is very high is seen from this figure. The rate of measles vaccination was 69% in 2003 which went up to 78% in 2006. However, it is recognized that the percentage of fully immunized children needs to increase further.

National immunization days (NID) being observed for many years have been very successful and there was not a single case of confirmed polio in the country between 2001 and 2005. However, several polio cases were detected in 2006 and NIDs have been strengthened. To reduce neonatal deaths due to tetanus, supplementary activities have been carried out. As a result, 86% of new-borns are protected at birth against neonatal tetanus (MNT). The government has also introduced from 2003 Hepatitis B vaccination into routine EPI, in six districts and one City Corporation on a pilot basis which has been expanded to all districts from 2005.

In order to reduce deaths from diarrhoea, the oral rehydration therapy (ORT) campaign has been in effect for a long time. The ORT campaign is a regular activity in ORT corners in government hospitals, EPI outreach sites, and home visits by health workers, throughout the country. Oral rehydration solution (ORS) use during diarrhoea increased from 62% in 2000 (BBS/UNICEF 2000) to 68% in 2003 (BBS/UNICEF, 2003) to 70% in 2006 (BBS/UNICEF, 2006).

High rate and number of neonatal mortality in Bangladesh is one of the major concerns for child survival and challenge to accelerating progress towards achieving millennium development goal-4 (MDG-4). Despite significant reduction in childhood mortality since late-1980s, the neonatal mortality is still high. Whereas the rates of under-five mortality decreased from 94 per thousand live births in 2000 to 88 deaths in 2004, there was only 1 percent reduction in both infant and neonatal mortality rates during same reporting period (BDHS 2004). Neonatal death rate of 41 per one thousand live birth (BDHS 2004) is due to three main causes: infections (pneumonia, neonatal sepsis), birth asphyxia and low birth weight / preterm delivery.

6.5 Goal 5: Improve maternal health

According to the Bangladesh Maternal Mortality Survey 2001, the maternal mortality ratio is in the range 320-400 per 100,000 live births reduced from 478 in 1990. In 2006, only 35% of urban births and 15% rural births are assisted by skilled health workers (BBS/UNICEF, 2006). The health seeking behaviour of women during pregnancy and childbirth is far from optimum, with less educated and poorer women being less likely to seek qualified care. Maternal malnutrition, infections during pregnancy, anaemia, and repeated pregnancies, contribute to a high rate of maternal mortality, which is among the highest outside sub-Saharan Africa.

The number of 24 hour comprehensive Emergency Obstetric Care facilities in the country increased from 59 in 2000 to 189 in 2005 and it helped case fatality decrease from 2.9% in 2001 to 1.8% in 2004.

6.6 Goal 6: Combat HIV/AIDS, malaria and other diseases

HIV/AIDS prevalence is still very low in Bangladesh. Although there is no official data on children with HIV/AIDS, the Human Development Report 2003 mentions that there were 310 children within the age group of 0-14 in 2001, having HIV/AIDS in Bangladesh.

According to MICS 2006, 60 per cent of adolescent boys (aged 10-19) and 57 per cent of adolescent girls heard of HIV/AIDS. Among those who heard of HIV/AIDS, only 52 per cent of boys and 34 per cent of girls knew that they can protect themselves from HIV by using condom.

6.7 Goal 7: Ensure environmental sustainability

Over 98 percent of households have access to improved source of drinking water in Bangladesh although arsenic contamination of tube well water has been found in at least 48 of the 64 districts, reducing the coverage of safe water to about 70 percent. About 20 million people are potentially at risk of arsenicosis. Again, more than half of the total population used sanitary latrine in 2006. The government has a target of achieving 100 percent sanitation coverage by 2010 and higher level of effort over last four years resulted in an increase in sanitary latrine use. It is worth to note that sanitation coverage, as per the reports of the National Sanitation Secratariate, has reached an impressive figure of 71.77 percent - an increase by 38.54 percent points just in approximately three years (The baseline of 2003 found it to be 33.23%).

The total urban population is expected to reach between 60 and 80 million by 2020. Dhaka city alone is projected to reach 15 million by 2025 of which one-third may living in slums. Although quality of services in urban areas in general is better than the rural areas, the situation in the slums and urban fringes is not good. The children and women are worst sufferers in slums.

A number of studies show worrying indicators in the urban slum areas. The disparity between the national level data and the urban slum areas illustrates that the children in the slums have limited access to schools and lack other basic social services. For example, net enrolment rate in urban slums is more then 20 % lower that of the national net enrolment rate. (Urban slum: 58% for boys and 61% for girls, National 81% for boys and 84% for girls) (MICS 2003). In terms of access to sanitary latrines, only 17 percent in urban slum area have access to these latrines as compared to the national coverage of 33% in 2003 (MICS 2003 and National Sanitation Baseline Survey 2003). Immunization coverage amongst the urban slum areas is slightly lower then the national average (DPT3 is 63% in slum areas and 69% at the national level) (MICS 2003).

Comparison of basic indicators between slum and other areas

Indicator		Slum	Urban non-slum	Rural	National
IMR (per 1000)	-	**138**	**47**	**-**	**66**
MUAC<12.5 cm (%) (Severely Malnourish)*	Boy	**7.1**	**1.1**	**4.1**	**3.8**
	Girl	**8.9**	**3.6**	**6.4**	**6.0**
Sanitary Latrines (%)*	Total	**17.1**	**72.2**	**48.6**	**53.6**
Diarrhea Prevalence (Last 15 days)*	Boy	**29.5**	**17.2**	**26.0**	**24.8**
	Girl	**30.4**	**19.9**	**23.8**	**22.7**
Measles Immunization*	Total	**75.3**	**87.9**	**82.7**	**83.7**
Primary School Net Enrolment*	Boy	**56.9**	**81.5**	**80.8**	**80.8**
	Girl	**60.7**	**82.4**	**84.8**	**84.1**
Marriage Registration	Total	**91.7**	**92.6**	**90.2**	**90.6**

Sources:
IMR: (Slum) UNICEF Estimate; (Urban) Sample Vital Registration Survey 2001
* MICS 2003, BBS/UNICEF

6.8 Millennium Declaration and Goal 8: Develop a global partnership for development

Birth registration data collected in the country found that only 7% of the under-five children had been registered (MICS 2003). MICS 2006 found the rate has gone up to 10%.

Adolescents, defined by WHO as individuals between the ages of 10 to 19, constitute about 23 % of the total population of 140 million. Of these, about 48% are female and 52% are male. The legal age of marriage is 18 years for girls and 21 years for boys in Bangladesh. Girls usually drop out of school as soon as they are married and dowry demands contribute to gender inequality and abuse of adolescent girls. Child sexual abuse, exploitation and trafficking is related to family violence and misinformation about employment opportunities in cities and outside the country.

The government with support from UNICEF has repatriated and reintegrated 167 out of 168 children formerly involved in camel racing in the United Arab Emirates (UAE). Community Care Committees (CCC) were established to ensure sustainable integration of these children.

7. Summary of lessons learned and initiatives undertaken since 2002 for accelerating the progress

Bangladesh adopted sector-wide approaches in health and primary education in recent years. This enables more participatory planning, implementation and monitoring of programmes relating to children. This is helping avoid duplication of efforts and achieve unified results. The government and many development partners and UN agencies are working together to plan and implement these programmes.

The past experience shows that there is regional variation in performance in the lives of children although country-wide actions were taken in immunization, vitamin A supplementation, salt iodization and enrollment in educational institutions. The Reach Every District (RED) strategy is being used to increase immunization coverage in low-performing districts including CHT and urban areas. As about 14 confirmed polio cases were identified in early part of 2006, the government has again strengthened polio immunization in the country holding four NIDs this year.

One of the main causes of child disease is prevalence of unsanitary latrines and poor hygiene bahaviour. The government has now has a policy of achieving 100% sanitary latrines by 2010. In arsenic mitigation, the ongoing programme has resulted in better understanding of the problem. Blanket testing of tubewells and emphasis of arsenic mitigation activities in high arsenic-affected areas have been useful strategies to cover larger number of population. The government has decided to go for community-based approach to ensure quality of drinking water.

The findings from the Bangladesh Health and Injury Survey conducted in 2003 showed that accident and injury have a very big implication on the achievement of MDGs for child survival. This new knowledge has significant policy dimensions and resulted in adopting a new injury prevention project by the government of Bangladesh. It is a major strategy to reduce child mortality included in the Poverty Reduction Strategy Paper (PRSP), Health Nutrition Population Sector Programme/Sector Investment Plan (HNPSP-SIP), and National Plan of Action for Children (NPA).

The fact that neonatal mortality is still high in the country has resulted in a renewed commitment by the health sector and the issue is being addressed by higher investment in Integrated Management of Childhood Illness (IMCI) in about one fourth of the country in next five years improving critical life-saving newborn practices such as thermal protection, initiation of breastfeeding and treating neonatal illness by trained health providers. Strengthened supervision

and administrative support are being provided to ensure optimal functioning of Emergency Obstetric Care (EmOC) facilities. In addition, measles control and neo-natal tetanus elimination has been given priority attention. The Alliance against Neonatal Mortality will be expanded and strengthened. The maternal and neonatal health aspects of the existing local level planning toolkit has been strengthened, based on the concept of the "Three-delays" model for reduction of maternal mortality.

While the HIV prevalence rate is still very low, the government and the people in general have now become aware of the potential danger of it. Alongside the government initiatives, the NGOs in good numbers have been participating in the national response to HIV through the HIV/AIDS Prevention Project (HAPP). The experience gained through working with nearly 100 NGOs will be consolidated and used for better planning and implementation. The strategy of focused interventions among high risk groups has proved to be a cost-effective response mechanism. Specific needs of children and youth within the high risk groups are being identified and addressed. The National Strategic Plan for HIV-AIDS 2004-2010 has prioritized five programme objectives: provision of support and services for priority groups, prevention of vulnerability to HIV infection in Bangladesh society, promotion of safe practices in the health care system, provision of care and support services for people living with HIV, and minimizing the impact of the HIV epidemic.

The Intensive District Approach to Education for All Project which ended in 2004 covered about half of the country has effectively introduced child friendly and interactive teaching methodologies in primary schools. The experience from this project has been fully integrated into the PEDP-II so that the good work of the previous project is not lost. Under PEDP-II, good quality primary education for girls and boys will be promoted through in-service training of teachers, innovative interventions for inclusive education, social mobilization and community participation to ensure that schools are child-friendly, gender-sensitive, efficient and effective.

The Basic Education for Hard to Reach Urban Working Children Project which ended in 2004 was successful in enrolling large number of urban working children, but it was recognized from this project that alongside literacy and numeracy, more appropriate learning materials and greater focus on life skills-based education can bring sustained change in the lives of children. In its new phase, the project will cover 200,000 adolescents who will also receive livelihood skills training to expand their employment horizons.

The Early Childhood Development Project has been an effective approach to early stimulation and care, paving the way to a greater understanding about the appropriate environment for children to grow. This initiative led to a new phase of early learning programme since 2006.

The National Plan of Action against Sexual Abuse and Exploitation of Children including Trafficking, is a major policy document has been the basis for child rights based and gender appropriate interventions. The minimum age of criminal responsibility was raised from 7 years to 9 years. However, in addition to further raising the age, efforts will be made in order to carry out comprehensive reform in this area, with the participation of stakeholders, with the aim of establishing a child-oriented juvenile justice system.

The momentum created with the entering into force of the new Birth and Death Registration Act, coupled with the adoption of a strategy on universal birth registration, will provide for free of cost service for the following two years which will be key to clear up the backlog with the aim of registering 90-95% of children. Pilot initiatives linking birth registration activities to the

education and immunization system proved successful and will therefore be scaled up to national level.

The Empowerment of Adolescents project has been supporting adolescents to access peer education for life skills, including HIV/AIDS, and livelihood options to protect themselves from exploitation, violence, and abusive practices, including dowry and child marriage. About one million adolescent boys and girls will be covered under this project, running from 2006-2010.

As part of knowledge management, quality data collection, storage and dissemination is being undertaken with Multiple Indicator Cluster Survey conducted in 2003 and 2006, and DevInfo database updated regularly. More innovative, cost-effective and regular data collection system will be experimented by the Bangladesh Bureau of Statistics (BBS) in the next two years. BBS will ensure collection of disaggregated quantitative and qualitative data highlighting situation of poor communities including ethnic minorities.

To focus more on disadvantaged districts, the government with the support from UNICEF agreed to converge future efforts in 14 districts of the country. However, country-wide activities will also continue as usual. Emphasis will be placed on disadvantaged groups, including urban poor communities and ethnic minorities. Communication has been part of every programme with emphasis on more inter-personal methods employed for greater effectiveness. Large-scale communication interventions have been used in child nutrition, education, child health, HIV/AIDS and Avian Influenza in recent years.

The Ministry of Women and Children Affairs has been working to have a Child Rights Commissioner equivalent to child ombudsperson for last one year. The proposal is currently under active consideration of the cabinet for final decision. With its approval, child protection will receive more attention.

The government recognizes the contribution of the informal sector to the economic growth of the country. Drawing on lessons learned from the project for service delivery in urban poor communities, a new package of basic services will be delivered through a cross-sectoral approach. In the three Chittagong Hill Tracts (CHT) districts, the *para* (community) *centres* will also provide an integrated package of basic services. The existing *para centres* will be strengthened and new *para centres* will be added to cover the entire three CHT districts. These efforts are helping increase enrollment, immunization, water supply and hygiene bahaviour change in most disadvantaged areas of the country.

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Acronyms

ADB	Asian Development Bank
ADP	Annual Development Programme
AIDS	Acquired immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BANBAIS	Bangladesh Bureau of Educational, Information and Statistics
BBF	Bangladesh Breastfeeding Foundation
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BCG	Bacillus of Calmette Guerm
BDHS	Bangladesh Demographic and Health Survey
BEOC	Basic Emergency Obstetrics Care
BEHTRUC	Basic Education for hard to reach Urban Children
BEUWC	Basic Education for Urban Working Children
BHIS	The Bangladesh Health and Injury Survey
BMI	Body Mass Index
CBO	Community Based Organization
CBR	Crude Birth Rate
CC	City Corporation
CDD	Control of Diarrhoeal Diseases
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHT	Chittagong Hill Tracts
CRC	Convention on the Rights of the Child
DG	Director General
DPE	Directorate of Primary Education
DPHE	Department of Public Health Engineering
DPT	Diphtheria, Pertussis, Tetanus
DPT3	Diphtheria, Pertussis, Tetanus, three shots
DWA	Department of Women Affairs
ECD	Early Childhood Development
EFA	Education for All
EmOC	Emergency Obstetrics Care
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunisation
ERD	Economic Relations Division
ESP	Essential Services Package
GDP	Gross Domestic Product
HAPP	HIV/AIDS Prevention Project
HKI	Helen Keller International
HPSP	Health and Population Sector Programme
HNPSP	Health, Nutrition and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICMH	Institute of Child and Mothers Health
IDEAL	Intensive District Approach to Education for All
IEC	Information, Education and Communication
ILO	International Labour Organisation
IMCI	Integrated Management of Childhood Illness
IMED	Implementation Monitoring and Evaluation Division

IMR	Infant Mortality Rate
IPHN	Institute of Public Health and Nutrition
LBW	Low Birth Weight
MDGs	Millennium Development Goals
MDMR	Ministry of Disaster Management and Relief
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare
MOPME	Ministry of Primary and Mass Education
MOWCA	Ministry of Women and Children Affairs
NAC	National AIDS Committee
NASP	National AIDS/STD Programme
NER	Net Enrolment Rate
NGO	Non Government Organisation
NID	National Immunisation Day
NIPORT	National Institute of Population Research and Training
NPA	National Plan of Action
ORT	Oral Rehydration Therapy
PEDP-II	Primary Education Development Programme - 2
PMED	Primary & Mass Education Division
PRSP	Poverty Reduction Strategy Paper
SAARC	South Asian Association for Regional Cooperation
SVRS	Sample Vital Registration Survey
TBP	Time Bound Programme
TFR	Total Fertility Rate
U5MR	Under 5 Mortality Rate
UDC	Urban Development Centres
UN	United Nations
UNDAF	United nations Development Assistance Framework
UNICEF	United Nations Children's Fund
USI	Universal Salt Iodization
WATSAN	Water and Sanitation
WFFC	World Fit for Children
WHO	World Health Organization
WSC	World Summit for Children