

C
O
U
N
T
R
Y

P
R
O
G
R
E
S
S

R
E
P
O
R
T



**PLUS 5 “WORLD FIT FOR CHILDREN”
REVIEW FOR THE KINGDOM
OF BHUTAN
2006**

TABLE OF CONTENTS

TABLE OF CONTENTS	i
GLOSSARY - Acronyms and Abbreviations	ii
EXECUTIVE SUMMARY	iii
Chapter 1- Introduction	1
Process towards Preparation of Plus Five WFFC Report.....	1
Chapter 2- Major Actions Taken for Children and towards the WFFC targets since 2002	2
Gross National Happiness and Bhutan 2020: A Vision for Peace, Prosperity and Happiness	2
Draft Constitution of the Kingdom of Bhutan.....	2
The Tenth Five Year Plan (2007/08 to 2011/2012)	3
National and Sector Actions towards WFFC Goals and Relevant MDGs	3
WFFC 1: Promoting Healthy Lives	3
WFFC 2: Providing Quality Education for All	5
WFFC 3: Protecting Children against Abuse, Exploitation and Violence	6
WFFC 4: Combating HIV/AIDS	7
Chapter 3- Resource trends for children	8
Chapter 4- Development and use of monitoring instruments to track WFFC targets since 2002	10
Chapter 5- Enhancing partnerships, alliances for children and participation	13
National Based Partnership	13
International Based Partners	15
Chapter 6- Achievements of WFFC Plan of Action and related MDG targets	16
WFFC 1: Relevant Targets under Promoting Healthy Lifestyles.....	16
WFFC 2: Relevant Targets under Promoting Quality Education.....	19
WFFC 3: Relevant Targets under Child Protection against Abuse, Exploitation and Violence	22
WFFC 4: Combat HIV/AIDS	22
Chapter 7- Summary of lessons learned and future initiatives	24
Annexure.....	27
Annex 1: LIST OF Tables	27
TABLE SERIES 1: WFFC INDICATORS SUMMARY [1 TABLE].....	27
TABLE SERIES 2 - WFFC INDICATORS FOR HEALTH [7 TABLES].....	a
TABLE SERIES 3 - WFFC INDICATORS FOR EDUCATION [8 TABLES].....	d
TABLE SERIES 4 - WFFC INDICATORS FOR CHILD PROTECTION [2 TABLES]	g
TABLE SERIES 5 WFFC INDICATORS FOR HIV/AIDS AND OTHER DISEASES [1 TABLE].....	h
Annex II: Bibliography	j

GLOSSARY - Acronyms and Abbreviations

AIDS Acquired Immuno Deficiency Syndrome	MMR Maternal Mortality Rate
ATP Apprenticeship Training Program	MoF Ministry of Finance
BCCI Bhutan Chamber of Commerce & Industry	NER Net Enrolment Ratio
BHU Basic Health Unit	NFE Non-Formal Education
CBR Crude Birth Rate	NHDR National Human Development Report
CDR Crude Death Rate	NHS National Health Survey
CMR Child Mortality Rate	NNS National Nutritional Survey
DC Developing Countries	NWAB National Women's Association of Bhutan
DYT Dzongkhag Yar-gye Tshog-chung	NGO Non-Government Organisation
EFA Education for All	NSB National Statistical Bureau
EPI Expanded Program of Immunisation	Nu Ngultrum [the Bhutanese currency unit]
EIA Environmental Impact Assessment	PHC Primary Health Care
FDI Foreign Direct Investment	PLP Post-Literacy Programme
FYP Five-Year Plan	PPD Planning and Policy Division
GDI Gender Development Index	RGoB Royal Government of Bhutan
GDI Gross Domestic Investment	RMA Royal Monetary Authority
GDP Gross Domestic Product	SAARC South Asian Association for Regional Cooperation
GEM Gender Empowerment Measure	SAFTA South Asia Free Trade Agreement
GER Gross Enrolment Ratio	STD Sexually Transmitted Disease
GNH Gross National Happiness	TFR Total Fertility Rate
GYT Geog Yar-gye Tshog-chung	TVI Technical Vocational Institutes
HALE Health-Adjusted Life Expectancy	U5MR Under-5 Mortality Rate
HDI Human Development Index	UNDP United Nations Development Programme
HPI Human Poverty Index	VET Vocational Education and Training
HDR Human Development Report	VSDP Village Skills Development Programme
HIV Human Immunodeficiency Virus	WB World Bank
IMR Infant Mortality Rate	WHO World Health Organisation
IT Information Technology	WSSD World Summit for Social Development
LEB Life Expectancy at Birth	
LFPR Labour Force Participation Rate	
LDC Least Developed Country	
MDGs Millennium Development Goals	

EXECUTIVE SUMMARY

The Kingdom of Bhutan ratified the Convention on the Rights of the Child (CRC), without reservation, on 1 August 1990. That pledge was renewed at the UN General Assembly Special Session for Children in 2002. Children in Bhutan are better off today than they were five years ago – they are born healthier, to healthier mothers, and are more likely to live to their fifth birthday. They have better access to education, greater opportunities and higher hopes than the generation before them.

Bhutan has made considerable socio-economic progress since planned development began in 1960s. In keeping with the past five year plans, even in the current Ninth Five Year Plan (2002-2007), Bhutan has committed 24 percent of capital and recurrent expenditures to social investments. Bhutan continues to strive to redeem its pledges to children in full measure; to this end the Royal Government of Bhutan is working within a web of partnerships, which includes communities, Non-Governmental Organisations, religious leaders and children themselves. An institutional achievement is the setting up of the National Commission for Women and Children – to promote and protect children's and women's rights.

Recognising child rights as a priority the Royal Government has signed both Optional Protocols to the CRC on the sale of children, child prostitution and child pornography, and on the involvement of children in armed conflict. It has ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), as well as the SAARC Convention on Regional Arrangements for the Promotion of Child Welfare in South Asia and the SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution.

Important national legislations and regulations have been passed since 2001- such as the Penal Code (2004), the Civil and Criminal Procedure Code (2001), to codify child rights and make them actionable in national courts. As part of Bhutan's shift to constitutional democracy, a draft Constitution [draft Tsa-Thrim Chhen-mo] is scheduled for adoption by the National Assembly in 2008. The draft Constitution guarantees children and other citizens fundamental rights in Article 7, and Article 9 provides for principles of State Policy which include provision of free education, quality healthcare and protection of children from abuse and violence.

Since the UNGA Special Session for Children, many concrete goals and targets relevant to children have been incorporated in the country's development process and five year plans. As a step towards attaining the World Fit For Children targets and Millennium Development Goals, the Royal Government has evolved a consistent set of intermediate targets and benchmarks during the course of the current plan period [2002-2007] and in the forthcoming plan [2008-2012] in the priority areas of action.

The goals, strategies and actions have been appropriately adapted to Bhutan's unique circumstances, within the country's development philosophy of Gross National Happiness.

Chapter 1 - Introduction

Process towards Preparation of Plus Five WFFC Report

The General Assembly in its resolution GA 58/282 decided to convene a commemorative plenary session in 2007, the mid decade point for the "*Plan of Action for a World Fit For Children*" [WFFC], to review progress made since the 2002 UNGA Special Session on Children.

In the preparation of this review, the Royal Government in collaboration with the National Women and Children Commission [NCWC] and UNICEF Bhutan have recruited an independent international consultant and an independent national consultant to carry out a national review of progress towards the goals and strategies for children contained in national commitments to creating a Bhutan Fit For Children. In concurrence to the Guidelines, Bhutan has prepared the country progress report on the WFFC Plan of Action to be submitted to the UN Secretariat before the end of 2006 using the framework based on the suggested format. A Task Force for the WFFC review and report was formed with representatives from key ministries of the Royal Government and the NCWC, and in close collaboration with UNICEF provided guidance and assistance in the consultative process of preparing this country progress report.

To provide a realistic assessment of Bhutan's on-track progress to achieve the targets of the WFFC Plan of Action, the most recent available information and data, provided by sectoral representatives through this Task Force, was drawn upon. The following steps were carried out in preparation of this report by the two-member consultancy team:

- Review of existing data, information, reports, policies and strategies and analysis of the trends and achievements related to the goals and targets of the WFFC and related MDGs.
- Meetings with Task Force and sector representatives to gain views on initiatives and lessons learned since 2002 for accelerating towards achievement of WFFC and relevant MDGs
- Following the preparation of the draft report, the consultants provided a verbal presentation of the report to the Task Force and UNICEF and received first round of comments, after which the revised report was circulated for review and comments that were incorporated to produce the final report.

The outcome of this process is the "Country Progress Report for the Plus 5" review of the 2002 Special Session on Children and WFFC. The report has seven chapters that discuss major achievements, trends partnerships and lessons learned, with annexed tables.

Chapter 2 – Major Actions Taken for Children and towards the WFFC targets since 2002

Gross National Happiness and Bhutan 2020: A Vision for Peace, Prosperity and Happiness

1) Bhutan's development process is guided by the policy of **Gross National Happiness [GNH]** which has four main pillars *i) Promotion Of Equitable and Sustainable Socioeconomic Development, ii) Preservation and Promotion Of Cultural Values, iii) Conservation of Natural Environment, and iv) Good Governance*. These are built upon through the twenty year strategy, **Bhutan 2020: A Vision for Peace, Prosperity and Happiness** with principles of *a) maintaining a distinct identity; b) strengthening unity and harmony; c) nationwide stability for peace and prosperity; d) promoting self-reliance; e) pursuing sustainable development*. This strategy was the culmination of intensive consultations between communities, private and non-governmental organizations, and Royal Government agencies, and provides a framework for Bhutan's five-year developmental plans through annual budgets, and amongst other broad goals have a priority focus to improve access to quality health and education services for all Bhutanese with a strong focus on children.

Draft Constitution of the Kingdom of Bhutan

2) The Draft Constitution of the Kingdom of Bhutan is soon going to be adopted in 2008. Public consultations and open discussions on the draft Constitution have been completed in all 20 districts with all Bhutanese. These discussions also saw an unprecedented **participation of children** in open discussions at a public forum for national political change. The draft Constitution has provisions that guarantee fundamental rights and outlines specific rights for children. Article 9 sections 16 and 21 of the draft Constitution states that access **to free basic education and free health care are an inalienable right of all Bhutanese**, and sections 17 and 18 include provisions on violence against children including human trafficking. The draft Constitution has provisions for the state to take all measures to eliminate trafficking, prostitution, abuse, violence, and economic exploitation of children.

3) Given that the current Ninth Five-Year Plan [Ninth Plan] already focused on achievement of various WFFC goals, the Royal Government is using this FYP as the framework for progressive achievement of these and the Millennium Development Goals [MDGs] and will continue to do so with the forthcoming Tenth Five Year Plan [Tenth Plan]. The Ninth Plan has five overall objectives which are: *i) Improving quality of life and income, especially of the poor; ii) Ensuring good governance; iii) Promoting private sector growth and employment generation; iv) Preserving and promoting cultural heritage and environment conservations; and v) Achieving rapid economic growth and transformation*. The Royal Government is implementing Bhutan's poverty reduction strategy through the Ninth Plan. Poverty is identified as predicating every aspect of development and the ability of communities in terms of food security, income generation, and school enrolment. The recent *Poverty Analysis Report (PAR) 2004* is a comprehensive study undertaken by the Royal Government to seek strategic entry points that would alleviate poverty. Based on the findings of the PAR 2004, Bhutan will likely achieve almost all of the income and non-income MDGs by 2015. Bhutan is a party to the *SAARC Social Charter 2004*, which under Article III, has affirmed the highest priority to poverty alleviation with the aim to triple rural per capita income by 2012, and the SAARC Plan of Action on Poverty Alleviation adopted in 2004. Bhutan also recently launched the SAARC Development Goals which comprise of 22 goals for the period of 2007-2012 in the areas of poverty alleviation, health, education and environment. The Royal Government continues to ensure the provision of quality education and health services, while expanding infrastructure of telecommunications, electricity, and housing and other urban facilities.

The Tenth Five Year Plan (2007/08 to 2011/2012)

4) *The Guidelines for the Formulation of the Tenth Plan*, prepared through consultations with all relevant stakeholders in various discussion forums such as the brainstorming Session, the National Consultation Workshop and the Good Governance Task Force, have emphasised that the development-planning approach of the forthcoming **Tenth Plan shall be to strengthen the four pillars of GNH**, and will be an **MDG-based National Development Strategy** with **poverty reduction and achievement of MDGs** as principal objectives. The Tenth Plan focus to reduce the proportion of population living below the poverty line from 31.7 % to about 20 % by 2012 is consistent with Royal Government commitments to the (MDGs), especially MDG 1; and the declaration of 2006-2015 SAARC Decade of Poverty Alleviation.

National and Sector Actions towards WFFC Goals and Relevant MDGs

WFFC 1: Promoting Healthy Lives

5) Bhutan has achieved some of the WFFC goals and relevant MDGs related to promoting healthy lives, and is on track for others. Relevant policies, institutional mechanisms and comprehensive child health programmes in place include the EPI, Maternal and Child Health, Nutrition, ARI and Diarrhoeal Disease Control programmes and measures such as promoting exclusive breast feeding, designation and equipping of mother and child friendly hospitals. The cross-sectoral nature of programmes and initiatives are coordinated under the *Integrated Management of Childhood Illness* (IMCI) strategy. The Royal Government also **expects several health related targets to be met by end of the Ninth Plan**, and seeks to facilitate 100 % access to clean water and safe sanitation, halve the infant mortality rate to 30, reduce the under-5 mortality rate from 84 to 50 per 1000 live births, and lower the maternal mortality rate from 2.6 to 1.5. per 1000 live births Other national maternal health targets include increasing the proportion of births attended by skilled personnel to at least 50%; halving anaemia in pregnant women to below 30%; ensuring full attendance of antenatal and post natal visits; and reducing the total fertility rate to below 3% and population growth to less than 2%.

6) **Nutrition** and improving people's nutritional status, particularly for women and children is treated as an integral component of primary health care. The nutrition programme in communities includes promotion of school agriculture and kitchen gardening, is linked to childcare initiatives. Bhutan has ratified the *SAARC Code for the Protection of Breast Feeding and Young Child Nutrition* in 2004. Breastfeeding is universal in the country, and continued efforts are being made to encourage mothers to breast feed exclusively for four months and continue for two years. Knowledge on complementary feeding and other aspects of care are also emphasized. Particular attention has been paid to addressing **anaemia**, which has been prevalent widely among both women and children, by providing iron and folic acid supplements free of cost, and by promoting vegetable consumption. Meals are provided to students through a School Feeding Programme with wide coverage that not only increases the likelihood of children attending school but also ensures that students are healthier and better able to learn.

7) The RGoB's commitment to **enhance child and maternal survival** through provision of **free basic and preventative health care services** has been ongoing since introduction of the modern health care system and is a major focus of the current FYP. Maternal and Child Health (MCH) clinics and Antenatal Care (ANC) clinics are conducted at all Hospitals and Basic Health Units (BHUs), and access for those in the most remote areas is available through monthly ORCs. The government has improved access to services by establishing 10 more BHUs, 30 more ORCs and increasing the cadre of additional trained health staff (Table 2.7). At these clinics, all under five children are provided with **basic child survival interventions** including immunisation, vitamin A, growth monitoring and promotion, deworming, and in endemic areas, to malaria prophylaxis. One major achievement for child survival and development was the introduction of Rubella immunisation, through a combined Measles-Rubella vaccine in 2006. This was initiated through a nation-wide measles-rubella campaign

in early 2006 which was followed by introduction of the combined vaccine into the routine system.

8) Through ANC, **pregnant women** are provided with check ups, Tetanus Toxoid immunization, iron-folate tablets, education on topics including nutrition and safe delivery, and where endemic, to intermittent preventative treatment for malaria. In 2005, universal deworming in the third trimester was introduced. The National HIV/AIDS Commission approved the provision of **Anti-Retroviral Therapy for people living with HIV/AIDS, including pregnant women**, and has also approved voluntary testing for pregnant women who are encouraged through counselling to undertake the tests. Guidelines were also developed for counselling and health service delivery for HIV infected mothers.

9) The country is currently on track towards achieving the MDG target of **institutional delivery rate of 50%** of the proportion of births attended by skilled health personnel. Bhutan's national policies and programmes to lessen maternal mortality and correspondingly increase the proportion of births attended by skilled personnel are in conformity with the recommendations of the programme of action of the International Conference on Population and Development (ICPD). The country as a party to CEDAW upholds the right of women to receive appropriate health services during pregnancy, period of confinement and access to adequate natal care. The Annual Health Conference 2005 accorded priority to move towards **100% institutional delivery** as a strategy to decrease maternal mortality. The Royal Government views the promotion of institutional deliveries as the most effective strategic measure to raise the proportion of attended births and thereby improve the survival of mothers and babies. Health centres are being better equipped and delivery rooms are being made more women friendly and comfortable. To further improve child and child survival and given their role in delivery at the BHU level, an attachment programme for in service Auxiliary Nurse Midwives (ANM) was initiated in 2005. To date, 54 ANMs have undergone an attachment at the National Referral Hospital where they gained hands on experience on birth complications. Given their role in delivery at the BHU level the programme will continue and expanded to include other health care providers who perform deliveries such as Health Assistants and Basic Health Workers, with a focus on female staff.

10) Efforts to increase availability of **Emergency Obstetric Care (EmOC)** for pregnant women also continued. To equip comprehensive EmOC centres with required staff, over 25 health care professionals, including 6 doctors, received specialised training in comprehensive EmOC service provision. Equipment was also purchased to upgrade 2 more hospitals to comprehensive EmOC centres. In 2003, the Ministry of Health introduced a training programme on Basic EmOC service provision for all new doctors and B.Sc. nurses entering the health care system. This will help ensure that at least all hospitals and Grade 1 BHUs can function as Basic EmOC centres at all times. It has been difficult to maintain the number of comprehensive EmOC centres given frequent transfer of staff between health facilities. By end 2006, 11 health facilities will be functioning as Comprehensive EmOC centres, up from 9 in 2002. In 2005 and 2006, 150 BHUs were provided with delivery beds and over 130 were equipped with heaters (kerosene heaters for remote BHUs lacking electricity) and sheep skins. These efforts are important as delivery outside of the home in cold mountainous areas can be uncomfortable. In addition, some BHUs were provided with electricity, and labour rooms of some hospitals were upgraded to have attached toilets for patients. Given results of the recently revitalised Maternal Death Investigation System, MoH has made oxytocin available, even in BHUs, starting in 2004. Prior to this, oxytocin was only available in hospitals. [Refer Chapter 4]

11) Among Royal Government programmes to **promote healthy lifestyles** the *Move for Health Initiative* in Bhutan was launched in 2002 to promote physical activity, exercise and healthy lifestyles and to raise funds for the Health Trust Fund. The campaign successfully raised US\$ 1.7 million, a large part of which came from local contributions. The Move for Health Walk, covering 550 kilometers from the east of the country to the west, reached out to rural communities and spread vital health messages. On 17 December 2004, Bhutan introduced a complete ban on tobacco sales, following a resolution taken by the National Assembly. With the *Tobacco Free Initiative* Bhutan has actively promoted anti-tobacco campaigns at national and international levels, and is party to the global Framework Convention on Tobacco Control.

12) Efforts to include **water and sanitation** facilities (with separate facilities for girls) in all newly established schools have been particularly important in terms of decreasing the gender gap in enrolment.[See WFFC 2] Despite improvements in water and sanitation, hygiene remains a problem, and poor hygiene also accounts for high levels of other infections and worm infestations. Health personnel have, however, noticed that messages about **hygiene** and sanitation are getting through, and in recent years the rate of diarrhoeal infections has declined. The virtues of safe sanitation and personal hygiene are a continuing programme in schools. To help attain the goal of full **safe water coverage and sanitation** by as early as 2007, the Royal Government is targeting a 100 percent provision of piped potable water supply by end 2007 that entails repairing 150 old systems and constructing 130 new schemes. This involves communities funding around 25% of the cost in terms of materials and labour, the government 15%, and the rest from external funding.. Numerous water caretakers are being trained to manage and maintain rural water and sanitation schemes. The Community Planning and Management Workshop and Community Development for Health Workshop approaches have been developed and instituted for local communities to implement water and sanitation facilities by themselves.

WFFC 2: Providing Quality Education for All

13) Bhutan's goal to actualize the *Education for All* (EFA) goals and targets has been incorporated into the policy document *Education Sector Strategy: Realising the Vision 2020* formulated in 2003. This policy provides a comprehensive strategy for educational development at all levels and emphasizes the relevance of maintaining education quality standards while enhancing access. The Royal Government continues to give highest priority to education for all girls and boys through the provision of **free basic education** which has been ongoing since introduction of the modern education system. In 2002, free basic education was expanded from class VIII to class X and the Ministry of Education has had great success in bringing schools closer to rural and remote children with the establishment of 60 more CPS and 6 more Primary Schools in remote areas (Table 3.1). In addition, as some CPS do not house all primary level classes, multi-grade teaching is being encouraged in case of low student numbers. This is expected to decrease drop out, especially among girls, given that they will be able to continue studying up to class VI in a **school near to their home**. In addition, the Ministry has made efforts to include **water and sanitation facilities** (*with separate facilities for girls*) in all newly established schools. Recent efforts have been made to provide over 80 existing schools without previous access to or with defunct water and/or sanitation facilities with separate sanitation facilities for girls and access to piped water by the beginning of 2007. To further enhance enrolment, the Ministry of Education worked with local leaders from rural communities to help them plan and undertake community level enrolment campaigns in 2003 through non-formal education.. The Ministry of Education also expanded their NFE programme which offers free literacy and numeracy courses to youth and adults.

14) To address issues of **educational quality**, in 2005, the Ministry of Education initiated a pilot Child Friendly School programme based on the UNESCO Toolkit in 20 schools with the aim of improving the quality of education and reducing repetition and drop out rates.¹ The programme is expected to expand to 100 schools in the next FYP. The quality of education was discussed at the highest level during the 85th session of the National Assembly in July 2006. Major **reforms in curriculum** were initiated in 2004 starting with English, Dzongkha (National Language) and Mathematics. The Ministry of Education is taking this opportunity to **mainstream gender into the new curriculum**. With the aim of standardising the quality of preschools, the Ministry of Education also began licensing private day care centres in 2005² and provided free training on the newly developed comprehensive guidelines for all day care centre proprietors. The Ministry of Education has also drafted a national policy on **Early Childhood Care and Development** [ECCD] to strengthen early childhood care and development. Good childcare and development practices are shared with

¹ Ministry of Education (2005) 24th Education Policy Guidelines and Instructions. Royal Government of Bhutan.

² Ministry of Health (2005) Implementing the ICPD Programme of Action in Bhutan. Royal Government of Bhutan

communities through multi-media public information programs including radio, television, the national newspaper and other emerging technologies. To meet special needs of urbanization and social transition, private initiatives on profit or non-profit basis to establish childcare centres and nurseries are encouraged based on strict regulations on quality service.

15) A Royal Decree issued in 1998 emphasized that **girls' and women's participation** in all areas are to be significantly enhanced. Further, to monitor and ensure gender sensitivity and concerns are integrated into all spheres of development policy and activity the NCWC has revitalized the forum of gender focal persons that had been established by the Royal Government in 2001. In the specific context of a **supportive environment for achieving gender equality in education**, women enjoy equal access to educational opportunities at the primary level; although at the secondary and tertiary levels efforts continue to be made to close the gender gap. Through education, particularly through special programmes such as **Scouts and career counselling**, girls are able to participate equally in all spheres. Due to governmental encouragement many schools that encounter teen pregnancies **accept student mothers back to school** after the baby is born, or assist in transferring the young mother to another school if she so chooses.

WFFC 3: Protecting Children against Abuse, Exploitation and Violence

16) The **definition of the child in Bhutan is consistent with UNCRC Article 1 and the CRC**, as anyone who has not attained the age of 18 years of age. This definition is embedded in laws including the Regulation for Wage Rate, Recruitment Agencies and Workmen's Compensation (1994), the Amended Marriage Act of 1996; The Penal Code of Bhutan 2004. The **age of minimum criminal responsibility [MACR]** under the Penal Code is 10 years. The issue of raising the MACR to 13 was discussed during the National Consultation on Women and Child Friendly Judicial Procedures, and it has been recommended to review the Draft Juvenile Act. Voting rights are given at the age of eighteen. The National Assembly has enacted legislations regarding children and protection of their rights, all in consistency with Bhutan's international commitments and provisions of the Draft Constitution. : These various legal instruments include the Civil and Criminal Procedure Code of Bhutan, 2001, Penal Code of Bhutan 2004, and the Evidence Act 2005. Further, a draft Labour and Employment Act of the Kingdom Bhutan has been drafted with special provisions to protect children. As a reaffirmation of its commitment to child rights, Bhutan has signed the two optional Protocols to the Convention on the Right of the Child on the involvement of children in armed conflict and sale of children, child prostitution and child pornography, and is party to the SAARC Conventions on Preventing and Combating Trafficking in Women and Children for Prostitution 2002 and Regional Arrangements for the Promotion of Child Welfare 2002, the Single Convention on Narcotic Drugs 1961, the Convention on Psychotropic Substances, 1971, the UN Convention against Illicit Traffic in narcotic Drugs and Psychotropic Substances 1988, the Yokohama Global Commitment made at the 2nd World Congress Against Sexual Exploitation of Children 2001. Bhutan became the 183rd member of Interpol (International Police), on September 19, 2005.

17) Bhutanese law assures any person the right to institute court proceedings. Article 227 of the Penal Code of Bhutan 2004 was the first legal instrument in Bhutan to prohibit trafficking of a child. Trafficking of a child is a third degree felony, while trafficking of a child for prostitution is a second degree felony if the child is above 12 and below 18 years and a first degree felony if the child is 12 years and below. The Penal Code also includes various provisions on violence against children. The draft Labour and Employment Act will also address issues relating to child labour. The *Amendment to the Marriage Act* 1996 has made the **legal marriageable age 18** for both sexes, and prohibits marriages of minors such that whoever presides over such marriages is liable to fines. Regarding **adoption** of a child, the 67th session of the National Assembly in 1988 had passed a resolution that adoption of any child, whether Bhutanese or non-national, should be permitted provided the cases are processed through the *Thrim Khang* (Courts) and appropriate agreements stating that the child would be entitled to full benefits under the Inheritance Act as applicable to natural born children are undertaken. The children so adopted through these procedures shall be legally recognized as foster

children and registered in the census as citizens. This resolution protects the paramount interest of the adopted child and the law does not discriminate between boys and girls.

18) The National Consultation on **Violence** against Children (21st-22nd April 2005) organised by the NCWC looked into prevailing forms of violence and its causes, and reviewed effective interventions, gaps and challenges. The Consultation also aimed at increasing commitment of the State, civil society and other stakeholders, and building stronger partnerships.

WFFC 4: Combating HIV/AIDS

19) Although **prevalence in Bhutan is currently low**, efforts to prevent, reduce and treat STIs and HIV/AIDS receive the **highest political support** in Bhutan. A royal decree was issued in 2004 emphasising the importance of preventing the spread of HIV. The UNFPA Goodwill Ambassador, Her Majesty the Queen Ashi Sangay Choden Wangchuck is pursuing ongoing advocacy campaigns that focus on HIV/AIDS and STDs. The Royal Government initiated a *National AIDS/STD Control Programme* (NACP) in 1988, a few years prior to the detection of the first two HIV positive cases in 1993. For a more effective coordination and implementation of HIV/AIDS prevention and control activities at the **community level**, multi-sectoral task forces [MSTF] comprised of all stakeholders were created in each Dzongkhag. Manuals have been developed to guide the MSTFs as an essential mechanism to effectively mobilize local communities and resources to ensure appropriate and adequate responses at the local level in combating the spread of HIV infection.

In 2003, the Health Department introduced voluntary counselling and training of counsellors, and testing kits and surveillance systems in all the hospitals by the end of the 9FYP. In 2005, the Commission approved the provision of free Anti-Retroviral Therapy for those infected who require it, including pregnant women to prevent the vertical transmission of HIV. It also approved voluntary testing for anybody, and for which pregnant women are encouraged through counselling to undertake the tests. Medical treatment of HIV/AIDS patients is done in strict confidentiality and patients are provided full treatment, including counselling and the free supply of anti-retroviral drugs. Two Health Information and Service Centres were opened in 2005 to provide information, confidential and free testing for HIV/AIDS and STDs outside of the formal health care setting, and counselling services on family planning (including free contraceptives), substance and alcohol abuse, tobacco control and mental stress. All services provided by the centre are free of charge. The aim is to have one centre in each Dzongkhag by 2007.

After a pilot programme initiated in 2003, the *Guidelines on Medical Standards for Contraceptives* were updated and new sections added on **female condoms and emergency contraceptives**. Due to this effort, women can now access female condoms and emergency contraceptives in all 29 hospitals and the 7 Grade 1 BHUs. Free family planning services, including free condoms, have expanded to include distribution of free condoms outside the health system at restrooms of bars, restaurants, hotels and gas stations. Condoms continue to be available free of cost at village level through Village Health Workers.

Chapter 3- Resource trends for children

20) Bhutan has consistently accorded high priority to the development of social sectors which contributes to the achievement of MDGs and relevant WFFC goals. Because of high rate of investment in those sectors, Bhutan has met its part of the 20:20 compact of 20 % of public investment in health and education. In 2004 and 2005, health and education sectors accounted for 27% of total government outlay. This increased to 30% of total outlay in 2005/2006; with 12% for health sector through construction of water supply schemes, BHUs and outreach clinics, and 18% for education sector with emphasis on primary education, human resources development, and infrastructure expansion. Annual budgeted public expenditures for education alone constitute a high level of about 7% of GDP that places Bhutan among those countries with the highest ratio of public expenditure on education to GDP. On per capita basis, public expenditure on education and health is estimated at US\$ 108 a year. Sixty percent of recurrent educational expenditures are invested into primary education. Health takes around 12% of the national budget, and of total health expenditure 90% goes to public health which corresponds to around 4% of GDP. To consolidate financial sustainability of rising recurrent costs for procurement of vaccines and drugs, the **Bhutan Health Trust Fund** (BHTF) - launched in 1997- became operational in 2003 with US\$ 18 million out of US\$ 24 million target capitalization.

21) As per the overall Ninth FYP budget outlay for the Health and Education Sectors the allocations for recurrent and capital expenditures are almost equal. The allocation for Health is 52% and 48%, and for Education it is 61% and 39% respectively for recurrent and capital expenditures. Although, the country is still dependent on external grants and loans for financing of the capital expenditures, the recurrent expenditures are fully met by its domestic revenue.

22) In efforts to strengthen the overall budgetary process and management of public expenditures, the Royal Government introduced a two-year rolling budget from fiscal year 2003 onwards. Based on Ninth Plan financial projections, a provisional Medium Term Fiscal Framework covering three years from 2003 to 2006 was presented in the PRSP cover note to the Ninth plan. The MTFF budget deficits are around 4 % of GDP, and overall spending between 35 and 40 % of GDP. Since 2003, GDP growth had averaged around 7% per annum, and inflation and exchange rate remained steady. The major source of domestic revenue is hydropower and Bhutan continues to invest in tapping its hydropower potential.

23) Community ownership of productive resources has been enhanced through labour contributions and local materials in beneficiary schemes, with the government contributing finances. From 2002, the GYT retains rural taxes and user charges to foster ownership and participation in development activities. The financial powers of the elected bodies, like the DYT and GYT, have been broadened to include prioritization and allocation of annual budget, re-appropriation of budget, review and ratification of accounts of *Gewog* and *Dzongkhag* administrations.

24) Total **external funding assistance** was projected at around 45 percent of total Ninth Plan outlay. The Royal Government seeks grant financing before resorting to loans, which is sought mainly for revenue-generating projects in the economic sector. Loan financing in the social sector is resorted to only if grant financing is not available. With improvements in financial reporting and accountability systems over the years that meet requirements of both the Royal Government and development partners to avoid the establishment of parallel systems, funding from donors is now increasingly sought on a program-funding basis, as project based financing adds significantly to the Government's administrative costs. Among the many advantages of such an approach is the opportunity to focus on larger goals and objectives and benefit from economies of scale and scope. While **technical capacity** in Bhutan is rapidly expanding, external technical expertise is still required in specialized fields. The Government of India is the major donor in developing health services and facilities in the 9FYP. The Danish government has also been a supporter of the health programme. Other contributors include bi-

lateral partners and the UN system. Assistance provided in the form of food items are aimed at improvement of general nutrition intake and meeting objectives of primary school enrolment or community participation. Food aid assistance is anticipated to be less than 2 percent of total external assistance. The two yearly Round Table Meetings are the highest level of aid coordination between the Government and external partners and at the same time provides all development partners an opportunity to deliberate on issues of common interest.

25) The **main agencies involved in mobilizing external assistance**: The Planning Commission determines the main priority sectors and programs which need to be accentuated. The Ministry of Finance assesses the requirement of external assistance and its utilization together with the line agencies. The Ministry of Foreign Affairs is responsible for dialogue with development partners.

26) With an objective to further enhance the alignment of the country's long-term planning path with the MDGs through a collaborative effort of all key stakeholders, the Planning Commission Secretariat [PCS], in collaboration with the UNDP and the UN Country Team (UNCT) is undertaking a **MDG Needs Assessment and Costing** exercise to estimate how much resources the country would require to achieve the MDGs by 2015. Once finalized [expected by December 2006], the MDG Needs Assessment and Costing report will provide comprehensive and flexible financial models and policy recommendations, which the Government and its partners could use to discuss development scenarios for achieving the MDGs, as well as estimates of resource needs from the Government and donor sources.

27) The Royal Government plans on refining the cost of attaining MDGs, and during the Tenth Plan will start using the "Alternative Planning Framework (APF)" that would result in a structured transfer of greater resources to the local level while at the same time tracking expenditures, the good governance initiatives strengthen and supplement such efforts. To provide maximum flexibility for the APF, the Government has requested development partners to consider a change in the mode of external assistance financing from project-tied to program-type assistance and budgetary support. In line with the draft Constitution and the Good Governance Plus Report which recommended greater fiscal decentralization all Dzongkhags and Gewogs shall be entitled to financial resources from the government in forms of annual grants. Resource allocation among the central sectors and agencies will be based on justification of proposed programmes vis-à-vis overall national priorities and objectives.

Chapter 4- Development and use of monitoring instruments to track WFFC targets since 2002

28) A mid-term review is carried out halfway through the National FYPs. For the *Dzongkhag*, the mid-term review of the plan is undertaken in individual *Dzongkhags* and attended by people representatives. This has been an effective monitoring and evaluation mechanism where the outcome is fed back into the remainder of the FYP. The large number of programs supported by various donors had resulted in an emergence of different monitoring and evaluation systems over the years. The Planning Commission Secretariat is currently developing National Monitoring and Evaluation System., Gross National Happiness numerical indicators to measure GNH are currently being developed by the Center for Bhutan Studies. The Royal Government also recognized the severe limitations of a poorly integrated database for the developmental planning process and thus efforts were made at all levels of the government, *Dzongkhag*, and *Geog* to improve information systems and networks. The Planning Commission will focus on monitoring and evaluation (M&E) at outcome levels to ensure that plan performances are consistent with the defined indicators. The Department of National Budget will monitor annual budget performance in terms of outputs.

Box 1: List of Relevant Surveys

1. The *National Health Survey* (NHS) 2000, provides data on health;
2. The *Gender Pilot Study 2001* was first of its kind to analyse gender differences and roles in the country
3. The *Bhutan Urban Poverty Study* (BUPS) 2001 on urban poverty in Thimphu and Phuentsholing
4. The *Bhutan Living Standards Survey* (BLSS) 2003 provides information on health and education as well as detailed consumption module that facilitates the determination of poverty and inequality indicators and poverty proxies. The *Poverty Analysis Report* (PAR) 2004 based on the BLSS 2003 presents community level data on a number of dimensions of well-being including education, health, environment, communications etc;
5. The *National Labour Force Survey* (NLFS) 2004 has data on unemployment, underemployment and participation rates;
6. The *Bhutan Housing and Population Census* (BHPC) 2005: is the first country wide census, conducted in May 2005 and enhanced attempts to making available disaggregated data by gender, age, urban and rural, *Dzongkhag* and even *Gewog*. The level of disaggregated data now available will be instrumental for isolating and addressing gaps through critical analyses and is a major step to develop disaggregated poverty data to design more focused and targeted poverty intervention measures.

29) Concerning the improvement of data collection, the Central Statistical Organization-restructured into an autonomous body, the National Statistics Bureau [NSB] in 2004- has nearly doubled its trained staff in order to improve its work in all 20 *Dzongkhag*, and closely worked with the Office of the Census Commissioner to conduct the **first National Population and Housing Census** in May 2005, the outcome of which has largely been the source of data for this report. This exercise also helped in refining baseline indicators for Bhutan, both for the urban and rural areas. The NSB is developing a disaggregated data base that will require time to test and to train people on its usage. The Royal Government's development partners are jointly working together to support the government in developing disaggregated data in all sectors. Once in place, data will be improved and more effective planning, monitoring and evaluation can take place, particularly in determining the gaps in reaching vulnerable groups. Training and capacity building have been provided to various counterparts to

improve data collection and to plan for a gender disaggregated data bank including the use of the **Druk Info**, an information system for children and women are being developed.

30) In addition, the Ministry of Education is in the process of developing an **Education Monitoring and Information System** [EMIS], which is expected to improve monitoring, reporting, and programming in the education sector. Also, the Ministry of Health has the **Health Management Information System** [HMIS] for improvement in the quality of health care and management, identification of problems; performance evaluation, strategic planning and optimizing the use of limited financial resources require information. Linkages between these systems and the financial management information system will be reinforced. By training user groups, the capacity for collection and analysis of education and health related data will be strengthened and accessibility to and dissemination of general statistical information will be improved through information technology. The recently revitalised **Maternal Death Investigation System** falls under the umbrella of the HMIS and works to gather and utilise data specifically related to maternal mortality, and provide an accurate insight into the causes, age and area profiles, and other relevant details of maternal fatalities. The Maternal Death Investigation System has already impacted on programming by expanding availability of oxytocin at BHUs after results showed that the leading cause of maternal death was post partum haemorrhage. Therefore, the recent efforts to improve monitoring and evaluation are expected to impact programming in the near future in similar ways.

31) In addition to national indicators used to measure human development progress, Bhutan has also embraced **international benchmarks** for improving the quality of life for its people. The adoption of the **Millennium Declaration**, at the United Nations Millennium Summit in September 2000, sets several numerical and time-bound goals in key development areas. The **first MDG Report** for Bhutan reveals significant gains toward achieving the Goals and is potentially on track for most targets. The **2005 MDG progress report** also shows the country remains on track for meeting most of the income and non-income MDGs and is ahead of the region with respect to progress in meeting some MDGs. Bhutan published in 2000 its **first National Human Development Report**, "*Gross National Happiness and Human Development—Searching for Common Ground*" that focused on development challenges that touched areas of concern to global UN conferences, including high population growth, employment of educated youth and rapid urbanisation. That first Report measured and reported on human development progress in Bhutan for the first time, tracing rapid socioeconomic achievements attained since planned development began in 1961. The **second National Human Development Report** "*The Challenge of Youth Unemployment*" published in 2005 updates the assessment of human development, with focus on the challenge of youth employment in view of its immense relevance to Bhutan. The **operationalisation of GNH**, which entailed transposing cultural, social, spiritual and environmental consciousness into development priority setting, has been conducted in Bhutan essentially through the Five Year Plans. Four main pillars of GNH have been elaborated to guide public policy: equitable socio-economic development, conservation of the natural environment, promotion of cultural heritage, and establishment of good governance.

32) Bhutan **ratified the Convention on the Rights of the Child** [CRC] in 1990 and submitted its initial report to the Committee on the Rights of the Child in February, 1999. At its 715th and 716th meetings (*see CRC/C/SR. 715-716*), held on 5 June, 2001, the Committee considered the initial report of Bhutan (CRC/C/3/Add.60) and adopted the concluding observations which recognized positive developments and made recommendations for improvement. The second report of Bhutan will shortly be submitted to the Committee. As a reaffirmation of its commitment to child rights, **Bhutan has signed the Optional Protocols** to the CRC on the sale of children, child prostitution and child pornography, and on the involvement the involvement of children in armed conflict in September, 2005.

33) The Ministry of Labour and Human Resources, established in 2003, will undertake regular monitoring to assess compliance of businesses and employers. With laws now in place to protect women and children from exploitation through trafficking and commercial sex work (although not a

major problem), NCWC works towards **improving surveillance, protection, prevention, and rehabilitation** in coordination with the Women and Child Protection Unit under Royal Bhutan Police, which is under establishment, and other agencies. Given that human trafficking is a trans-border problem, Bhutan's entry into Interpol will help Bhutan improve cooperation in this area with neighbouring countries.

Chapter 5 – Enhancing partnerships, alliances for children and participation

National Based Partnership

34) The **National Commission for Women and Children** [NCWC] was formally launched on May 6 2004 to promote and protect children's and women's rights. With the Secretary of Health as Chairman, the Commission meets quarterly and has established its office in the capital, Thimphu. NCWC has the following mandate; reporting functions, providing a forum for receiving and investigating reports on the violations of the rights of children and women, and reviewing policies/actions/legislations pertaining to women and children including making recommendations to the government. The *Assessment of Protection Factors for Vulnerable Children in Bhutan* was conducted with a child sensitive approach, and sought responses and views of 300 children through child-friendly interviews and discussion groups. The *National Consultation on Violence Against Children* was organized in April 2005, aimed at providing a broad national forum to discuss the issues of violence against children, the prevailing forms of violence, and its causes. The report of the Consultation was presented at the Regional Consultation on Violence against Children in Islamabad, Pakistan in May 2005.

35) A key element in implementing anti-tobacco initiatives and HIV/AIDS prevention was to involve the Buddhist clergy, considering their strong moral influence on society. This synthesis of religious beliefs and basic health care education is widely acknowledged by national health authorities to have extended into other health issues. Advocacy messages have been widespread to all Bhutanese to take preventive measures and the imperative to extend to all HIV patients the utmost compassion and care, and to avoid any kind of discrimination against those who are infected. The advocacy on HIV/AIDS to reach out and communicate to all sections of Bhutanese society has been championed by the Bhutan UNFPA Goodwill Ambassador.

36) The **Parliamentarians and local government representatives** from the two districts of Western Bhutan (Haa and Paro) were briefed on the CRC and the CEDAW. This Briefing represented the start of a nationwide briefing on these two Conventions. The trained local representatives are guided by national policy to raise awareness on children and women issues with their respective local government bodies of the DYT and GYT. Also, a handbook "*Child Protection: A Handbook for Parliamentarians*" has been submitted for translation in Dzongkha and distribution.

37) The **Royal Court of Justice** (RCJ) works towards developing women and child friendly judicial procedures. The RCJ and the NCWC jointly organized a **National Consultation on Women and Child Friendly Judicial Procedures** in March 2006 to identify gaps and explore areas in this respect, resulting in an 8 point recommendations adopted as the Gedu Recommendations. The RCJ has lectured various schools and institutions on legislations, emphasizing on issues related to rights and duties of children for better protection of rights, as part of its "*Know the Law to Protect Your Rights*" campaign. Presently the RCJ is working towards establishing a Juvenile Bench and is considering the establishment of a Family Court.

38) The **Royal Bhutan Police** [RBP] together with the NCWC organized a **National Consultation on Women and Child Friendly Police Procedures**, in October 2005 to deliberate on various concerns related to women and child friendly procedures, and the development of a complaints mechanism. Representatives from RBP, national gender focal points, and representatives from the RCJ, members of the NCWC, and UNDP participated in the consultation. Based on these discussions, 16 recommendations were made, some of which are being implemented such as the establishment of the **Women and Child Protection Unit** within the police force.

39) A number of activities to build the capacities of **gender focal points** representing the different government agencies and autonomous organizations and to sensitise **policy makers on gender issues and on gender analysis and mainstreaming** have been pursued. Also such initiatives as the Gender sensitization Workshop for Policy Makers, Capacity Building of National Gender Focal Points in Gender Mainstreaming, and Training Workshop on Gender Analysis and Mainstreaming have proved to be important inputs for the development of the draft **National Plan of Action for Gender**.

40) **Youth information centres** were established in Phuentsholing and Thimphu, in 2000. These centres provide access to information on Reproductive Health, career opportunities, and have organized youth forums, and dramas for students and out of school youth. In 2005, for example, the centres conducted a substance abuse workshop for disadvantaged children and those who are not employed. Volunteer groups, including students and young working adults have started organizing fund raising activities, youth forums, and discussions on health, sanitation, drug abuse, HIV/AIDS, and other issues. Skills training continue for teachers, health workers, and briefings for parents and community leaders in the districts to encourage them to seek the views of children. Other activities to increase child participation include the Boys and Girls Scouts, programmes and the Youth Guidance and Counselling Division under the Ministry of Education.

41) Existing systems of **community mobilization** are based on informal mutual assistance that by tradition are self-reliant and contribute voluntary labour and materials for community events. People also cooperate for shared resources such as water, or footpaths, or grazing land, and when building houses or labour/capital-intensive agricultural activities. Following the passing of the Cooperative Act in 2001, the Government has been encouraging the formation of agricultural cooperatives which would offer channels for voluntary activity and a potential forum for community concerns.

42) Several new **non-governmental organisations and associations/Trust Funds** have been established such as the National Women's Association of Bhutan, the Health Trust Fund, the Bhutan Chamber of Commerce and Industry. More recent initiatives are RENEW, the Youth Development Fund and Tarayana. RENEW was founded in response to the needs of disadvantaged women and young girls, and has established support groups in communities (pilot project in 6 zones in Thimphu) and training volunteers in gender awareness, basic counselling skills and data collection. The Youth Development Fund (YDF) is carrying out an increasing number of activities to care for the disadvantaged youth in the country. For example, YDF funds the Vocational Training Centre for the Disabled, Drak-Tsho, and REWA, a recovering community for substance abusers in Thimphu. The Tarayana Foundation was founded in 2003 to help the needy, poor and socially and economically disadvantaged people in the country through sponsorship, maintenance allowances for people living in difficult circumstances, sponsoring students in disadvantage circumstances, supporting needy patients to receive medical care and other charity works.

43) Literature on the CEDAW and the CRC, Bhutan's Initial and Combined reports, and the Committee's recommendations has been widely circulated and are posted on the PCS and NCWC websites. The Royal Government, in cooperation with development partners and relevant NGOs have developed training packages for teachers, law enforcers, health workers, and guidance counsellors that include perspectives on women and child rights. UNICEF and the Royal Government produced flyers, books, and resource materials on both CEDAW and CRC for use in schools and public distribution. Programme Communications is done frequently through BBS and Kuensel, the first newspaper in Bhutan, and more recently the Bhutan Times and Bhutan Observer, which are two private newspapers that began circulation in 2006. Also, Bhutan's first private Radio Station Kuzoo FM began operations in September 2006 with specialized focus on children and youth. The Media Act and existing regulations ensure that children are protected in stories of rape and juvenile crime. In the media, names are not used in news stories involving youth below 18 years, particularly in stories related to rape and child abuse. Where students are involved, the media avoids using the names of schools to protect the youth. The juvenile section in the Civil and Criminal Procedure Code of Bhutan (Ch. 44),

ensures full representation of juveniles by their parents. The print and broadcast media is also represented among the members of NCWC and the Gender Focal Point Network.

International Based Partners

44. The development partners have been supporting the socio-economic development of the country since planned development began in the 1960s. Since then, inline with the policy of achieving economic self-reliance, continuous efforts have been made to harness and utilize the available resources in the most productive and judicious manner. Hence, Bhutan has come to a stage where it is now able to finance through our domestic revenue all recurrent expenditures which form about half the total budget outlay of the Ninth Five Year Plan. However, the need for external assistance is still very prominent. The capital expenditures are being financed through external grants and loans. The government's policy is to mobilize assistance through grant financing before resorting to loans.

45. Bhutan receives external assistance in diverse areas of development. In the context of improving the lives of children, the development partners have supported numerous government initiatives which have come a long way in giving the Bhutanese children better opportunities in life.

46. UNICEF is one of the main organizations that support the government in enhancing the quality of life for children. They support initiatives in improving quality and access to education, better health care for children and mothers, increased protection for children from abuse, violence and exploitation and support to NCWC. UNDP's focus in areas such as poverty reduction, promotion of GNH and gender empowerment has consequent positive impact on the well being of children. UNFPA supports in increasing the availability of services and information on reproductive health including HIV/AIDS and also advocacy for population and development strategies. WHO is generally involved in the Health sector and due emphasis is placed on the four priority areas of WHO – Health for all policy development, health system development, protection and promotion of health, and prevention and control of disease and disability. Promotion of child and adolescent health, prevention of HIV/AIDs and immunization and vaccine development are some of the relevant projects supported by WHO. WFP is primarily involved in the school feeding programme with the Ministry of Education

47. India is the largest development partner for Bhutan and today, it provides programme and project tied support in various sectors including health and education. Budgetary support for Health and Education sectors are also granted by Danida for implementation of the Ninth Five Year Plan priorities. JIAC contributes to improving accessibility to education and other bilateral donors such as Canada and the Swiss are involved in improving quality of education and enhancing sports for children.

48. World Bank loans support major projects such as the Education Development Project which aims to built and upgrade secondary schools and improve quality of education. Government initiatives in prevention and control of HIV/AIDS and STI are also being supported.

49. Besides the various development partners mentioned above, there are many others who have contributed directly or indirectly towards improving the lives and opportunities of the Bhutanese children. The contribution of the development partners will still remain to be most critical in any sphere of socio-economic development for the country.

Chapter 6 – Achievements of WFFC Plan of Action and related MDG targets

Box 2: Matrix for WFFC Goals and Relevant MDGs

MDGs / MD		WFFC Themes and Targets
MDG 1	Poverty & Hunger	Relevant targets under <i>Promoting healthy lifestyles</i>
MDG 2 & 3	UPE & Gender	Targets under <i>Promoting quality education</i>
MDG 4	Infant Mortality	Relevant targets under <i>Promoting healthy lifestyles</i>
MDG 5	Maternal Health	Relevant targets under <i>Promoting healthy lifestyles</i>
MDG 6	HIV/AIDS/Malaria/Others	Targets under <i>Combating HIV/AIDS</i> relevant targets in <i>Promoting healthy lifestyles</i>
MDG 7	Environment	Relevant targets under <i>Promoting healthy lifestyles</i>
MDG 8	Global Partnership	Relevant targets or actions under Mobilizing resources
MD	CRC Articles	Targets under <i>Child protection against abuse, exploitation & violence; commitments relating to the rights of children</i>

WFFC 1: Relevant Targets under Promoting Healthy Lifestyles

44) The country remains on track to achieve the goal of reducing poverty in half by 2015. Indications from the Poverty Analysis Report 2004 suggest potential elimination of poverty by 2013 on the basis of sustained equitable economic growth and effective implementation of targeted poverty interventions. The proportion of Bhutanese living under the poverty line decreased by more than a percentage point a year from 36.3% in 2000 to 31.7% in 2003. On the basis of household units, 24.7% of all Bhutanese households were poor in 2003 as compared to 27.1% in 2000. The target of reducing by half those suffering from poverty is regarded by the Royal Government as the appropriate national target than that of halving extreme poverty, although efforts will continue towards completely eliminating any forms of extreme poverty. According to PAR 2004, poverty affects only 4.2% of the country's urban population in contrast to 38.3% of the rural population, and 93% of Bhutan's poor live in rural areas of which 95% depend on semi-subsistence agriculture for their livelihood. Substantial progress was made since 2001. About 78.2 % of Bhutanese villages now have access to health facilities within two hours walking distance, and about 89 % have such services within three hours walking distance. The 2005 census reported electricity as the main source of lighting in 40% of rural households, followed by kerosene (51.3%). One objective set in the 10th FYP Guidelines is to increase coverage under the rural electrification project to 84%. Although cooking with firewood may not be ideal with respect to health, at last count, 22% of the population was using inexpensive stoves designed to use less fuel and minimize smoke.

45) Various improvements occurred in health related indicators denoting an enhanced situation for children in Bhutan. The 2005 census allowed for calculation of various indicators, all showing great progress since the 2000 National Health Survey. Improvements were seen for **the Infant Mortality Ratio (IMR) and Under-five Mortality Ratio (U5MR)** between 2000 and 2005 when the IMR decreased from 60.5 to 40.1 and U5MR from 84.0 to 60.6. The major causes of under-five deaths and morbidity in the country are due to acute respiration infections (ARI), diarrhoea and worm infestation. Additionally, malnutrition remains a key underlying cause of child morbidity and mortality even as vast improvements have been made on this account.

46) A key factor for the sharp declines in child mortality has been attributed to the successful **expanded programme of immunization (EPI)**. One major achievement for child survival and development was introduction of Rubella immunisation, through a combined Measles-Rubella vaccine in 2006. This was initiated through a nation-wide measles-rubella campaign in early 2006

with close to 100% coverage, which will be followed up by introduction of the combined vaccine into the routine system. Following the launch of the EPI in 1979, the country achieved **universal child immunization** in 1991. The national immunization levels are based on coverage for BCG, diphtheria, tetanus, pertussis, poliomyelitis, measles and hepatitis B. The average coverage levels for these antigens for children with proper immunization cards showed that 89.7% of all children were fully vaccinated while 10.3% were partially vaccinated. Vaccination coverage for TT2 though remains very low at 46.15%. Sustaining UCI gains and expanding immunization coverage, introducing new vaccines, and strengthening surveillance are to be implemented under the Immunization Plus programme.

47) The figures for 2005 presented in Table 2.7 are based on administrative data from the Ministry of Health for number of women attending at least one ANC clinic (numerator) and census data for the total number of live births (denominator) while the 2000 figures are based on a sample survey. In spite of potential discrepancies with regard to the ANC attendance rate, available figures indicate that it is likely to be high. High ANC attendance may have contributed to the **Zero maternal and neonatal Tetanus** status maintained between 2002 and 2005.

48) The **Institutional Delivery Rate** more than doubled from 19% in 2000 to 42% in 2005 and indicators for **skilled attendant at birth** or deliveries attended by a trained health professional increased to 55% in 2005 from 36.5% in 2000. [Table 1.1] Although there is no update for **Maternal Mortality Ratio** (MMR), process indicators such as ANC attendance and institutional delivery rate are important to track progress in women's health. Like many other countries Bhutan is struggling with a problem of deficient registration, reporting and analysis of maternal deaths with an ensuing problem of under registration of such deaths. The small population size and low number of annual births make MMR neither a satisfactory nor a useful indicator to monitor progress over short periods of time. An improved notification of maternal deaths will be indispensable for the future.

49) As reported in the first MDG Report, there is **no evidence of widespread hunger** in Bhutan but certain pockets of the country do experience transient food insecurity and seasonal hunger. While there is insufficient data to assess progress in halving the percentage of population suffering from food energy deficit, the country is extremely well placed to do so. Child nutrition has improved steadily over the last decade as has the national situation on micronutrients. On the basis of the caloric intake, Bhutan does not suffer from lack of food for its population. It is adjudged that only 3.8% of the population currently does not meet the required caloric intake of 2,124 Kcal per day, but this is not due to the lack of food. As figures for previous years were not estimated, progress towards halving this figure from 1990 cannot be assessed. Estimating progress toward the goal using an even more ambitious target, i.e. of halving the existing 2004 figure down to 2.1% by 2015, this still remains comfortably achievable. Furthermore, the PAR 2004 report estimates that bringing the percentage of people living below 2,124 Kcal to 0% could potentially be achieved within the MDG timeframe of 2015 or probably by 2020. All these strongly suggest an **excellent rate of progress toward attainment of the target** on the basis of this indicator.

50) The incidence of food deficiency is closely associated with under-nutrition, particularly among children. Severe malnutrition is rare and trends in the nutritional status of Bhutan's children are positive with marked improvements. The percentage of **under-five children who are underweight has been halved** from 38% in 1989 to 19% in 2000 and the MDG target in regard to this acute under-nutrition indicator has been achieved. There had been rapid progress in reducing the incidence of **stunting or the height deficits** in relation to age for under-five children. Stunting has been reduced from 56% in 1990 to 40% in 2000. The country currently remains on track in regard to this indicator too but further reductions are expected to be more difficult to come by due to the well-known constraints of the last mile effect and hence will require sustained efforts. The available indicator for **prevalence of wasting** was 2.6% in 2000. There are no data on the prevalence of low birth weight or proportion of children weighed. The *2002 National Anaemia Survey* found women and children to be at highest risk for **anaemia** with prevalence rates of 28% for men, 55% for women of childbearing

age and 81% for children under 2 years of age. These figures, however, are derived after considering "altitude correction". Programmes are being implemented to address anaemia using a life cycle approach, such as through a school iron supplementation programme initiated in 2004 which provides a weekly iron-folate tablet and a 6 monthly de-worming tablet to school going girls and boys and a similar programme for non-formal education learners, most of whom are women. Provision of iron tablets to pregnant and post partum women have also been ongoing. In 2001, the Royal Government reported 95% iodised salt consumption at the household level and in 2003, Bhutan was the first country in the region to be declared as having **eliminated iodine deficiency disorder** by an independent evaluation led by the *Network for the Sustained Elimination of Iodine Deficiency*. This was a remarkable achievement given the marked iodine deficiency in Bhutan in the past, with a 65.4% goitre rate in 1983, which was last estimated at less than 5%.

51) Access to **safe drinking water** has improved considerably since 1990. The proportion of population with access to safe drinking water increased from 45% in 1990 to 78% in 2000 and to 84.3% in 2005. The target of reducing by half those without access to safe drinking water has thus already been achieved. In 2005, access to an improved water source was estimated to be 78.2% in rural areas (83.4% national; 98.0% urban) and access to improved sanitation facilities 81.8% in rural areas (81.0% national; 79.1% urban) (Table 1.1). Almost all of those with access to improved water had piped water within or outside of the house, The other major water source in rural areas was classified as spring/river/pond (19.9%) by the census, and so actual coverage may be higher, but it is not possible to ascertain given that protected spring and protected well sources were not included as a separate category. **Access to basic sanitation**, defined and understood to mean access to a minimum facility of a pit latrine, has improved substantially in the country. In 1990, 33% of the country's population did not have access to basic sanitation, which improved considerably by 2000 during which only 12% did not have basic sanitation facilities, and which increased slightly to 19% in 2005 (Table 2.6).

52) **Malaria and Tuberculosis** remain major public health concerns for Bhutan. Rapid progress has been made in reducing the incidence of both diseases and the goals to halt and reverse their spread are potentially achievable. There is a more uncertainty though about the prospects of reversing malaria fully. The number of **confirmed malaria cases** in 2004 was 2,670, down from 22,126 in 1991 and 38,901 in 1994. There has been a downward decline in the number of confirmed malaria cases and malarial mortality, though this has been marked by sharp fluctuations that indicate periodic resurgences and outbreaks. Along with the decline in malarial morbidity, mortality from malaria too shows a general decrease. From 63 deaths caused by malaria in 1993, only fifteen deaths were recorded in 2000 and five in 2004. Most deaths occurred among those who sought treatment late after the onset of symptoms. From these trends it would appear that the incidence of malaria has been reversed and the goal of halting it is potentially achievable. However, this can be viewed within the light of the complexity of the epidemiology of the disease and possible resurgences and outbreaks recur and new variants emerge. Hence, there is every need to strengthen and sustain ongoing efforts at controlling and containing malaria.

53) The incidence of **Tuberculosis** has declined significantly from 720 cases per 100,000 in 1990 down to 168 in 2000 and 133 in 2004. On the basis of these steep declines, it is highly probable that the goal of halting and reversing the spread is achievable. As reflected in tale 6.3, TB related deaths were erratic and averaged 45 deaths a year. At 133 cases per 100,000, Bhutan still has a high tuberculosis burden in the region. In 2004, the country reported 1002 cases out of which 598 were pulmonary TB. Even as in absolute terms the numbers are small, they still represent a matter of serious public health concern for two reasons. One is that of these pulmonary cases, most were highly infectious cases. Additionally, the other cause of concern is that given TB is the most opportunistic infection among HIV/AIDS cases, there are serious implications of the rising spread of HIV/AIDS infection in Bhutan.

54)

55) The growth of **lifestyle diseases** that reduce life expectancy have serious resource implications, since these non-infectious diseases are expensive to treat. With decline in death rates, Bhutan has started to experience certain signs of an epidemiological transition. Even as leading causes of death of the past such as diarrhoea, respiratory infections, tuberculosis and malaria remain important causes of mortality and morbidity; lifestyle-related diseases – *cancer, cirrhosis and heart and hypertensive diseases* – have emerged as prominent health problems since the early 1990s. In 2002 leading causes of reported deaths were cardiovascular disorders (14.5 percent) and liver cirrhosis (9.3 percent). Tobacco use had increased over the years, particularly among the younger generation, who constitute a large part of the country's population. In addition, the rapid rise of lung cancer and other tobacco-caused illnesses have emerged as major causes of concern that constitute a serious health challenge, not only from a medical perspective, but from the real possibility that these preventable lifestyle diseases could create a major economic burden on limited health resources. With the promotion of **healthy lifestyles as a strategic health policy** in the early 1990s, tobacco control was identified as a priority focus area and extended the highest level of political commitment. A tobacco control programme was launched in 1998 that introduced several new initiatives and integrated past tobacco control measures in a more focussed, sustained manner. Multi-sectoral task forces at the district level also were set up to implement programme activities and mobilise grassroots support.

WFFC 2: Relevant Targets under Promoting Quality Education

56) Bhutan is on track towards achieving WFFC 1 and parallel MDG 2 of ensuring universal primary education but more attention needs to be given to enhancing the primary net enrolment rate (NER) and securing a higher primary completion rate. The Royal Government perceives achieving universal primary education not only in terms of numbers but through the quality of the basic education available. Improving the quality of primary education thus constitutes an important challenge that the Royal Government will be addressing on a priority basis as it simultaneously pursues the realization of this second MDG.

57) The impact of efforts in primary education is evident through the most recent enrolment figures. Bhutan's **primary NER increased** between 2003 and 2006 moving from 70.2 (67.1 girls; 73.4 boys) to 79 (79 girls; 80 boys) (Table 3.4). Although the rapid increase in primary NER may in part be due to the decreased population uncovered in the census in 2005, with 7,075 more girls and 4,206 more boys enrolled in primary classes in 2006 than in 2002 (Table 3.3), progress is obvious. Bhutan is now at par with the regional primary NER for South Asia (Table 3.2). In addition, the **gender gap for primary NER has virtually been eliminated**; being only 1% in 2006 while the gender gap in South and West Asia is 11.7.

58) The proportion of students starting grade 1 who reach grade 5 has increased steadily from 73% in 1990 to 91% in 2000 and 96% in 2004. As the full primary cycle in Bhutan starts from grade Pre-Primary (PP) through to grade 6, this indicator has also been included. The proportion of students starting grade 1 who reach grade 6 was 87.7 for girls and 81.1 for boys in 2005 (Table 3.6). All efficiency indicators for primary classes improved between 2002 and 2005 with girls doing better than boys. Drop out and repetition rates for class VI improved from 11.6% and 5.7% in 2002 to 3.5% and 3.3% in 2005.³ In 2005, for classes PP and V, girls were doing slightly better than boys while in class VI they were doing the same (Table 3.6). In addition, the student survival rate to class VI improved between 2002 and 2005 from 72.6 (77.3 girls; 68.6 boys) to 84.4 (87.7 girls; 81.1 boys)⁴. This indicates that once in the school system, girls are given an equal opportunity for success as boys up to the end of primary classes.

59) In 2002, **free basic education was expanded** from class VIII to X and the MoE successfully brought schools closer to rural and remote children with the establishment of 60 more CPS and 6

³ Ministry of Education (2006) General Statistics Royal Government of Bhutan

⁴ Ministry of Education (2002) General Statistics Royal Government of Bhutan AND Ministry of Education (2006) General Statistics Royal Government of Bhutan

more Primary Schools in remote areas (Table 3.1). As some CPS do not house all primary level classes, it was decided during the 9th Annual Education Conference⁵ in 2005 that all CPS will offer classes PP to VI as much as possible, with multi-grade teaching in case of low student numbers. This is expected to decrease drop out, especially among girls, given that they are able to continue studying up to class VI in a school near home.

60) It is estimated that about 3.5 percent of the total population has some form of **disability** acquired before or after birth as a result of childhood illness, genetic factors, micro-nutrient deficiencies and accidents. Prevention of physical and mental disability and rehabilitation form an important component of primary health care. The National Institute for the Disabled which currently educates and trains visually impaired children is being diversified to include programs for children with other disabilities. The Royal Government's strategy is based on **integration of disabled children into regular classrooms**, instead of taking them away from their families and communities. A multi-sector group has been formed to initiate community-based rehabilitation programs, to integrate health care, education and training with the ultimate objective of helping disabled children to become productive members of the society. The NID provides instruction in reading and writing Braille so that children skilled in Braille can be integrated into regular schools toward the end of the primary cycle. All children with disabilities and special needs - including those with physical, mental and other types of impairment - should, therefore, be able to access and benefit from education. This will include full access to the curriculum, participation in extra-curricular activities and access to cultural, artistic, recreational and leisure activities. A small number of schools in each Dzongkhag will be equipped with appropriate resources for enabling children with disabilities to access education locally. The NID will be developed as a resource center to support education for the visually impaired children and a Braille production unit will be set up at NIE Paro to ensure curriculum and relevant materials are available in Braille for these children. A support center for the deaf will be set up in one of the schools to support hearing impaired children. A special education unit has been established within the Department of Special Education.

61) Bhutan has made impressive progress towards ensuring **gender equity in education**. The number of girls to boys at the primary and secondary education levels are now virtually at par. The achievement of complete gender parity at these levels is well on track and the target for these levels is most likely to be achieved by 2005. The ratio of girls to boys at the primary level has been steadily rising from 0.69 in 1990 to 0.99 in 2006. The **student survival rate** up to the end of the primary cycle has also been consistently higher for girls with the rate climbing each year. In 2005, the student survival rate for boys was at 81.1% as compared to 87.7% for girls.⁶ Gender parity at the secondary level classes of VI to X was 0.98 in 2006 (Table 3.3). However, the girl to boy ratio drops to 0.71 for the secondary classes of XI and XII, which are not yet part of the basic education system provided free of cost by the government. Likewise, there has been significant progress in reducing the gender parity at the tertiary education level. The number of pupils studying at the different institutes that make up the Royal University of Bhutan was 3,525 (1,135 girls; 2,390 boys; 0.47 girl boy ratio) in 2006. In 2006, the female to male ratio was highest for the Royal Institute of Health Sciences (0.86) and the two National Institutes of Education (0.60) and lowest at the National Institute of Traditional Medicine (0.04) and the Natural Resource Training Institute (0.11). In 2006, the female to male ratio for pupils in science related courses (B.Sc. in Physical, Biological or Computer Science) at Sherubtse College of the Royal University of Bhutan was 0.30 compared to 0.56 for non science courses (BBA, Bachelors in Commerce, BA in English, Dzongkha, Geography or Economics).⁷ Progress toward the goal has been satisfactory but needs to be accelerated through targeted interventions on facilitating the transition of girls into tertiary education, including technical and vocational education, if there is to be any realistic prospects for attaining the target.

⁵ Ministry of Education (2006) *Ninth Annual Education Conference Report and Resolutions* Royal Government of Bhutan

⁶ Ministry of Education (2002) *General Statistics* Royal Government of Bhutan. AND Ministry of Education (2006) *General Statistics* Royal Government of Bhutan

⁷ Royal University of Bhutan (2006) *Staff and Student Statistics of May 2006 (Brochure)*. Royal Government of Bhutan.

62) It was possible to calculate **secondary Gross Enrolment Ratio (GER)** for the first time using denominator data from the 2005 census and numerator data from the Ministry of Education's enrolment figures (Table 3.7) from which future progress can be tracked. The 2006 GER for classes VII to X was 58 (girls 57; boys 59) and 27 (girls 22; boys 31) for classes XI to XII. Enrolment in secondary level classes is entirely in urban areas given that all MSS and HSS are situated in urban or semi-urban areas. Students from rural areas are enrolled in these schools as boarders. The proportion of students in these schools that are from rural areas is not known. Given that secondary GER is not available prior to 2006; it is difficult to ascertain if progress occurred with respect to enrolment ratios since the WFFC declaration. Progress is however evident in the increased numbers enrolled in classes VII to X (5,118 more girls; 3,668 more boys) and classes XI and XII (1,668 more girls; 1,957 more boys) between 2002 and 2006 (Table 3.3).

63) The **student survival rate up to class VIII** does point to better status for girls with an improved rate between 2002 and 2006 from 62.1 (67.5 girls; 57.8 boys) to 75.0 (79.2 girls; 71.0 boys). Given that girls are on par with boys for promotion, repetition and drop out and do better than boys in overall survival to class VIII, it is evident that once in the school system, girls are given an equal opportunity for success up to class VIII.

64) Regarding **the gender parity index**, progress was also seen in increased girl to boy ratios between 2002 and 2006 for classes VII to X (from 0.87 to 0.98) and classes XI and XII (from 0.61 to 0.71) (Table 3.3). The greatest increases were seen in classes IX (0.12), X (0.17) and XI (0.12). The 2006 girl to boy ratio for classes XI to XII were higher in private schools (1.00) than public schools (0.55).⁸ This may be due to the fact that girls do not perform as well as boys on examinations, and so do not gain access to higher secondary classes in public schools. It does indicate an interest among girls to participate in secondary education given the opportunity and willingness of families to support the studies of girls on par with boys.

65) **National literacy rate** increased from 54 % to 60 %. With the efforts made to expand the Non-formal Education programme, especially for rural women, and the increase in primary enrolment, Bhutan's literacy rates have passed the regional and are moving towards the global averages. Progress was seen for adult females and females aged 15 to 24, for whom the reported literacy rate increased from 14.3% to 39% and from 48.9% to 68% between 2003 and 2005, respectively (Table 3.8). Progress in rural areas was also seen with an increase from 22.0% to 44% for adults and from 52.5% to 68% for 15 to 24 year olds.

66) **Women in Bhutanese society** enjoy equal legal status as well as a fair degree of equality of opportunity. Gender gaps in the labour force where female participation has traditionally been lower for Bhutanese women are because many women continue to be primary caregivers in families and are engaged in family responsibilities. In 2003, female labor force participation stood at 54% as compared to 72.5% for men. Women also have a slightly higher unemployment rate (2%) as compared to men (1.6%). The annual labor force surveys also reveal for instance, in 2003, that 87% of employed women worked primarily in the agricultural sector as compared to 69.9% of men. The percentage of women in private business presents a positive picture with virtual parity in the numbers of trade and hotel establishments run and operated by women. Notably, some of the most successful entrepreneurs and business leaders in the country are women. Additionally, a gender study in 2001 revealed that in terms of equality in property distribution, women owned 60% of the land in rural areas while in urban areas, they owned 45% of all assets such as shares, properties and business establishments. The annual Bhutan Labour Force Surveys reports unemployment rates have increased from 1.9 percent to 2.7 percent between 1998 and 2003. Although not a high level of unemployment it draws attention to the need for policy and interventions. The Ministry of Labour and Human Resources was created in 2003 to establish policies and strategies to enhance employment. Bhutanese women in the National Assembly, in public administration, and in decision-making positions though are under-represented.

⁸ Ministry of Education (2006) General Statistics Royal Government of Bhutan

67) In the National Assembly, percentage of elected people's representatives increased to 16% between 1990 and 2004 but this still remains low. The number of women in civil service stands at 23% as compared to 19% in 2000 and 12% in 1990.

WFFC 3: Relevant Targets under Child Protection against Abuse, Exploitation and Violence

68) There are no reports of female infanticide and organized trafficking of women and children in Bhutan. Figures for the indicator [early marriages covering girls 15-19 years of age currently married or in union] show 14.3 percent in 2003 with a slight increase to 15.4 in 2005. The prevalence is higher in rural areas at 18.7 compared to 9.8 for urban areas in 2005. Data for other indicators are not available, or are not at all relevant for Bhutan such as female genitalia mutilation. [Table 1.1 Goal 3 Child Protection] Major initiatives and actions for child protection have been discussed under the relevant Chapter 2, and future initiatives are dealt with in Chapter 7.

WFFC 4: Combat HIV/AIDS

69) Bhutan is at the early phase "*nascent low-grade HIV epidemic*" and so has the opportunity to avert a full-scale **HIV/AIDS** epidemic. Since the first HIV/AIDS case was detected in 1993, 21 people have died. The current HIV prevalence rate is 0.01%, and assuming that only 10% to 20% of cases have actually been detected, this would mean that while the numbers in themselves are small it still represents a rising trend of HIV infection from 38 in 2000 and 72 as of February 2005, to 90 confirmed cases as of October 2006. Projections based on various scenarios indicate that with adequate prevention controls in place, the HIV infection would peak by 2012 and subsequently be reversed. As the supportive policy framework and environment is extremely strong, it is reasonable to expect that this MDG target of halting and reversing the spread of HIV/AIDS can be achieved. Attaining the target, however, will be critically dependent on the effective implementation of relevant prevention programmes, particularly raising the condom usage levels and promoting widespread awareness and knowledge about HIV/AIDS. Additionally, there can be no complacency about the efforts to combat and contain the growth of HIV infection as the country faces several risk factors. These include proximity to population groups in the region with high HIV prevalence rates, presence of sex workers in border towns, high mobility across borders, the relatively common incidence of sexually transmitted diseases, the emerging issue of substance abuse and the country's youthful demographic profile.

70) The *Exploratory Study on HIV/AIDS 2005* found 89% of youth were aware of HIV/AIDS. Even when people are aware of the dangers, they do not necessarily take appropriate action. The risk assessment study in 2003 found, for example, that only 22% of people were consistently using condoms, while the rest did so irregularly or never. One reason that they gave for not using condoms was that there were none in their village or that they were shy of going to health facilities to collect them. There was also a study in 2003⁹ of people living with HIV/AIDS. This found that they were very fearful of the stigma they may face with the possibility of discrimination in employment. There were also concerns about the lack of counselling and of confidentiality in testing. Previously, most of the detected cases were in the two principal urban centers of Thimphu and Phuentsholing, but the infection has now spread to other towns, including rural areas. Also, with the exception of a single case, all known HIV infections earlier had been contracted through heterosexual sex. The situation has changed with cases detected among wives and children of infected males through Mother to Child Transmission. The average age of infection among cases reported between 1993 and 2002 was 23 years for women and 32 years for men¹⁰. The prevalence of HIV infection now was found to be highest in the productive age group of 25-39

71)

⁹ Study Report on PLWHA in Bhutan. STI & HIV/AIDS Programme, Department of Public Health 2004
¹⁰ HIV/AIDS Issue Brief: Bhutan. Washington, World Bank 2005

72) Bhutan does not have an established commercial sex industry and sex work is illegal. However, mobile groups such as long-distance drivers and traders, migrant workers and the armed forces are potentially at risk and may accelerate the spread of HIV/AIDS. A study of some of these groups in 2003 found that migrant workers had had up to 12 sexual partners, soldiers up to 20, and truck drivers up to 280¹¹. A 2005 report on out-of-school youth, found that more than half had sexual experience, and that the boys on average had had around 10 partners¹². Of the 90 detected HIV cases, 7 were commercial sex workers, 5 of which were non-Bhutanese.

73) The emergence of sex workers, majority of who are non-Bhutanese, can be mainly attributed to the porous borders. In 2004, a study showed that majority of the HIV/AIDS cases detected, admitted to having had sex with a sex worker. In 2000, the Ministry of Health's findings of high-risk "sero-surveillance" in Phuentsholing had revealed that 72% of sex workers (majority of whom were non-Bhutanese), tested had syphilis, a sexually transmitted disease that is an important factor in HIV infection. Starting in 2005, children infected by mother to child transmission were also detected and the first HIV orphans declared, so the disease profile is changing. Programmes thus far have been hampered by a lack of knowledge about how the epidemic is spreading in Bhutan and the limited resources and staff available to the Ministry of Health. This will work through a National HIV/AIDS Commission chaired by the Ministry of Finance. The project has four main components: *prevention; institutional strengthening and capacity building; care, support and treatment; and surveillance and information gathering* with the broad objective to ensure everyone who is diagnosed as HIV-positive will have access to anti-retroviral treatment, especially pregnant mothers in order to prevent mother-to-child transmission.

74) The total fertility rate among 15 to 49 year olds decreased from 4.7 in 2000¹³ to 2.5 (2.1 urban; 2.7 rural) in 2005 (Table 2.4), and the general fertility rate also decreased from 142.7 in 2000 to 86.4 (75.3 urban; 92.5 rural) during the same time period. Both **crude birth and crude death rates** decreased from 34 and 8.6 per 1,000 population, to 20 and 7, as such decreasing the rate of natural death from 2.55 to 1.3. Although age specific fertility rates for 15 to 19 and 20 to 24 year olds have decreased significantly between 2002 and 2006 (Table 2.4), one area for further improvement is pregnancy among young girls. In 2005, 11% of all births were among 15 to 19 year olds and 10.2% of all 15 to 19 year olds reported having at least one child.¹⁴ Although there is no update on the **contraceptive prevalence rate**, the decrease in fertility rates indicate success of the efforts aimed at increasing awareness on and access to family planning services. The last figures available in 2000, however, show an increasing trend for contraceptive prevalence rate which increased from 18.8% in 1994 to 30.7% in 2000. Looking specifically at available data for condom usage against other contraceptive methods, the *1994 Annual Health Bulletin* indicates that only 4% of those utilizing contraceptives reported using condoms. This has however increased three fold to 13% in 2000. No current data are available beyond 2000 for this indicator. Even as there has been a rapid increase in the numbers of those using condoms, there is considerable scope for expanding the usage rates.

¹¹ *Assessment of Risk and Vulnerability to STI and HIV/AIDS in Bhutan STI & HIV/AIDS Programme, Department of Public Health 2004*

¹² *Exploratory Study on HIV/AIDS Issues Affecting Out-of-School Youth in Bhutan* ICB, Ministry of Health, ROYAL GOVERNMENT and UNICEF Bhutan 2005

¹³ *Ministry of Health (2000). A Report National Health Survey 2000. Royal Government of Bhutan.*

¹⁴ *Calculated using information sourced from (Table 5.2 live births by age group, Table 5.4 child ever born, and Table 3.4 Total population by age) from Office of the Census Commissioner (2006) Results of Population and Housing Census of Bhutan 2005 RCoB*

Chapter 7-Summary of lessons learned and future initiatives

75) Factors impeding the implementation towards meeting some of the WFFC Goals and relevant MDG target, and of some of the provisions of the Convention on the Rights of the Child are the difficult mountainous terrain, relatively recent socio-economic development, the pressures posed by high population growth on the provision of social services and the shortage of human and economic resources.. Constraints that further impede progress toward achieving related WFFC goals are poverty and hunger, including challenges of accelerating growth and investment in agriculture, improving quality of and access to essential rural social services, promoting rural employment and industry, mitigating rising income inequalities and strengthening the collection of poverty data and poverty monitoring and evaluation. Remote and isolated communities are more vulnerable to poverty than those with adequate road access and links to markets. At the household level, there appears to be a clear correlation between poverty incidence and the level of educational attainment. Insufficient poverty data in the past did not permit an accurate projection and despite strong pro-poor development policies and interventions, the Bhutan Poverty Analysis Report 2004 revealed that 31.7% of total population fell below the national poverty line. The generally lower levels of adult literacy and educational attainment among females can also be potentially linked to the finding in the PAR 2004 of a slightly higher incidence and severity of poverty among female-headed households. More specifically, the country is faced with the important task of strengthening agriculture growth and promoting rural income generation through: raising agricultural productivity, diversification into cash crops , export of high value niche agriculture commodities, continued strengthening of animal husbandry and horticulture support, creating an enabling environment to attract and retain young people in rural areas, expanding and intensifying rural development.

76) A strategic meeting point of poverty alleviation is balanced regional development and removing existing disparities in access to social services and market opportunities between rural and urban areas. With the devolution of major decision powers to the local governments under the decentralization program, the quality of local governance will be critical to ensure the effective ownership and management of local development and economic activities as these evidently have a significant bearing and impact on poverty alleviation. This had previously been severely challenged by the lack of reliable data and analytical information and the weak poverty monitoring and evaluation institutional capacity. In an effort to address the above challenges, the priorities for action are to further develop rural road infrastructure and other linkages and access to markets; improve access to and quality of social services, particularly education; strengthen rural access to IT services to prevent the emergence of a digital divide; develop a coherent poverty policy framework; adequately sequence and initiate targeted poverty interventions; and strengthen institutional capacity for poverty data collection, monitoring and evaluation .

77) Bhutan will potentially attain the MDG goal of reducing child mortality provided sustained levels of partner support are addressed and intensification of efforts to improve access to child health care services for hard to reach communities are met. Basic preventive and curative health services have increased their overall population coverage from 70% to 90%, complemented by rapid progress in better water supplies and sanitation, extending health services to the more remote areas, and developing basic and equitable systems in difficult terrain. Attaining universal coverage however for institutional water supply will prove to be a significant challenge. There are also issues of quality and hygiene, access difficulties to water sources and seasonal variations that mark the essential differences between rural and urban water supply and sanitation facilities.

78) Bhutan has made up an enormous amount of ground in improving the health of mothers in the country. This is broadly attributable to general developments such as the enhanced socio-economic well-being of the population, improved health standards and better access to and quality of

reproductive health services, including prenatal care. Despite progress seen, the prevailing low levels of adult literacy among women constitute a major barrier for substantive progress towards promoting gender equality and women's empowerment. Achieving the related WFFC goals and MDG targets for eliminating gender disparities in education and empowering women are dependent on greater levels of participation of women in the national economy and in decision making, which in turn will depend vastly on how effective national policies are in increasing the access of women into tertiary level education and vocational training programmes. The gender parities at primary and secondary education levels need to be translated into a greater proportion of females enrolling in institutions of higher education.

79) The lack of age and gender-disaggregated data in the country had previously been a major constraint in formulating appropriate policy responses. However, improvements have been made with the availability of data from the NPHC 2005, strengthening of the monitoring system in Bhutan through the National Statistical Bureau and in line ministries. As per the draft NPAG a revisiting of policies and legislations from a gender equity perspective which will have direct bearings on child concerns will be undertaken.

To ensure that disabled children receive good quality education within pilot centres and later in any school where they are enrolled, a process for identifying disabled children at pre-school age and for assessing their educational and health needs will be established. Cooperation of the parents of disabled children to send their children to school will be sought. This will require intensive advocacy work to develop positive attitudes toward disability among heads of schools and teachers, as well as within the general public, in order to gain commitment to the overall policy. School physical infrastructure must be modified to allow access for disabled children, with suitable classroom equipment, and transport to allow disabled children to travel from home to school. A specific section of the curriculum, teaching and learning resources will reflect the needs of disabled children.

80) In regard to WFFC 3 goals on child protection against abuse, exploitation and violence relevant laws have been enacted and others already drafted will be enacted soon. Further, gathering and analysis of disaggregated data at national/local levels and formulation of measurable outcomes/indicators for tracking progress in activities and programmes will be improved upon during the forthcoming plan period. In addition, NCWC will work with the Woman and Child Protection unit of the RBP and the Ministry of Health to develop a standardised data collection format on protection issues.

81) There remain several challenging concerns in addition to the constraints of risk factors highlighted in the first MDG Status Report that must be addressed in scaling up the national response in battling the spread of the infection and ensuring effective care for people living with HIV/AIDS. Mechanisms and activities that exist to contain the spread of the HIV/AIDS infection had been constrained by the lack of a national policy and plan of action on HIV/AIDS. A national policy directive on HIV/AIDS now guides concerned agencies to articulate the strategic approach for preventing mother to child transmission, providing anti-retroviral treatment, ensuring full care and support for people living with HIV/AIDS, and implementing other high impact preventive measures. The formulation of an effective and sensible national policy on HIV/AIDS requires more detailed data and information on risk factors, vulnerable groups, transmission modes, etc. The lack of adequate and precise information is thus a considerable constraint in this regard.

82) Bhutan continues to depend on donors, bilateral and multilateral organizations and international NGOs for funding for programmes for child rights and development. Ensuring the long-term financial sustainability of providing free and quality health care services, particularly in meeting the rising recurring costs of vaccines and medicines, will prove a major resource challenge. The following priority areas for example in relation to education and training in which cooperation with development partners would be particularly beneficial are expansion of non-formal education and implementing other relevant measures to raise literacy rates among women, particularly in rural areas;

Analytical study on the situation and causes of low transition of females from higher secondary to tertiary levels, particularly, technical, professional and vocational education; and Advocacy and promotion of appropriate proactive measures to enhance female enrolment in higher education

83) Service delivery costs are rising rapidly, especially as public investments in infrastructure and an array of social services are extended deeper into Bhutan's remote communities. The provision of social infrastructure in education, public health, transportation, and employment; provided free or at minimal direct cost to the public is a severe development challenge.

ANNEXURE

Annexure

ANNEX 1: LIST OF TABLES

TABLE SERIES 1: WFFC INDICATORS SUMMARY [1 TABLE]*Summary Table 1.1 Summary of Progress for Available World Fit For Children Indicator Data for Bhutan*

Indicators	Baseline						Update					
	Total	Male	Female	Urban	Rural	Year	Total	Male	Female	Urban	Rural	Year
Goal 1 – Healthy Lives												
Under-five mortality rate	84.0	NA	NA	NA	NA	2000	61.6	65.5	57.6	52.8	65.5	2005
Infant mortality rate	60.5	NA	NA	NA	NA	2000	40.1	42.8	37.4	32.8	43.4	2005
Maternal mortality ratio	255.0			NA	NA	2000	NA			NA	NA	
Skilled attendant at birth	36.5%			NA	NA	2003	55%			NA	NA	2005
Institutional Deliveries	19%			NA	NA	2000	42%			NA	NA	2005
Underweight prevalence	18.7	20.1	17.2	NA	NA	1999	NA	NA	NA	NA	NA	
Stunting prevalence	40.0	42.8	37.3	NA	NA	1999	NA	NA	NA	NA	NA	
Wasting prevalence	2.6	3.1	2.1	NA	NA	1999	NA	NA	NA	NA	NA	
Low birth weight	15	NA	NA	NA	NA	1999	NA	NA	NA	NA	NA	
Infants weighed at birth	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2005
Use of improved drinking water sources	78.0					2000	84.3			98.0	78.2	2005
Use of improved sanitation facilities	88.0					2000	81.0			79.1	81.8	2005
Exclusive breastfeeding rate (<4 months)	40	NA	NA	NA	NA	2000	NA	NA	NA	NA	NA	
Antenatal care				NA	NA	2000	110%			NA	NA	2005
Contraceptive prevalence rate	30.7			NA	NA	2000	NA			NA	NA	
Gross fertility rate	142.7			NA	NA	2000	86.4			75.3	92.5	2005
Total Fertility rate	4.7			NA	NA	2000	2.5			2.1	2.7	2005
Solid Fuels	NA			NA	NA							2005
Tuberculosis immunization coverage	NA	NA	NA	NA	NA	2002	NA	NA	NA	NA	NA	2005
Polio immunization coverage	94.9	NA	NA	NA	NA	2002	95.0	NA	NA	NA	NA	2005
Immunization coverage for DPT	93.5	NA	NA	NA	NA	2002	95.0	NA	NA	NA	NA	2005

ANNEXURE

Indicators	Baseline						Update					
	Total	Male	Female	Urban	Rural	Year	Total	Male	Female	Urban	Rural	Year
Measles immunization coverage	91.0	NA	NA	NA	NA	2002	93.0	NA	NA	NA	NA	2005
Hepatitis B immunization coverage	91.6	NA	NA	NA	NA	2002	95.0	NA	NA	NA	NA	2005
Fully immunized children	89.7	NA	NA	NA	NA	2002	89.4	NA	NA	NA	NA	2005
Neonatal tetanus protection	46.1	NA	NA	NA	NA	2002	NA	NA	NA	NA	NA	2005
Iodized salt consumption	95			NA	NA	2001	NA			NA	NA	
Goal 2 – Education												
Net Primary Intake Rate (Administrative data)				NA	NA	2002				NA	NA	2006
Primary school net enrolment ratio				NA	NA	2002	79	80	79	NA	NA	2006
Primary school net attendance rate	70.2	73.4	67.1	NA	NA	2003	NA	NA	NA	NA	NA	
Secondary school gross enrolment ratio (VII to X)	NA	NA	NA	NA	NA		58	59	57	NA	NA	2006
Secondary school gross enrolment ratio (VII to XII)	NA	NA	NA	NA	NA		48	50	46	NA	NA	2006
Survival rate to grade 5 (Administrative data)		NA	NA	NA	NA	2002	94	NA	NA	NA	NA	2004
Primary completion rate	NA	NA	NA	NA	NA					NA	NA	2006
Literacy rate (15 to 24 year olds)	57.84	68.26	48.91	79.61	52.55	2003	74	80	68	84	68	2005
Literacy rate (15 +)	33.45	49.29	14.34	58.55	22.02	2003	53	65	39	72	44	2005
Primary Gender Parity Index	0.89			NA	NA	2002	0.96			NA	NA	2006
Secondary Gender Parity Index (VII to X)	0.87			NA	NA	2002	0.98			NA	NA	2006
Secondary Gender Parity Index (VII to XII)	0.61			NA	NA	2002	0.71			NA	NA	2006
Child Protection												
Early marriage: 15-19 yr old girls currently married/in union	14.3			NA	NA	2003	15.4			9.8	18.7	2005
HIV/AIDS												
Prevalence of orphans	NA	NA	NA	NA	NA	NA						2005

Box in grey are not relevant. NA is not available

ANNEXURE

TABLE SERIES 2 - WFFC INDICATORS FOR HEALTH [7 TABLES]

Healthy Lives Table 2.1 Infant and Under-Five Mortality Rates in 2005

Dzong-khag	Total U1 deaths ¹	Total U5 deaths ¹	Live Births ²	IMR ³	U5MR ⁴
NATIONAL	503	772	12,538	40.1	61.6
Urban	126	203	3,845	32.8	52.8
Rural	377	569	8,693	43.4	65.5
Female	233	359	6,232	37.4	57.6
Male	270	413	6,306	42.8	65.5
Female-Rural	167	261	4,330	38.6	60.3
Female-Urban	66	98	1,902	34.7	51.5
Male-Rural	210	308	4,363	48.1	70.6
Male-Urban	60	105	1,943	30.9	54.0
Bumthang	8	11	285	28.1	38.6
Chhukha	38	111	1,248	30.4	88.9
Dagana	17	26	435	39.1	59.8
Gasa	0	1	72	0.0	13.9
Ha	3	11	205	14.6	53.7
Lhuentse	16	20	321	49.8	62.3
Mongar	42	59	832	50.5	70.9
Paro	13	17	613	21.2	27.7
Pemagatshel	13	17	270	48.1	63.0
Punakha	11	12	349	31.5	34.4
Samdrup Jongkhar	51	65	818	62.3	79.5
Samtse	40	67	1,182	33.8	56.7
Sarpang	45	66	830	54.2	79.5
Thimphu	56	82	1,866	30.0	43.9
Trashigang	68	93	1,082	62.8	86.0
Trashiyangtse	13	18	426	30.5	42.3
Trongsa	12	13	292	41.1	44.5
Tsirang	9	14	384	23.4	36.5
Wangdue	35	47	650	53.8	72.3
Zhemgang	13	22	378	34.4	58.2

1. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan) (Table 5.8).

2. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan) (Table 5.1)

3. IMR Calculated as follows: [Total number of deaths among under 1 year olds] divided by [total number of live births] multiplied by [1000].

4. U5MR Calculated as follows: [Total number of deaths among under 5 year olds] divided by [total number of live births] multiplied by [1000].

Healthy Lives Table 2.2 Antenatal Clinic Attendance in 2005

Dzong-khag	Number that Attended at Least One ANC Clinic ¹	Total Births ²	% that Attended at least one ANC clinic
National	13,818	12,538	110%
Bumthang	289	285	101%
Chhukha	1,686	1,248	135%
Dagana	335	435	77%
Gasa	54	72	75%
Ha	164	205	80%
Lhuentse	356	321	111%
Mongar	760	832	91%
Paro	682	613	111%
Pemagatshel	288	270	107%
Punakha	475	349	136%
Samdrup Jongkhar	967	818	118%
Samtse	1,273	1,182	108%
Sarpang	1,125	830	136%
Thimphu	2,456	1,866	132%
Trashigang	958	1,082	89%
Trashiyangtse	344	426	81%
Trongsa	241	292	83%
Tsirang	374	384	97%
Wangdue	609	650	94%
Zhemgang	382	378	101%

1. Ministry of Health (2006). Annual Health Bulletin 2005. Royal Government of Bhutan.

ANNEXURE

2. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan) (Table 5.1)

Healthy Lives Table 2.3 Percent of Attended Deliveries in 2005

Dzong-khag	% Deliveries Attended by a Health Staff ¹	Institutional Delivery Rate ²	% of Deliveries Attended at Home by Trained Health Staff ³	% of Deliveries Attended by Trained Health Staff (home and institutional) ⁴
National	51%	42%	13%	55%
Urban	75%	NA	NA	NA
Rural	40%	NA	NA	NA
Bumthang	47%	33%	27%	59%
Chhukha	59%	32%	7%	38%
Dagana	30%	10%	9%	19%
Gasa	43%	0%	29%	29%
Ha	60%	23%	2%	25%
Lhuentse	28%	22%	21%	43%
Mongar	34%	38%	16%	54%
Paro	70%	61%	7%	68%
Pemagatshel	32%	2%	14%	16%
Punakha	61%	37%	15%	52%
Samdrup	42%	36%	20%	55%
Samtse	45%	55%	10%	65%
Sarpang	51%	72%	18%	90%
Thimphu	79%	84%	1%	85%
Trashigang	36%	25%	20%	45%
Trashiyangtse	26%	12%	13%	25%
Trongsa	47%	20%	28%	48%
Tsirang	50%	49%	28%	77%
Wangdue	54%	16%	8%	25%
Zhemgang	45%	19%	30%	48%

1. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan. (Calculated using number of births attended by a health professional (Table 5.6) divided by number of live births (Table 5.1).

2. Ministry of Health (2006) Annual Health Bulletin (AHB). Royal Government of Bhutan. AND Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan. (Calculated using number of births attended in a health facility (Annex 3, AHB) divided by number of live births (Table 5.1, Census).

3. Ministry of Health (2006) Annual Health Bulletin (AHB). Royal Government of Bhutan. AND Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan. (Calculated using number of births attended in at home by trained health personnel (Annex 3, AHB) divided by number of live births (Table 5.1, Census).

4. Ministry of Health (2006) Annual Health Bulletin (AHB). Royal Government of Bhutan. AND Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan. (Calculated using total attended deliveries at home and health facility (Annex 3, AHB) divided by number of live births (Table 5.1, Census).

Healthy Lives Table 2.4 Age Specific Fertility Rates in 2005

Age Group	National	Urban	Rural
15 to 19	36.5	22.1	44.9
20 to 24	138.9	115.3	154.4
25 to 29	141.6	138.8	143.2
30 to 34	89.4	78.1	95.3
35 to 39	54.5	39.5	61.3
40 to 44	31.3	18.8	35.3
45 to 49	9.9	7.1	10.7
Total Fertility Rate³	2.5	2.1	2.7
Gross Fertility Rate ⁴	86.4	75.3	92.5

1. Ministry of Health (2000) A Report National Health Survey 2000. Royal Government of Bhutan

2. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005 Royal Government of Bhutan (Calculated using the number of births in the last year for each age group (Table 5.2) divided by the total female population in each age group (Table 3.4)).

3. for 2005, used the following formula [(sum of age specific fertility rates) x 5] / 1000

4. for 2005, used the following formula [total number of births in year preceding the census] divided by [total female population aged 15 to 44]. These figures were from Table 5.2 and Table 3.4 respectively of the 2005 census referenced above.

ANNEXURE

Healthy Lives Table 2.5 District-Wise Fertility Rates, Crude Birth Rate, Crude Death Rate and Rate of Natural Increase in 2005

Dzong-khag	Total Rate ¹	Fertility Rate ¹	Gross Fertility Rate ¹	Fertility Rate ¹	Crude Birth Rate ²	Crude Death Rate ³	Rate of Natural Increase ⁴
National	2.5		86.4		20	7	1.30
Urban	2.1		75.3		20	5	1.50
Rural	2.7		92.5		20	8	1.20
Bumthang	2.5		84.9		18	7	1.07
Chhukha	2.1		74.2		17	7	0.98
Dagana	3.2		107.1		24	7	1.69
Gasa	3.1		114.1		23	12	1.11
Ha	2.5		79.5		18	7	1.06
Lhuentse	3.1		99.1		21	8	1.29
Mongar	3.0		99.5		22	8	1.44
Paro	2.1		71.0		17	7	0.98
Pemagatshel	3.1		93.8		19	8	1.15
Punakha	2.6		83.1		20	8	1.17
Samdrup Jongkhar	2.7		92.9		20	6	1.45
Samtse	2.3		84.1		20	8	1.17
Sarpang	3.0		95.8		20	6	1.40
Thimphu	2.1		75.1		19	6	1.29
Trashigang	2.9		95.3		21	9	1.22
Trashiyangtse	3.5		112.7		24	9	1.50
Trongsa	3.0		101.3		22	8	1.38
Tsirang	2.7		90.1		21	7	1.36
Wangdue	2.8		95.0		21	8	1.29
Zhemgang	3.0		96.1		20	6	1.43

1. As per description under Table 12.3

2. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan. (Calculated using the number of births in the last year (Table 5.2) divided by the total population (Table 3.4)).

3. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan. (Calculated using the number of deaths in the last year (Table 5.2) divided by the total population (Table 3.4)).

4. Calculated using the following formula [crude birth rate – crude death rate] / 10

Healthy Lives Table 2.6 Access to Improved Water and Sanitation Facilities in 2005

Dzong-khag	Access to Improved Water Facilities ¹			Access to Improved Sanitation Facilities ²		
	<i>National</i>	<i>Urban</i>	<i>Rural</i>	<i>National</i>	<i>Urban</i>	<i>Rural</i>
Bhutan	84.3%	98.0%	78.2%	81.0%	79.1%	81.8%
Bumthang	92.1%	97.6%	90.1%	90.1%	87.2%	91.1%
Chhukha	83.2%	98.0%	70.1%	76.1%	85.1%	68.1%
Dagana	56.1%	85.0%	53.3%	83.5%	82.4%	83.6%
Gasa	47.7%	100.0%	40.9%	74.7%	86.9%	73.1%
Ha	87.7%	97.6%	85.5%	80.7%	83.3%	80.1%
Lhuentse	87.6%	98.3%	86.7%	83.2%	84.3%	83.1%
Mongar	82.0%	98.0%	78.8%	85.2%	87.1%	84.9%
Paro	87.5%	97.2%	86.7%	81.4%	74.6%	82.0%
Pemagatshel	87.0%	98.9%	85.3%	85.2%	74.9%	86.5%
Punakha	85.4%	100.0%	83.8%	81.0%	75.5%	81.6%
Samdrup Jongkhar	84.1%	96.1%	79.8%	83.5%	76.4%	86.1%
Samtse	75.8%	98.5%	70.5%	77.1%	58.2%	81.6%
Sarpang	86.4%	98.9%	80.9%	80.9%	74.2%	83.9%
Thimphu	96.3%	98.7%	86.6%	79.2%	79.8%	76.6%
Trashigang	83.1%	99.3%	81.2%	82.4%	83.8%	82.3%
Trashiyangtse	86.1%	95.2%	84.6%	87.4%	75.8%	89.4%
Trongsa	83.8%	93.4%	81.5%	78.3%	75.8%	79.0%
Tsirang	76.6%	97.3%	74.2%	85.5%	83.6%	85.7%
Wangdue	81.5%	96.3%	77.1%	81.1%	75.4%	82.9%
Zhemgang	77.8%	97.1%	74.0%	82.0%	80.6%	82.3%

1. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005, Thimphu: Royal Government of Bhutan. (Calculated from Table 5.18 (p 223) using the following as improved: (1) Piped water within house; (2) Piped water outside house; and (3) rainwater collection). Therefore, the actual coverage may be higher as some may be using protected springs or protected tube wells, but given that the categories were not distinct (e.g. category of spring/river/pond and artificial pond/tube well) could not include any other categories).

2. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005, Thimphu: Royal Government of Bhutan. (Calculated from Table 5.21 (p 231) using the following categories as improved: (1) Independent Flush toilet inside house; (2) Independent Flush toilet outside house; (3) VIDP latrine outside house; and (4) Pit latrine).

ANNEXURE

Table 2.7 Change in Number of Health Staff and Health Facilities between 2002 and 2005

Health Staff/ Health Facility	2002 ¹	2005 ²	Change
Medical Doctors	122	145	23
Assistant Clinical Officer	0	32	32
B.Sc. Nurses	5	14	9
General Nurse Midwives (GNM)	174	202	28
Health Assistant	173	210	37
Auxillary Nurse Midwives (ANM)	145	134	-11
Basic Health Worker	175	171	-4
Assistant Nurses	176	174	-2
Hospitals	29	29	0
Basic Health Units	166	176	10
Out Reach Clinics	455	485	30

1. Ministry of Health (2002). Annual Health Bulletin Royal Government of Bhutan
 2. Ministry of Health (2006). Annual Health Bulletin 2005 Royal Government of Bhutan

TABLE SERIES 3 - WFFC INDICATORS FOR EDUCATION [8 TABLES]

Education Table 3.1 Number of Schools and Institutes between 2002 and 2006

School Type	2002 ³					2006 ⁴					Change (Total)
	Urban	Semi Urban	Rural	Remote	Total	Urban	Semi Urban	Rural	Remote	Total	
Community Primary	2	16	78	86	182	4	29	66	146	245	63
Primary Schools	11	13	38	35	97	14	9	24	41	88	-9
Lower Secondary Schools	23	24	11	7	65	25	21	25	13	84	19
Middle Secondary Schools	16	11	0	0	27	17	11	0	0	28	1
Higher Secondary Schools	9	3	0	0	12	20	1	0	0	21	9
Private Schools ²	13	1	0	0	14					23	9
Tertiary Institutes					9					9	0
Vocational institutes					5					6	2
Non Formal Education					256					646	390

1. In 2006, categories were broken down to remote (87), very remote (56) and difficult (3). All three were put under remote for this table.
 2. In 2002, 9 were Primary Schools and 5 Higher Secondary Schools and in 2006, 16 were Primary Schools and 7 Higher Secondary Schools
 3. Ministry of Education (2002) General Statistics. Royal Government of Bhutan
 4. Ministry of Education (2006) General Statistics. Royal Government of Bhutan

Education Table 3.2 Primary Net Enrolment Ratio (NER)

	2003 ¹	2005 ²	2006 ²	South/West Asia ³	World ³
National	70.2	73	79	79.0	84.0
Girls	67.1	-	79	73.0	81.5
Boys	73.4	-	80	84.7	86.5
Gender Gap	6.3	-	1	11.7	5.0

Bhutan Living Standard Survey 2003. National Statistical Bureau, Royal Government of Bhutan, 2004.

Ministry of Education (2006) General Statistics. Royal Government of Bhutan

Education for All Global Monitoring Report, 2005. Accessed online on 08 July 2006, url http://portal.unesco.org/education/en/ev.php-URL_ID=36027&URL_DO=DO_TOPIC&URL_SECTION=201.html

Education Table 3.3 Numbers Enrolled and Girl to Boy Ratio between 2002 and 2006

Class	2002 ¹			2006 ²			Change between 2002 and 2006		
	# Girls	# Boys	G:B ratio	# Girls	# Boys	G:B ratio	# Girls	# Boys	G:B ratio
PP	7,500	8,104	0.93	8,193	8,676	0.94	693	572	0.01
I	6,987	7,841	0.89	7,467	8,079	0.92	480	238	0.03
II	6,779	7,747	0.88	7,899	8,210	0.96	1,120	463	0.08
III	6,058	6,889	0.88	7,307	7,465	0.98	1,249	576	0.10
IV	5,935	6,659	0.89	7,157	7,434	0.96	1,222	775	0.07
V	5,150	5,804	0.89	6,220	6,398	0.97	1,070	594	0.08
VI	4,529	4,962	0.91	5,770	5,950	0.97	1,241	988	0.06
PP to VI	42,938	48,006	0.89	50,013	52,212	0.96	7,075	4,206	0.07

ANNEXURE

Class	2002 ¹			2006 ²			Change between 2002 and 2006		
	# Girls	# Boys	G:B ratio	# Girls	# Boys	G:B ratio	# Girls	# Boys	G:B ratio
VII	4,313	4,546	0.95	5,600	5,614	1.00	1,287	1,068	0.05
VIII	3,368	3,761	0.90	4,651	4,617	1.01	1,283	856	0.11
IX	3,030	3,583	0.85	4,356	4,503	0.97	1,326	920	0.12
X	2,053	2,757	0.74	3,275	3,581	0.91	1,222	824	0.17
VII to X	12,764	14,647	0.87	17,882	18,315	0.98	5,118	3,668	0.11
XI	1,084	1,710	0.63	1,809	2,425	0.75	725	715	0.12
XII	616	1,067	0.58	1,559	2,309	0.68	943	1,242	0.10
XI to XII	1,700	2,777	0.61	3,368	4,734	0.71	1,668	1,957	0.10

1. Ministry of Education (2002) General Statistics. Royal Government of Bhutan

2. Ministry of Education (2006) General Statistics. Royal Government of Bhutan

Education Table 3.4 Primary Net Enrolment Ratio by District and Sex for 2006¹

Dzong-khag	Primary NER			Girl:Boy Ratio	Gender Gap
	Girls	Boys	Both Sexes		
National	79%	80%	79%	0.99	-1%
Bhumthang	95%	93%	94%	1.02	2%
Chukha	70%	71%	71%	0.99	-1%
Dagana	74%	76%	75%	0.97	-2%
Gasa	66%	69%	68%	0.96	-3%
Haa	88%	80%	84%	1.10	8%
Lhuentse	79%	83%	81%	0.95	-4%
Mongar	77%	78%	78%	0.99	-1%
Paro	88%	85%	86%	1.03	3%
Pemagatshel	89%	89%	89%	1.00	0%
Punakha	94%	83%	88%	1.13	11%
Samdrup Jongkhar	76%	81%	78%	0.94	-5%
Samtse	63%	67%	65%	0.95	-4%
Sarpang	71%	72%	72%	0.98	-1%
Thimphu	88%	86%	87%	1.03	2%
Trashigang	78%	87%	82%	0.90	-9%
Trashiyangtse	84%	89%	87%	0.95	-5%
Trongsa	94%	90%	92%	1.05	4%
Tsirang	67%	70%	68%	0.96	-3%
Wangdue	85%	81%	83%	1.05	4%
Zhemgang	90%	88%	89%	1.02	2%

1. Ministry of Education (2006) General Statistics. Royal Government of Bhutan

Education Table 3.5 Ratio of Girls to Boys in Primary Education by District

Dzong-khag	2002 ¹	2005 ²	2006 ³	Change between 2002 and 2005
National	0.89	0.95	0.96	0.06
Bumthang	1.04	1.03		-0.01
Chukha	0.87	0.93		0.06
Dagana	0.92	0.95		0.03
Gasa	0.89	0.87		-0.02
Ha	1.01	1.01		0.00
Lhuentse	0.88	0.98		0.10
Mongar	0.84	0.91		0.07
Paro	0.99	1.02		0.03
Pemagatshel	0.79	0.93		0.14
Punakha	1.03	1.05		0.02
Samdrup Jongkhar	0.78	0.93		0.15
Samtse	0.79	0.82		0.03
Sarpang	0.89	0.94		0.05
Thimphu	0.97	0.99		0.02
Trashigang	0.84	0.91		0.07
Trashiyangtse	0.91	0.96		0.05
Trongsa	0.97	1.01		0.04
Tsirang	0.83	0.91		0.08
Wangdue	0.97	1.05		0.08
Zhemgang	0.83	0.91		0.08

1. Ministry of Education (2002) General Statistics. Royal Government of Bhutan. (Calculated with Annex: Enrolment Details and Staff by School)

ANNEXURE

2. Ministry of Education (2005) General Statistics. Royal Government of Bhutan. (Calculated with Annex: Enrolment Details and Staff by School)

3. Ministry of Education (2006) General Statistics. Royal Government of Bhutan. (Calculated with Table 2.13)

Education Table 3.6 2006 Efficiency Indicators for Selected Classes¹

Efficiency Indicator	Classes						
	PP	V	VI	VII	VIII	IX	X
Girls							
Promotion Rate	92.6%	91.0%	94.3%	84.3%	93.0%	85.9%	90.6%
Repetition Rate	7.5%	5.5%	3.4%	8.9%	3.3%	7.3%	0.5%
Drop Out Rate	-0.1%	3.5%	2.3%	6.8%	3.6%	6.8%	8.9%
Adjusted Promotion rate	92.5%	91.0%	94.3%	84.3%	93.0%	85.9%	90.6%
Survivors to the Grade (per 1000 entering PP)	1000	911.3	877.4	856.6	792.5	762.6	706.7
Boys							
Promotion Rate	91.3%	88.5%	94.3%	84.1%	93.2%	90.6%	93.6%
Repetition Rate	8.6%	6.1%	3.4%	8.2%	2.8%	6.1%	0.4%
Drop Out Rate	0.1%	5.5%	2.3%	7.7%	4.0%	3.3%	6.0%
Adjusted Promotion rate	91.3%	88.5%	94.3%	84.1%	93.2%	90.6%	93.6%
Survivors to the Grade (per 1000 entering PP)	1000	861.5	811.4	775.3	710.1	680.9	657.0
Difference between Girls and Boys							
Promotion Rate	1.3%	2.5%	0.0%	0.2%	-0.2%	-4.7%	-3.0%
Repetition Rate	-1.1%	-0.6%	0.0%	0.7%	0.5%	1.2%	0.1%
Drop Out Rate	-0.2%	-2.0%	0.0%	-0.9%	-0.4%	3.5%	2.9%
Adjusted Promotion rate	1.2%	2.5%	0.0%	0.2%	-0.2%	-4.7%	-3.0%
Survivors to the Grade (per 1000 entering PP)	0.0	49.8	66.0	81.3	82.4	81.7	49.7

Ministry of Education (2006) General Statistics. Royal Government of Bhutan.

Education Table 3.7 Secondary Gross Enrolment Ratio (GER) for 2006¹

Class	Total Girls enrolled ¹	Total Boys enrolled ¹	Total population Girls ²	Total population Boys ²	Secondary GER	Secondary GER Girls	Secondary GER Boys	Gender Gap
VII	5,600	5,614	7,649	7,849	72%	73%	72%	1%
VIII	4,651	4,617	7,751	7,653	60%	60%	60%	0%
VII to VIII	10,251	10,231	15,400	15,502	66%	67%	66%	1%
IX	4,356	4,503	8,188	7,851	55%	53%	57%	-4%
X	3,275	3,581	7,992	7,543	44%	41%	47%	-6%
IX to X	7,631	8,084	16,180	15,394	50%	47%	53%	-6%
VII to X	17,882	18,315	31,580	30,896	58%	57%	59%	-2%
XI	1,809	2,425	7,412	7,251	29%	24%	33%	-9%
XII	1,559	2,309	7,580	7,831	25%	21%	29%	-8%
XI to XII	3,368	4,734	14,992	15,082	27%	22%	31%	-9%
VII to XII	21,250	23,049	46,572	45,978	48%	46%	50%	-4%

1. Ministry of Education (2006) General Statistics. Royal Government of Bhutan.

2. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005. Royal Government of Bhutan) (Table 3.5). Total Population given by age (i.e. 13 for class VII; 14 for class VIII, 15 for class IX, 16 for class X, 17 for class XI and 18 for class XII).

Education Table 3.8 Reported Literacy Rates

	2003 ¹		2005 ²		South Asia ³		World ³	
	Adult 15+	15-24 years	Adult 15+	15-24 years	Adult	14-24 years,	Adult	15-24 years
National	33.45%	57.84%	53%	74%	47.5%	61.5%	75.4%	84.3%
Urban	58.55%	79.61%	72%	84%				
Rural	22.02%	52.55%	44%	68%				
Female	14.34%	48.91%	39%	68%	34.3%	51.0%	69.1%	80.1%
Male	49.29%	68.26%	65%	80%	59.7%	71.1%	81.8%	88.2%
Females Rural			29%	61%				
Females Urban			60%	80%				
Males Rural			57%	75%				
Males Urban			80%	87%				
Ratio Of Literate Females To Males			0.51	0.74				
Ratio Of Literate Females To Males -			0.46	0.71				

ANNEXURE

Ratio Of Literate Females To Males - | 0.60 0.78

1. United Nations (2006). Common Country Assessment for Bhutan. (CCA is the secondary source; primary source is the Bhutan Living Standard Survey 2003. 2. National Statistical Bureau, Royal Government of Bhutan, 2004).
 3. Office of Census Commissioner (2006) Results of Population and Housing Census of Bhutan 2005, Thimphu: Royal Government of Bhutan. (Calculated using Table 6.4)
 3. Education for All Global Monitoring Report, 2005. Accessed online on 08 July 2006, url http://portal.unesco.org/education/en/ev.php-URL_ID=36027&URL_DO=DO_TOPIC&URL_SECTION=201.html

TABLE SERIES 4 - WFFC INDICATORS FOR CHILD PROTECTION [2 TABLES]

Child Protection Table 4.1 Percent of 10 to 14 and 15 to 19 year olds in marriage unions in 2005

Area/ Group	Age	Percent Currently Married ¹		Percent Currently or Previously Married ²		Percent Living Together ³	
		Girls	Boys	Girls	Boys	Girls	Boys
National							
	10 to 14	0.3%	0.1%	0.3%	0.1%	0.01%	0.02%
	15 to 19	15.4%	3.8%	16.1%	4.0%	0.21%	0.08%
Urban							
	10 to 14	0.1%	0.1%	0.1%	0.1%	0.02%	0.03%
	15 to 19	9.8%	1.5%	10.2%	1.6%	0.15%	0.07%
Rural							
	10 to 14	0.3%	0.0%	0.4%	0.0%	0.01%	0.02%
	15 to 19	18.7%	5.2%	19.5%	5.4%	0.25%	0.09%

Source: Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005 Royal Government of Bhutan

1. (Calculated using the number of people married by sex and age group (Table 3.12) divided by the total population in that sex and age group (Table 3.4).

2. (Calculated using the number of people married, widowed, divorced or separated by sex and age group (Table 3.12) divided by the total population in that sex and age group (Table 3.4).

3. (Calculated using the number of people living together by sex and age group (Table 3.12) divided by the total population in that sex and age group (Table 3.4)

Child Protection Table 4.2 District-Wise Percentages of Girls 10 to 14 and 15 to 19 Currently Married¹

Dzong-khag/ Age Group	National	Urban	Rural	
Bumthang				
	10 to 14	0.11%	0.00%	0.14%
	15 to 19	9.77%	8.59%	10.12%
Chhukha				
	10 to 14	0.50%	0.37%	0.61%
	15 to 19	16.51%	9.42%	24.40%
Dagana				
	10 to 14	0.70%	0.00%	0.78%
	15 to 19	20.84%	3.49%	27.75%
Gasa				
	10 to 14	0.00%	0.00%	0.00%
	15 to 19	23.13%	0.23%	26.85%
Ha				
	10 to 14	0.28%	0.00%	0.36%
	15 to 19	12.30%	4.49%	18.60%
Lhuentse				
	10 to 14	0.51%	0.00%	0.55%
	15 to 19	17.33%	4.55%	19.90%
Mongar				
	10 to 14	0.22%	0.00%	0.26%
	15 to 19	17.27%	5.82%	23.13%
Paro				
	10 to 14	0.05%	0.00%	0.05%
	15 to 19	8.92%	18.52%	8.16%
Pemagatshel				
	10 to 14	0.23%	0.00%	0.27%
	15 to 19	12.08%	5.88%	14.76%
Punakha				
	10 to 14	0.19%	0.00%	0.22%
	15 to 19	8.41%	2.77%	10.83%
Samdrup Jongkhar				
	10 to 14	0.31%	0.34%	0.31%
	15 to 19	21.14%	26.06%	19.60%

ANNEXURE

Samtse			
10 to 14	0.36%	0.00%	0.44%
15 to 19	22.02%	13.95%	23.94%
Sarpang			
10 to 14	0.69%	0.00%	0.99%
15 to 19	22.63%	16.42%	25.67%
Thimphu			
10 to 14	0.09%	0.09%	0.09%
15 to 19	10.28%	10.19%	10.77%
Trashigang			
10 to 14	0.25%	0.00%	0.28%
15 to 19	13.97%	3.29%	16.77%
Trashiyangtse			
10 to 14	0.18%	0.56%	0.10%
15 to 19	11.52%	3.27%	15.22%
Trongsa			
10 to 14	0.12%	0.00%	0.15%
15 to 19	13.47%	6.11%	15.77%
Tsirang			
10 to 14	0.24%	0.81%	0.18%
15 to 19	19.25%	14.56%	19.72%
Wangdue			
10 to 14	0.05%	0.00%	0.07%
15 to 19	14.89%	14.86%	14.90%
Zhemgang			
10 to 14	0.24%	0.00%	0.30%
15 to 19	16.65%	5.04%	22.22%

1. Office of the Census Commissioner (2006). Results of Population and Housing Census of Bhutan 2005 Royal Government of Bhutan (Calculated using number of people married by sex and age group and district (Table 3.13) divided by total population in that sex and age group (Table 3.4)

TABLE SERIES 5 WFFC INDICATORS FOR HIV/AIDS AND OTHER DISEASES [1 TABLE]

HIV/AIDS, Malaria and Other Diseases Table5.1 Indicator table 1 – Malaria and TB data

	199 4	199 5	199 6	199 7	199 8	199 9	200 0	200 1	200 2	200 3	200 4
Malaria prevalence per 100,000 people											
Female					924	0	677	678	721	412	282
Male					1,267	0	1,070	1,030	1,093	623	444
National	7,066	3,984	2,616	1,460	1,097	1,915	875	856	909	518	364
Death rate associated with malaria	8.51	6.70	4.50	2.26	2.67	3.35	2.21	2.00	1.54	2.04	0.68
TB prevalence per 100,000 people	367	299	370	305	240	339	390	180	145	144	148
Death rate associated with TB	4.08	10.65	8.50	5.33	8.62	6.08	3.69	6.72	5.72	3.40	3.00
Proportion of TB cases detected under DOIS (%)							70.0	70.0	69.0	69.0	69.0
							0	0	0	0	0

ANNEXURE

Proportion of the population with access to affordable essential drugs on a sustainable basis (%)	90.0	>90	>90	>90	>90	>90	>90
	0						

Sources: Prevalence and death rates are calculated using the number of cases reported in Annual Health Bulletins and the estimated national population of NSB. The accessibility of essential drugs can be equated with the proportion of health coverage as health care in Bhutan is free through the Primary Health Care approach

Note: In 2002, the TB prevalence per 100,000 people for South Asia was 343, and in the world 257.

ANNEXURE

ANNEX II: BIBLIOGRAPHY

- 1) RGoB *Assessment of risk and vulnerability to STI and HIV/AIDS in Bhutan*. Department of Public Health. (2004)
- 2) RGoB *Anaemia Among Men, Women And Children In Bhutan: How Big Is the Problem?* Study conducted for Ministry of Health and Education with financial and technical assistance from UNICEF.
- 3) RGoB *Annual Health Bulletins Report 2005* Ministry of Health (2006).
- 4) RGoB *Annual Health Bulletins Report 2002* Ministry of Health (2002).
- 5) RGoB “*Bhutan 2020: A Vision for Peace, Prosperity and Happiness.*” Planning Commission (1999)
- 6) RGoB “*Bhutan Living Standard Survey 2003*” National Statistical Bureau (2004)
- 7) RGoB “*Bhutan Millennium Development Goals Report 2002*” Ministry of Finance (2003)
- 8) RGoB “*Bhutan Millennium Development Goals Report 2005*” Ministry of Finance (2006)
- 9) RGoB “*Bhutan National Human Development Report 2000: Gross National Happiness & Human Development.*” Planning Commission (2000)
- 10) RGoB “*Bhutan National Human Development Report 2005: Gross National Happiness and Human Development.*” Planning Commission (2006)
- 11) RGoB “*Child Protection Study*” Ministry of Health (2003)
- 12) RGoB “*Poverty Reduction Strategy Paper 2003-Cover Note to 9th FYP*” Planning Commission Secretariat (2003)
- 13) RGoB “*Education Sector Strategy: Realizing Vision 2020 Policy & Strategy.*” Ministry of Health & Education (2003)
- 14) RGoB “*Employment Creation Strategies for the First Year of the 9th Five Year Plan*” Ministry of Health & Education (2003)
- 15) RGoB *24th Education Policy Guidelines and Instructions*. Royal Government of Bhutan. Ministry of Education (2005)
- 16) RGoB and UNICEF *Exploratory Study on HIV/AIDS Issues Affecting Out-of-School Youth in Bhutan ICB, Ministry of Health, 2005*
- 17) RGoB “*General Statistics 2006*” Ministry of Education (2006)
- 18) RGoB “*General Statistics 2004*” Ministry of Education (2004)
- 19) RGoB “*General Statistics 2003*” Ministry of Education (2003)
- 20) RGoB “*General Statistics 2002*” Ministry of Education (2002)
- 21) RGoB *Ninth Annual Education Conference Report and Resolutions*, Ministry of Education (2006)
- 22) RGoB “*Human Resource Development Master Plan for Private and Corporate Sectors (2002-2007).*” Ministry of Health and Education (2002)
- 23) RGoB *Implementing the ICPD Programme of Action in Bhutan*. Ministry of Health (2005)
- 24) RGoB “*National Accounts Statistics 1980-2003.*” National Statistical Bureau (2004)
- 25) RGoB “*National Labour Force Survey 2004*” Ministry of Labour and Human Resources (2004)
- 26) RGoB “*National Labour Force Survey 2003*” Ministry of Labour and Human Resources (2003)
- 27) RGoB “*National Labour Force Survey 2002*” Ministry of Labour and Human Resources (2001)
- 28) RGoB “*Ninth Plan Main Document [2002-2007].*” Planning Commission (2002)
- 29) RGoB “*National Health Survey 1994*” Department Health Services, Ministry of Health & Education (1994)
- 30) RGoB “*National Health Survey 2000*” Department Health Services, Ministry of Health (2000)
- 31) RGoB “*Poverty Assessment and Analysis Report 2000*. Planning Commission (2000)
- 32) RGoB “*Poverty Analysis Report 2004*. Planning Commission (2004)

ANNEXURE

- 33) RGoB “*Renewable Natural Resources Statistics 2000*” Ministry of Agriculture (2000)
- 34) RGoB “*Selected Economic Indicators – June 2003.*” Royal Monetary Authority of Bhutan (2003)
- 35) RGoB “*Selected Economic Indicators – December 2004.*” Royal Monetary Authority (2004)
- 36) RGoB “*Statistical Yearbook of Bhutan 2004*” National Statistical Bureau (2005)
- 37) RGoB “*Statistical Yearbook of Bhutan 2003*” National Statistical Bureau (2004)
- 38) RGoB “*Guidelines for Formulation of Tenth Plan [2002-2007].*” Planning Commission (2002)
- 39) RGoB *Staff and Student Statistics of May 2006 (Brochure).* Royal University of Bhutan (2006)
- 40) RGoB “*The Middle Path: National Environment Strategy for Bhutan.*” National Environment Commission (1998)
- 41) RGoB “*National Revenue Report 2004-2005.*” Ministry of Finance (2004)
- 42) RGoB “*National Revenue Report 2002-2003.*” Ministry of Finance (2003)
- 43) RGoB *Results of Population and Housing Census of Bhutan 2005.* Office of the Census Commissioner (2006).
- 44) RGoB “*Recommendations for Creation of Gainful Employment in Long Run by Private Sector*” Committee Private Sector Development (2002)
- 45) RGoB *Study Report on PLWHA in Bhutan,* Department of Public Health. 2005
- 46) RGoB “*Walking the Extra Mile Selected RNR Statistics 2003*” Ministry of Agriculture (2003)
- 47) National Commission for Women and Children (2005) *Report on the National Gender Planning Retreat 7 to 9 November 2005, Paro*
- 48) UNDP “*Human Development Report 2003-Millennium Development Goals: Compact among Nations to End Human Poverty.*” OUP (2003)
- 49) UNDP “*Human Development Report 2000*” OUP (1990)
- 50) United Nations *common Country Assessment for Bhutan.* [2006]
- 51) World Bank *HIV/AIDS Issue Brief: Bhutan.* Washington, World Bank 2005
- 52) Education for All Global Monitoring Report, 2005. Accessed online on 08 July 2006, url http://portal.unesco.org/education/en/ev.php-URL_ID=36027&URL_DO=DO_TOPIC&URL_SECTION=201.html
- 53) UN *Water for Life 2005-2015 Factsheet on Water and Sanitation* Accessed 4th July 2006 .url: <http://www.un.org/waterforlifedecade/factsheet.html>