SITUATION ASSESMENT AND ANALYSIS OF CHILDREN AND WOMEN IN BANGLADESH

TABLE OF CONTENTS

Contents

C O N T E N T S

Contents

CONTENTS

Contents

ACRONYMS

ACRONYMS

ADP	Annual Development Planning
ARI	Acute Respiratory Illness
ASK	Ain-o-Salish Kendra
ADB	Asian Development Bank
BBS	Bangladesh Bureau of Statistics
BEOC	Basic Education for Older Children
BGMEA	Bangladesh Garment Manufacturer's and Exporters Association
BMI	Body Mass Index
BDHS	Bangladesh Demographic and Health Survey
CAMPE	Campaign for Popular Education
CCA	Common Country Assessment
CPP	Country Programme Preparation
CRC	Convention on the Rights of Child
CMES	Center for Mass Education in Science
CHT	Chittagong Hill Tracts
CLS	Child Labour Force Survey
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CERD	Committee on the Elimination of All Forms of Racial Discrimination
CWRY	Children women Relief and You
DSS	Department of Social Services
DESA	Dhaka Electric Supply Authority
DPHE	Department of Public Health engineering
DCC	Dhaka City Corporation
DNFE	Directorate of Non Formal Education
DNC	Department of Narcotics Control
DOE	Department of Environment
ERD	Economic Relations Division
ECCD	Early Child Care Development
EFA	Education for All
EPZ	Export Processing Zone
ESCAP	The Economic and Social Commission for Asia and the Pacific
FDI	Foreign Direct Investment
GNP	Gross National Product
GDP	Gross Domestic Product
GDI	Gender related Development Index
GOB	Government of Bangladesh
HES	Household Expenditure Survey
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
ILO	International Labour Organization
IDP	Internally Displaced Peoples
IMR	Infant Mortality Rate
LWT	Low Water Table
MOHFW	Ministry of Health and Family Welfare
MOWCA	Ministry of Women and Children's Affairs
MoU	Memorandum of Understanding
MICS	Multiple Indicator Cluster Survey
NGO	NON Government Organization
NCBs	Nationalised Commercial Banks.
NNCB	National Narcotics Control Board
NCCADN	National Coordination Council of Anti Drug NGOs
NAC	National AIDS Committee
PCJSS	Parbattya Chattagram Jana Sanghati Samiti
PBDs	Professional Blood Donors
PDB	Power Development Board

ACRONYMS

SAD	Special Affairs Division
SOE	State-owned Enterprises.
SEDP	Secondary Education Development Board
SCEMRB	Society for the Care and Education on the Mentally Retarded Bangladesh
STDs	Sexually Transmitted Diseases
SITA-A	Situation Assessment and Analysis
SEMP	Sustainable Environment Management Programme
SWM	Solid Waste Management
SAARC	South Asian Association for Regional Cooperation
TFR	Total Fertility Rate
UNDAF	United Nations Development Assistance Framework
UP	Union Parishad
UNHCR	United Nations High Commissioner for Refugees.
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Emergency Fund
WB	World Bank

LIST OF TABLES, FIGURES & BOXES

LIST OF TABLES, ...

Introduction

Bangladesh is amongst the first of 191 countries to sign the Children Rights Convention (CRC) and participated actively at the world summit for children to launch the CRC. Bangladesh has also ratified convention on the elimination of all Forms of Discrimination against Women (CEDAW) and is a signatory to the charter of Human Rights of the United Nations. Thus Bangladesh has obligated itself to guarantee full enjoyment of political, economic, social and cultural rights irrespective of race, ethnicity, gender, age or any other criterion., The constitution of the Peoples Republic of Bangladesh prescribes specific principles of state management and administration that underscores this commitment.

The Common Country Assessment (CCA) completed in August, which is an integral part of the UN reforms, provide the strategic backdrop to the Situation Assessment and Analysis of children and women (SITA-A). The SITA-A is the product of the joint exercise undertaken by UNICEF and concerned ministries of GOB under the umbrella of Joint Government Unicef Advisory Group (JGUAG) with involvement of individuals and NGOs that are active in areas of child survival, child development and child protection. The entire exercise used secondary data primarily from BBS and supplemented by information available from Progotir Pathey, World Bank, research institutions, newspaper reports and micro studies.

A child has been defined as per CRC as an individual under and upto eighteen years of age. The foundation articles of CRC emphasises non-discrimination, best interest of the child, right to life, survival, development and protection to achieve the full potential of children individually and collectively and right to voice their concern and right to be heard in those matters. JUGUAG organized the technical teams to address the issues of survival (with a focus on health, healthy environment, shelter, water and sanitation), development (with a focus on education, skill development, recreation) and Protection (with a focus on identify, violence, abuse, child labour, parental guidance). The technical teams identified key elements through an accountability and causality analysis to examine current achievement and gaps in achievement. These were then presented in a two-day retreat session followed by discussion with co-chairs in the relevant ministries. A draft report was prepared and presented at sub-national level where GOB official from different sectors and tiers of administration as well as members of local government and civil society participated to discuss the key issues of the report in the light of their own experience. In Dhaka Youth Leadership Forum provided opportunity for participation of children to voice their own concern in their own words. The revised draft was then discussed in the technical teams. Thus methodology for preparation of this situation analysis has been participatory and enrichment through cross fertilization.

The National Context

Bangladesh is a small country (147,570 sq km) with a large population estimated at about 126m in mid 1999. This deltaic country shows diverse mixture of religions and cultural tradition exhibiting conservative values as well as emerging modernizing pressures. An elected government accountable to the parliament today governs Bangladesh. The governance is unitary in character with powers centralized in the capital though administration through civil service reaches from the ministry to division (6), district (64), thana (460), union (4451) and villages (68,000). Local government institutions are yet to be formulated in all of the proposed four tiers. The judiciary has the Supreme Court as the apex body but magistracy at various administrative levels and sub-ordinate courts at the district level do much of the judicial functions.

The policy is characterised by dominance of three or four parties and people despite being poor and less literate are conscious of their political rights. The economy has experienced over 5% growth in GDP in recent years; the gross investment has been over 20% of GDP despite a lower domestic savings rate (15%). The Tax-GDP ratio is low (less than 8%) but the fiscal deficit has been kept within limits. The currency has been devalued a member of times. .

The current account deficit has remained negative and utilization of aid has slowed down. The policy of promoting private sector has not borne the expected results and financial sector reform as well as other economic and administrative reforms have made slow progress. The performance of SOEs remain a vexing concern, as is the case with public sector service delivery system.

The poverty remains endemic even though aggregate poverty shows a declining trend. The micro studies indicate that the hard to reach poor have not been brought within the context of developmental dynamics despite GO-NGO initiatives in various sectors and regions. The social polarization has deepened since the introduction of structural adjustment programs and recent liberalization policies seem to have aggravated the situation, because of cuts in government spending.

Women and children, especially from poor families suffer from the impact of gender discrimination and violation of their rights, despite many affirmative actions initiated by the Government of Bangladesh. Bangladesh has been ranked 140th in terms of the gender-related index due to gender gap in literacy, income, asset ownership, education and health care.

Bangladesh has an adverse man-resource ratio. The natural resources (e.g. forests) have been rapidly depleting. The soil degradation is said to be alarming. Bio diversity is at peril. The water resource management has not always been people friendly. Environmental pollution in urban areas has increased the morbidity rates in urban areas. Bangladesh is vulnerable to natural disaster form which despite increased coping power, the impoverishment of the poor has deepened over the years.

Survival Rights

Survival is threatened throughout the life cycle with high vulnerability in the period which begins in the womb upto the age of five years. The child is however, most vulnerable as a neonate -- birth to the first month of life. This is particularly so, given the high rates of maternal malnutrition which includes deficiency in critical micronutrients, poor uptake of critical maternal care services and harmful traditional practices relating to pregnancy and child birth. There has been a reduction of 30% in the infant mortality rate and close to 25%in that of under fives since 1990. This improvement is associated with concomitant increase in immunization and vitamin A supplementation coverage, improvement in control of diarrhoeal diseases. It has also been complemented by improvements in age at marriage, birth spacing and reduction in fertility. There is, however, no evidence of any significant improvement in neonatal mortality associated with prematurity, LBW, birth trauma and asphyxia. Accidental deaths are another important cause of death with drowning being responsible for nearly 19 % of deaths of children 12 –59 months.

Estimates of the deaths prevented by immunization highlight the important role played by the EPI programme. However, there has been a slow decline in this effect related to the persisting problem of high drop out rates (30-40%). This means that although more than 50% of children under 1 year are immunized, 1.0 –1.5 million children remain unprotected.

Low levels of knowledge on critical child survival issues and inappropriate care seeking practices remain a key aggravating factor. This is particularly so with pneumonia emerging as the key killer of children under the age of five and the finding that less than 20% of children with the condition are taken to a qualified service provider. Another crucial gap remains between knowledge and practice.

Trends in malnutrition indicate that it persists as a critical problem. Comparisons over a ten year period have shown a modest decrease by 1.4% per year in underweight, 1.7%per year in stunting and virtually no change in prevalence of wasting. Further, the situation is worst among children in urban slums. There has been a strong effort to promote exclusive breastfeeding and appropriate weaning and the impact is yet to be reviewed.

There is a significant downward trend in the incidence of night blindness in children under six years of age from 3.76 % in 1982-83 to 0.8% in 1997. However, it must be noted that recent reduction in Night Blindness prevalence in early childhood to less than 1% does not mean that the deficiency does not remain. The shift in night blindness to school children and to pregnant and lactating women means that this vitamin deficiency still remains an important public health issue. Protection from iodine deficiency through the use of iodized salt has increased sharply. In 1994 less than 20% used iodized salt but by 1998 almost 80 % used it. Yet, concerns remain on the quality of salt iodination.

In the years of late childhood, from 6 –10 years, the same forces of poverty, gender discrimination and inappropriate care continue to affect the survival of children. The pattern of malnutrition continues with over 60% malnourished, 78 % of boys and 83 % of girls anaemic, and 2.1 % boys and 1.6 % girls suffering night blindness.

23% of the population of Bangladesh is aged between 10 to 19 years. Girls are particularly vulnerable at this age. They are often married and have begun child bearing with little attention to their nutritional needs during their growth spurt and their needs for care during pregnancy. The fertility rate for 15 –19 year olds is 155 per thousand and it is estimated that each year 800,000 young girls enter this risky stage of marriage and child bearing. Accidents, violence including septic abortion and suicide are responsible for about a third of the deaths of young girls of this age. Malnutrition persists as a problem with the rural situation worse than the aggregated urban figures and the figures are showing that a significant number of adolescent boys and girls suffer from malnutrition.

Though BBS(SVRS) data has shown a steady downward trend in MMR, concerns remain with the low uptake of critical maternal care services, without an improvement in which substantial reductions in MMR will not be possible. Critical is the coverage and utilisation of Emergency Obstetric Care Services. 1994 estimates showed that less than 5% of estimated women with life threatening complications actually get the service they need. Another disturbing fact that has passed unnoticed till recently, is that violence and injury account for 14% of deaths during pregnancy and a higher proportion of female deaths than even pregnancy related problems.

About 97 per cent of the population in rural areas and 99 percent in urban areas drink water from tubewell, tap or ringwell. However, recent surveys of arsenic contamination in ground water reveal that 22% of the tubewells contain arsenic above the nationally accepted standard of 50 parts per billion. This means that about 21 million people (about 17% of the population) are potentially at risk from arsenic poisoning. The magnitude and extent of the problem are far from being fully understood. What is clear is the urgency of a coordinated effort on the part of the Government, civil society and donors to respond at an emergency pace with activities ranging from the testing of existing tubewells with reliable kits, determination of health effects on people, installation of alternate safe options in affected areas, and communication campaign for raising awareness about the problems of arsenic poisoning as well as mitigation measures

Also important to be kept in perspective are three other persistent problems that impede the progress in safe water use: saline water intrusion in the Coastal Belt, lowering of ground water table during the dry season, and special problems in the rocky and hilly areas. Other issues of concern are the inequity in access to safe water, especially in poor, underserved communities and the long time spent by women in water collection. Adolescent girls in the 11-20 years' age group contribute 27% of their time collecting about water (see details in Table 4.19). 26% of the women collect drinking water from a distance of over 200 meters and about 8% women spend over 3 hours per day during the dry season in this activity (the percentage of women goes up to 18% during the rainy season).

Analysis shows strong correlation between diarrhoeal prevalence and malnutrition vs. the non-use of sanitary latrines as well as use of unsafe water for household work. Logistic regression confirms that younger children of 12-23 months are more prone to diarrhoeal incidences than children of 4+ years. Also households that do not use sanitary latrines are 15% more prone to suffer from diarrrhoea and those that do not use tubewell water for

household work are more likely to get diarrhoea by 40 to 67%. Diarrhoea and dysentery are at the top of 15 major causes of death in Bangladesh. Together they account for 15% deaths in the country. Over the past 7 years diarrhea mortality has decreased significantly, from 260,000 annual deaths of children under the age of 5 years to 110,000 in 1996. However, the diarrhea morbidity still remains high. The annual average annual incidence of diarrhea among children under five years of age is 3-5 episodes. Each episode may last from 2-3 days up to 2 weeks or more, resulting in severe dehydration, malnutrition and sometimes death.

It is a matter of serious concern that only about 34% of the population use safe water for household work and about 20,000 metric tones of human excreta everyday contaminate land and water bodies with harmful bacteria, thus contributing to an unhealthy environment. The use of sanitary latrine has remained between 30 and 40 per cent since 1993. More than half of the schools do not have even the basic water and sanitation facilities. Basic hygienic practice such as hand washing after defecation is not prevalent at satisfactory level. There is also a mistaken belief amongst some limited number of people, mostly illiterate that children's excreta are not harmful. As a consequence disposal of children's (under five) faeces into latrines is done by only 10% of the households in rural areas and only 50% even in the non-slum urban households. The problem is further complicated by a very limited knowledge about the link between sanitation facilities, hygienic behaviours, safe environment and illnesses. What stands out as an imperative is the need to enable household members to develop hygienic behaviours through a multi-level multi-media communication campaign, motivational interventions targeting the poor, and intensive social mobilization involving various partners and allies.

Improper solid waste management has emerged as environmental hazard especially in urban areas. For city corporations and pourashavas, interventions like community based waste collection, source separation, and recycling (including decentralized composting) need to be promoted. Projects like community based decentralized composting integrated with door-to-door waste collection system that is being replicated in three communities of Dhaka can be emulated in other municipalities. Moreover, in urban slums where the municipalities are not providing services, community based recycling and resource recovery (composting) should be promoted. This will not only solve the waste disposal problem at source, but also be a source of income to slum dwellers.

Development Rights

Child development is the front end of human development. With annually two and a half million births a year and 21.5 million children under six years of age, proper caring and stimulation in *shisukal* starting from birth is important for optimum physical and mental development and the ability to interact successfully in social relationships and the physical environment. The general awareness of the needs of children for their optimum mental development and their ability to interact socially is quite low in both rural and urban areas, even though urban people have had relatively greater exposure to messages on child development.

The family plays a critical role in the development of the child in the early years. It is to be noted that the family unit is in transition from a large, extended group to an increasingly small nuclear group, thus changing patterns of child caring practices and social interaction for children in Bangladesh. Studies show that the raising of children under five is primarily the responsibility of the mother, and the father's role is minimal. Availability of adequate support for child care is a primary concern for working mothers. A survey shows that a fifth of children under age five of urban poor families have been forced to live away from their parents. Studies indicate that due attention and support are not given for the cognitive development of young children, but indirectly they are helped through common practices such as physical contact, showing of things, babbling to the child and identifying people and objects. Young children are generally well protected from danger. However, child care practices are not always based on health related knowledge and this is an area of potential vulnerability, particularly for children of low

income groups and working mothers causing high morbidity amongst them. Parents do encourage certain behavioral norms as well as social and emotional development, e.g. cooperation, perseverance, sharing, manners. However, there are disparities in the care provided. Generally a girl child is more often disciplined and enjoys less liberty than boys.

Neither the GoB nor Bangladesh society has a holistic early childhood development policy or practice. The National Plan of Action for Education for All (EFA) does mentien early childhood care, education and development. The plan includes advocacy on Early Childhood Care and Development (ECCD) needs and benefits, educating parents on physical and nutritional requirements of children and developing pre-school learning for school readiness. However, the plan does not address the mental and social development needs of children below 4 years old and focuses more on centre based activities than the family. While the central role of the family is acknowledged, there are no concrete proposals for the active involvement of families to optimize the mental and physical development of the young child.

There are nearly 20 million children aged 6 to 10 in Bangladesh. Enrollment in primary schools is about a8 million, and at least another 1.5 million primary aged children attend nonformal learning centres. In the past decade Bangladesh has made great strides towards the EFA goals. Gross enrollment was 96 percent in 1997, an increase of 20 percent in just 6 years. Retention rates have increased by 21 percent in the same period. The participation of girls in primary education has greatly increased during the past decade, and Bangladesh is one of the few countries in South Asia which can claim gender parity in enrolment. Primary education receives almost 50 percent of the education sector budget.

The Government has been highly successful in increasing enrollments. However a number of persistent problems remain in the primary education sector. Almost one fifth of children of primary school age (nearly 4 million children) are not enrolled in school. Attendance rates are low, averaging less than 60 percent. Approximately one third of those who enter primary education do not complete primary school, and those who do take on average over 6 years to complete the 5 year cycle. Pupil-teacher ratio is high and the number of hours spent in school in meaningful teaching-learning activities is low. Teacher morale and motivation are low, and they tend to rely primarily n traditional didactic teaching methods which on their own do not promote effective learning. Only about half those who complete primary school achieve a minimum basic education criteria.

The problems of primary education revolve around issues of access, equity and quality. Nearly 10 percent of children never enroll and drop out before achieving a useful level of basic skills. Children from poor families are the most adversely affected. While generally enrolment is higher in urban than rural areas, in urban slums the enrolment rate is nearly 20% lower than the national average. Many working children are unable to attend school, and there is only very limited educational provision for children with special educational needs. The enrolment of girls is now equal to that of boys, but there are still many practices within the school which favour boys, and minimum facilities for girls are still absent in many schools. Gender stereotypes and gender biased classroom communication are drawbacks faced by the female students. Low attendance, high drop-out rates and low achievement levels are all indicators of poor quality of the teaching and learning experiences in the classrooms. Only a minority of teachers use approaches and methods which stimulate creative and critical thinking, which stretch the child developmentally and which are likely to contribute to the achievement of the child's full potential. Communities often see the school as the responsibility of outside agencies, but recent efforts both by Government and NGOs have shown that when communities become involved in schools the result is greater accountability and an improved learning environment.

There are over 27 million children aged from 11 to 18, comprising close to a fifth of the population. As is the case all over the world, adolescence is a complex time for young people in Bangladesh. Children both from poor and middle class families do not feel that there is adequate recognition of their particular needs for health and family life information, for life and vocational skills and for continuing education.

School enrolment rates fall drastically from primary to the secondary level. In 1998 about 78 percent of pupils completing Grade 5 made the transition to the first year of secondary school. Gross enrolment in the secondary phase is only 7 million (38%). Due in part to an innovative stipend programme, enrolment of girls has increased rapidly during the past few years and is now equal to that of boys in the secondary phase (grades 6-10). However this declines to only 34 percent for higher secondary (grades 11-12). Girls from poorer families have less chance of enrolling and of completing secondary education. Drop-out rates remain high and attendance low. Classrooms are overcrowded. The teaching-learning process tends to be didactic, focusing on the memorization of information rather than on the development of analytical skills. The curriculum is academic with little emphasis on practical or vocational skills.

There are more than 6.3 million working children in Bangladesh. In rural areas they largely work in the family. In urban areas the income of working children can form a significant part of a poor family's overall income. Many children who work are unable to have access to education and become tapped in low skilled, low return work that further cements them into the cycle of poverty. Along with lack of education there is limited knowledge of their rights and they have poor access to health, education, social and protection services. In addition, working children have very little access to recreation. A recent survey in Dhaka noted that some child domestics recorded about 17 hours a day at work. Currently nonformal education offers a flexible model for working children to access learning opportunities, and nonformal education shows equal rates of participation by girls. However, the provision of nonformal education is still inadequate to meet the needs of the large number of working children, and issues of quality and equivalency with the formal system need to be addressed.

Protection Rights

The situation of children whose rights are victims of violence, sexual abuse, exploitative child labour and who are deprived of their rights to identity were examined. In the absence of quantified data this assessment has relied on case studies and other qualitative data sources. From available information it appears that incidence of violence, sexual abuse and exploitation of children appears to be on the increase. Unfortunately some of these abuses take place even at the hands of law enforcement agencies. Sexual abuse of children and adolescent girls is a serious problem, but this remains largely hidden due to the stigma attached to the victims of such offences. Many such children are forced into the sex trade. Trafficking of children both within the country and across international borders is another serious problem. Many children in deprived environment also become inured to violence as they are frequently exposed to violence and some young women are subject to the heinous crime of attack with acid and other corrosive substances. Child labour is common under the conditions of poverty and destitution. Many of them work in hazardous conditions and for long hours. It is estimated that 6.3 million children under 14 are in the labour force of whom 12% are between 5 and 9 years of age. Prevalence of child labor is more common in rural (37%) and informal sector. There are an estimated 300,000 child domestic workers in Dhaka city alone and most often the household employing them do not provide opportunities for education, health care, recreation, safe environment, humane treatment and personal development.

All children who come into conflict with law do not get always the protection provided in the law from the police, magistrates and probation officers or jail warders. The provisions for "safe custody" often results in deprivation of liberty without cause. Though Government and NGOs have interventions targeting street children, many such children are still outside the reach of such interventions. The children of sex-workers, deceased parents and other socially ostracized groups are particularly vulnerable. Children in institutions like orphanages also suffer from many problems due to poor management of such institutions.

Births of children are generally not registered, despite the existence of law requiring such registration. Consequently the children are deprived from a range of protection. The fact that many children who come into

conflict with law are not able to seek the protection under the provisions of the Children Act of 1974 or the difficulty of enforcing laws relating to the age of marriage are a direct consequence of this situation. In addition accurate demographic information is not available. However recent attempts to revive interest in birth registration particularly in the urban areas show promises of improvement of the situation over time.

The situation of children of refugees, tribals and those living in remote and inaccessible areas merit special attention. Some communities report that they are treated as outcastes. Health and educational indicators of children in the Chittagong Hill Tracts are below the national average due to limited reach of interventions caused both due to topographical difficulties as well as dislocation due to the civil unrest in the area prior to the historical Peace Accord. Disabled children also experience discrimination in many cases due to largely to ignorance among parents and the community.

Conclusion

It is important to help overcome social economic and administrative obstacles and create awareness amongst service providers and the community about their obligation and sensitize the policy makers for creating and enforcing enabling environment legally and otherwise. In this context, restoration of community and family values along with reinforcing institutions and program integration of CRC related interventions by GO-NGO and reporting system in this regard stand out as important strategic direction.

The issue that surfaces prominently is reorientation of the mind set and behavioral norms of all actors across the family, community, service providers and policy makers so that CRC objective of making all children subject with rights not passive recipient of services where they are taken as object. This is necessary for realization of all children's full potential. The caring of children is far from ideal, particularly in poor and marginal families.

This situation assessment and analysis has identified varying degrees of knowledge and awareness among different groups in society—care providers, service providers, communicators and policymakers among others—of various aspects of rights and the care required by children and women in order to reach their full potential. Less information was available on attitudes and actual practices in providing care to children and women. Overall, major and persistent gaps were identified, as well as opportunities for strengthening and formulating new strategies.

Among the survival rights, key findings included:

- In the area of safe motherhood, it was found that ignorance, the disadvantaged situation of girls and women, and the lack of an enabling environment contributed to high rates of maternal deaths and complications resulting from pregnancy and childbirth;
- Low levels of knowledge, inappropriate care-seeking practices for child illness and elements of gender discrimination contribute to persistent challenges. Only 20% of children with pneumonia are taken to the qualified service provider. EPI coverage rates are recovering from a decline in recent years, but are low (just over 50%), considering the ling history and achievements in social mobilization in this area;
- In sanitation, a big gap was found between what people know should be done, for example two-thirds knew that they should wash their hands with soap and water after defecation, but only 9% actually did so. There is also a situation where people want a private latrine, but 39% of households are using hanging latrines, which are not hygienic, and only 37% are using hygienic latrines. Thus demand exists for latrines, but knowledge of what qualifies as a hygienic one, and access to producers selling the components necessary to build one, need to be ensured, showing that service delivery needs to keep pace with communication, and vice versa.

In the area of development rights, it was found that knowledge and awareness levels of the care and resources needed to promote child development at all stages of childhood were limited among care providers, service providers, communicators (including the media), and policymakers. While some traditional practices provide good protection and care at the very early stages of a child's life, there is a need to increase knowledge and practice of different types of care required at later stages. Of particular note was the need to increase knowledge, positive attitudes towards, and practice of providing adequate and appropriate support to adolescents, who, while taking on an increasing number of adult roles and responsibilities, need to enhance their own knowledge of life and family-related skills.

In the area of protection rights, there was no data available to assess the awareness of child rights in the community, family, or even among children themselves. A key challenge is of ensuring that an understanding of child rights is fully internalized among policy makers and implementers.

While many communication initiatives have been implemented and many are still ongoing, greater prioritization at all levels, greater coordination, and greater support to ensure behaviour development and/or change are required. Particularly in the context of a rights-based approach it is essential for programmatic effectiveness and sustainability that all communities, providers of care to children, communicators and policymakers have an understanding of rights, the principles and means for action, and be motivated to respond to challenges positively and appropriately. At the family level, it is essential to empower families with the knowledge, skills and support they need to fulfill the needs and rights of children to maximize their potential.

The urban dimension merits special attention since it is often misconceived that the urban areas are better off than the rural areas. While this is generally true, the situation in the slums and urban fringes is far worse than in the rural areas. The poor and the vulnerable in these areas are primarily children and women. Given the patriarchal nature of the society, which is prevalent, not only in Bangladesh but also throughout South Asia, and the social relationships, the status of women in Bangladesh remains an area of concern. The situation assessment and analysis is not only based on the foundation of the CRC but equally on CEDAW, and as such the gender dimension has been flagged as a major cutting issue. Since the issue of participation rights have been dealt with in a comprehensive manner in the Common Country Assessment (CCA), the participation rights of children have been addressed here briefly.

The strategy for addressing the issues highlighted in the situation assessment and analysis include (a) taking a holistic non-compartmentalized approach in implementing CRC related programmes through GO-NGO initiative which create synergic effect in empowering women at family and community level, in creating conditions for ownership of such initiative by the people for facilitating implementation, supervision and monitoring of programmes and policies, (b) developing child and mother friendly environment in service delivery for health care, education and protection, (c) improving and networking institutions involved in child related education, health care and protection related activities so that education becomes a pleasurable experience, health care and hygienic practices become routine and ingrained in culture and protection rights are appropriately implemented, (d) enacting and implementing laws that focuses on child and women rights particularly those related to violence, abuse exploitation and injustice,(e) strengthening family values and community institutions for enhancing understanding and practice of child Rights for which coordinated intervention by policy makers and GO-NGO institutions is vital and (f) mounting special intervention program for children in need of special attention particularly those belonging to indigenous group, these who are disabled stigmatized in deprivation of caring environment and those in conflict with law.

PART ONE

METHODS AND PROCESS

CHAPTER ONE

CHAPTER ONE

Introduction

1.1 BACKGROUND

The Convention on the Rights of Child (CRC) establishes an essential framework for a forward-looking strategy to promote and protect the fundamental rights of children, and decisively eradicate inequality and discrimination. (See Box 1 for Child Development Rights in the CRC)

BOX-1

Child Development Rights—CRC

- Right to develop to maximum extent possible (Art. 6)
- States Parties render appropriate assistance to parents and legal guardians in the performance of child-rearing responsibilities and ensure the development of institutions, facilities and services for the care of children (Art. 18.2)
- Right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development (Art. 27)
- Right of the child to education, with a view to achieving this right progressively and on the basis of equal opportunity (Art. 28)

Bangladesh ratified the CRC in September 1992, joining the international community's consensus in recognizing the rights of children. Bangladesh have made significant strides in a number of social indicators, which is an indication of its potential. Under-five mortality rates and infant mortality rates continue on a downward trend and many of the Year 2000 goals will be reached, for example, infant mortality rate, severe malnutrition, net primary school enrolment and disparities between boys and girls, iodized salt consumption, and measles vaccination.[1] However, the country continues to face many challenges that must be overcome before the CRC is fully realized. It continues to be one of the poorest countries in the world, with 47 percent of its population living below the poverty line.[2]

The international community continues to support Bangladesh with development assistance.[3] Major sectoral programmes under the leadership of the World Bank dominate the policy discussion. Bangladesh also have large non-governmental organizations (NGOs) whose expertise and overall size is unparalleled in other developing countries. One important recent development is the decentralization process in the country.

3 Although the dependency of the national economy on foreign aid is gradually declining, Bangladesh continues to receive large sum of external assistance (US$ 1.3 Billion in 1996)

4 CF/EXD/IC/1992-02 12 February 1999

5 It should be pointed out that although the distinction between assessment and analysis is made, they are not separable.

UNICEF Bangladesh is embarking on a Country Programme Preparation (CPP) exercise for the next Country Programme (2001-2005). It will based on:

- the lessons learned from previous experience, especially in the current country programme
- an assessment and analysis of the situation in Bangladesh
- UNICEF global priorities and strategies as reflected in "The Focus of UNICEF's Work Beyond 2000."[4]
- National Development Plan and Policies

An important part of the CPP exercise is the Common Country Assessment (CCA)/United Nations Development Assistance Framework (UNDAF) processes currently underway in Bangladesh. Under the Resident Coordinator System, the draft of the CCA was completed in August 1999, and will feed into the situation assessment and analysis. The UNDAF, which is scheduled to be complete in October, will also be an important input to the Strategy Paper. Bangladesh provides a unique (rather fortuitous for UNICEF) opportunity for effective implementation of the UNDAF process as the programme cycles of UNDP, WFP and UNICEF are harmonized and which coincide with the mid-cycle of UNFPA. The preparation of the CCA/UNDAF comes with on-going efforts to enhance collaboration and co-ordination of UN system activities in the country. It also builds on the attention given by UN agencies in Bangladesh including the World Bank to co-ordination of development assistance in the extended community of development partners, by means of the Local Consultative Group.

The rights-based Situation and Assessment of Children is the foundation upon which the new Country Programme of Co-operation will be based on.

1.2 SITUATION ASSESSMENT AND ANALYSIS THROUGH A RIGHTS PERSPECTIVE

The integration of human rights with UN activities and programmes was reaffirmed by Secretary General Kofi Annan in his report to the General Assembly, *"Renewing the United Nations: A Programme for Reform."* The report echoes the Final Declaration of the 1993 Vienna World Conference on Human Rights, adopted by 171 states including Bangladesh, which maintains that:

> *"Democracy, development and respect for human rights and fundamental freedoms are interdependent and mutually reinforcing.... The promotion and protection of all human rights and fundamental freedoms must be considered as a priority objective of the UN in accordance with its purposes and principles, in particular the purpose of international cooperation."*

The UN system-wide organization, agencies and funds has a responsibility for the realization of human rights. UN agencies have three corresponding duties: the duty to respect, the duty to protect and the duty to promote or fulfil human rights. From these emerge several human rights-related tasks and functions: performing studies, setting standards, promoting awareness of and implementing those standards, and monitoring progress. United Nations agencies including UNICEF support Governments in their efforts to fulfil the commitments and obligations of various international agreements and conventions. These instruments aim to create the positive global, national and local environments that allow all people to flourish and to enjoy their rights.

4 CF/EXD/IC/1992-02 12 February 1999

Recent efforts to reaffirm human rights as an integral focus of development activities has been strengthened by a number of political and social trends and events since the early 1980s. Taken together these changes are creating renewed demand for public accountability, good governance and the realization of human rights as the ultimate purpose of development efforts. The extraordinary momentum behind the process of ratifying international human rights treaties, has also reinforced the concept of public accountability and since States commit themselves, in ratifying such treaties, individuals and institutions can be held accountable when human rights are not realized or violated. The global conferences held in the 1990s have further reinforced social and political support for human development and human rights.

Assessment and analysis from a rights perspective will lead to an understanding of the mix of causes that together prevent some children from enjoying their rights. The manifestations of unrealized rights have immediate, underlying and structural causes, which are interconnected and which together impact on the realization of rights in various ways. The situation assessment and analysis will identify the level of causes and the linkages between various problems. An explicit conceptual framework facilitates this process and will identify the possible, immediate, underlying and structural causes of problems and the relationships between them.

In going through the various levels of causes, it will be obvious that many problems have common roots. The identification of the root causes of the problems is very important in the understanding of how these multiple factors impact on people.

A rights perspective conceptual framework involves moving from a child as 'objects with needs to be satisfied' to seeing and dealing with them as 'subjects who possess rights'. That entails that there are obligations on the part of various actors and institutions at different levels of society - family, community, service providers, policy makers - national, national and international, which are essential for realization of rights. Therefore, this relationship between the child as the claim-holder and a number of duty-bearers with duties and obligations becomes important.

CHAPTER TWO

CHAPTER TWO

Conceptual Framework

2.1 AN ANALYTICAL FRAMEWORK FOR A RIGHTS-BASED SITUATION ASSESSMENT AND ANALYSIS (SITA-A)

In order to design more rational and effective policies and programmes for children, it is essential to identify each factor affecting their survival, development and protection within the context of the wider national, and societal trends. A Child Rights approach to programming requires a better understanding of the WHYs and HOWs and demands an enhanced approach, which takes into account the larger programmatic context and enables in-depth analysis of basic causes of violations of rights and identification of structural issues.

The rights-based SITA-A will be a comprehensive assessment of children's situation vis-à-vis rights and related obligations. The SITA-A will cover *all children under 18 years of age.*

BOX-2

Life Cycle Approach for Identifying Children"S Needs and Rights

Prenatal- 5 AGE GROUP
- Health Care
- Healthy Environment
- Early Child Stimulation & Development
- Nutrition
- Protection
- Caring Practices
- Participation
- Identity
- Recreation

6-12 AGE GROUP
- Health Care
- Education & Development
- Recreation
- Protection
- Participation
- Identity
- Healthy Environment

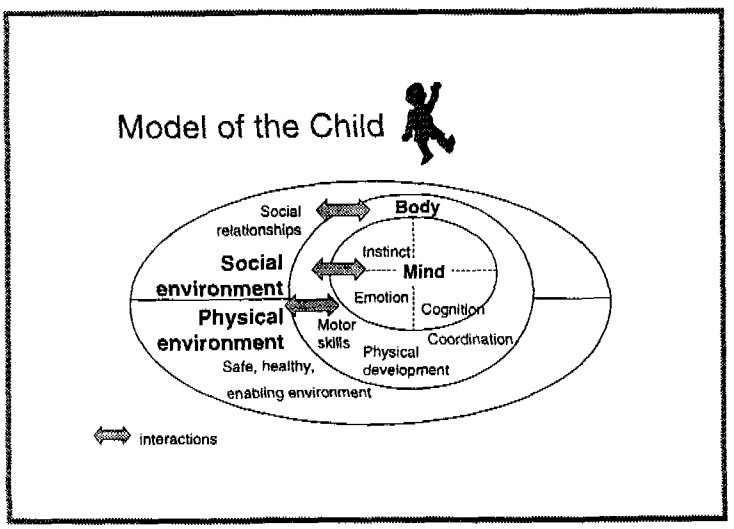
13-18 Age GROUP
- Reproductive Health
- Health Care
- Healthy Environment
- Education & Development
- Livelihood
- Protection

The assessment and analysis will use the life-cycle approach for identifying children needs and rights. It will cover all age groups under 18 years, with gender issues highlighted. The focus will be on the poor and other vulnerable groups The SITA-A will be guided by List of Issues, Concluding Observations and Summary Records of the CRC Committee. The situation of children will be assessed and analyzed through rights-based approach, based on the four foundation articles of the CRC ·

- Non-discrimination
- Best Interests of the Child
- Life, survival and development
- Participation

A conceptual framework (See Figure 1) was developed to facilitate a rights-based situation assessment and analysis. This framework puts the "fulfillment of the full potential of the Child", as the highest value of the CRC and the desired outcome. In addition, the CEDAW also provides the context to the framework. Development of three areas of human potential; mental, physical and social capacities directly contributes to the fulfillment of the child. Contributing to the development of these potentials are the clusters of rights – survival, development, and protection will influence these. (Participation rights are imbedded in these three clusters.) The following set of rights are further identified:

SURVIVAL	DEVELOPMENT	PROTECTION
Health & healthy environment	Education	Expression
Food & nutrition	Skills	Protection from Violence, Abuse & Exploitation
Shelter	Leisure & Recreation	Identity and Equity
Water & Sanitation	Empowerment	Family Environment & Parental Guidance



These are in turn determined by the structural determinants such as the resource base, the environment, the economic structures, the political and legal institutions and the societal norms and values. The rights-based SITA-A adopts, a "life cycle" approach. (See Box 2)

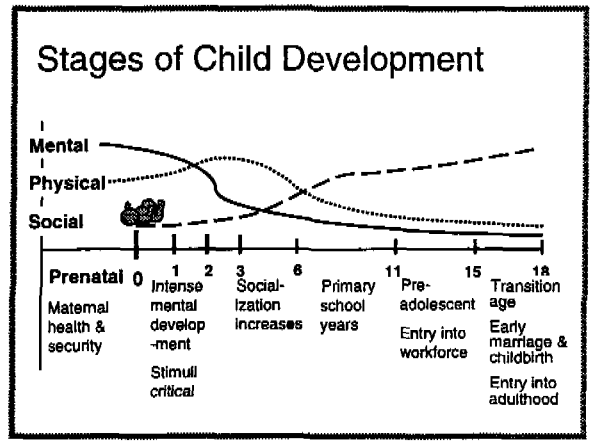
The basis of the SITA-A rests on a Child Development Framework, which is:

- A foundation for all human development
- Provides framework for development and rights-based action and support
- Holistic – whole child, all childhood stages (prenatal-18)
- Key actors – family, community, service providers, policy makers

As seen in the Model of the Child, the key areas of development are:

- Cognitive, mental and emotional development
- Control over body, motor skills and coordination
- Ability to interact successfully in social relationships
- Ability to interact successfully with the physical environment

It indicates the major components of the child and the surrounding environment, which correspond to the development of the various potentials that the child develops. The child has a "mind" and a "body" and interacts with the "social" and "physical" environment. The child's mind and the body also mutually interact. Through these interactions, the child develops mental, physical, and social capacities.



As the child grows, the mental, physical and social development changes as seen the various stages of development. From the time of conception and through the life cycle, starting in the mother's womb through birth, early childhood, middle childhood and adolescents, the child's mind and body and his/her capacity to successfully interact with the physical and social environment will be developed.

A rights-based SITA-A is a comprehensive assessment of the children's situation vis-à-vis rights and related obligations. It is a major milestone in programme planning which provides reliable information, and determines the strategy mix for the new country programme. It identifies the immediate, underlying and structural causes of problems affecting children. SITA-A must be expressed in practical terms, focusing on major challenges, in order to formulate viable and sustainable strategies to address the immediate, underlying and structural causes.

While it is acknowledged that all analytical models such as the conceptual framework are simplification of complex social phenomena, the models help in the understanding of which factors have the most impact on the child development, and how these factors interact with each other. They are also useful in selecting strategies in order that the key duty-bearers fulfil their duties. The emerging series of causal factors will facilitate the development of appropriate social interventions designed to break the cycle of deprivation.

2.2 THE PROCESS OF SITUATION ASSESSMENT AND ANALYSIS

SITUATION ASSESSMENT[5]

For each cluster of rights indicated in the conceptual framework, the manifestations of unrealized rights and the extent and the affected groups was identified and assessed by developing indicators and measuring them. The following set of questions were addressed:

- What are problems confronting children in Bangladesh?
- How are they manifested?
- Who are the effected groups?
- How widespread is it?

5 It should be pointed out that although the distinction between assessment and analysis is made, they are not separable.

The assessment is based on the Child Rights Indicators provided by the Regional Office, The CRC Monitoring Guidelines, and the CCA indicators together with the review of existing government documents and reports. It focuses mainly on the gaps in the CCA in relation to these rights, cross-referencing the CCA as needed, to avoid duplication of the same data/analysis. In order to ensure consistency official sources were usually used. There is no dearth of data related to Survival and Development Rights, and secondary data sources were used. On the other hand, given the nature of Protection Rights, a mix of instruments and approaches was used to generate the required data, which were often not available through official sources.

SITUATION ANALYSIS

It examines the immediate, underlying and basic causes of unrealized rights and addresses the questions:

- Why do the problems confronting children exists?

The focus of the analysis was on the immediate, underlying and structural determinants. In terms of the structural issues, the cultural context, prevailing norms, values and behavioural patterns, and the institutional frameworks – economic, political, and legal institutions were examined. The situation analysis involved a two-step process. The first involves accountability analysis, which determines the major obligations of the duty-bearers (adults), to ensure that the rights of the child are fulfilled. Four levels of duty-bearers were identified – family, community, service providers and policy-makers. Based on this accountability analysis, the next step was the causality analysis, which identified the major obstacles facing the duty-bearers in fulfilling their obligations. These obstacles were classified into immediate, underlying and structural factors. Inherent in the causality analysis is the analysis of the patterns of relationships between the claim holder (child) and the duty-bearers (adults) at various levels of society. The use of this framework moves the focus from the child alone to duty-bearers, with the child becoming subject of rights and facilitates the examination of the immediate, underlying and structural causes of the unrealized children's rights.

Three Technical Teams - Survival, Development and Protection headed jointly by the head of the UNICEF Programme Sections and the respective Joint Secretaries/Director Generals from GoB were established, to undertake the situation analysis. Members of these teams include, key GOB national, sub-national counterparts and relevant NGOs and other stakeholders. In the case of the Survival Team, two groups were established: one looking at Health and Nutrition and the other at Water and Sanitation. The first task the Technical Teams undertook was to validate the situation assessment results. After reviewing the situation assessment results, they selected areas for in-depth analysis. The selection of the areas depended on the following criteria:

- Number of children effected, especially the poorest and the most marginalized
- Seriousness of the consequences of the problem
- Trends and direction of change, for e.g., a sharp deterioration
- Solution of the problem likely to have positive effect on other problems

The selected areas are shown below.

Areas for Accountability and Causality Analysis

Survival		Development	Protection
Health & Nutrition	**Water & Sanitation**		
1. High incidence of childhood morbidity and mortality	1. High incidence of morbidity/mortality due to Arsenic poisoning	1. Inadequate care of the young child	1. Trafficking
2. High incidence of maternal morbidity/mortality	2. High incidence of diarrhoeal morbidity/mortality due to problems of safe water use	2. Inadequate access, equity and participation in quality education	2. Violence
3. High child malnutrition	3. High incidence of diarrhoeal morbidity/mortality due to unsafe excreta disposal and unhygienic practices	3. Lack of out-of-school opportunities for development of full potential	3. Sexual Abuse
	4. Solid Waste Management mainly in slums and urban firnges	4. Inadequate recognition of the needs, capacity and potential of the 11-18 age group.	4. Child Labour
			5. Juvenile Justice

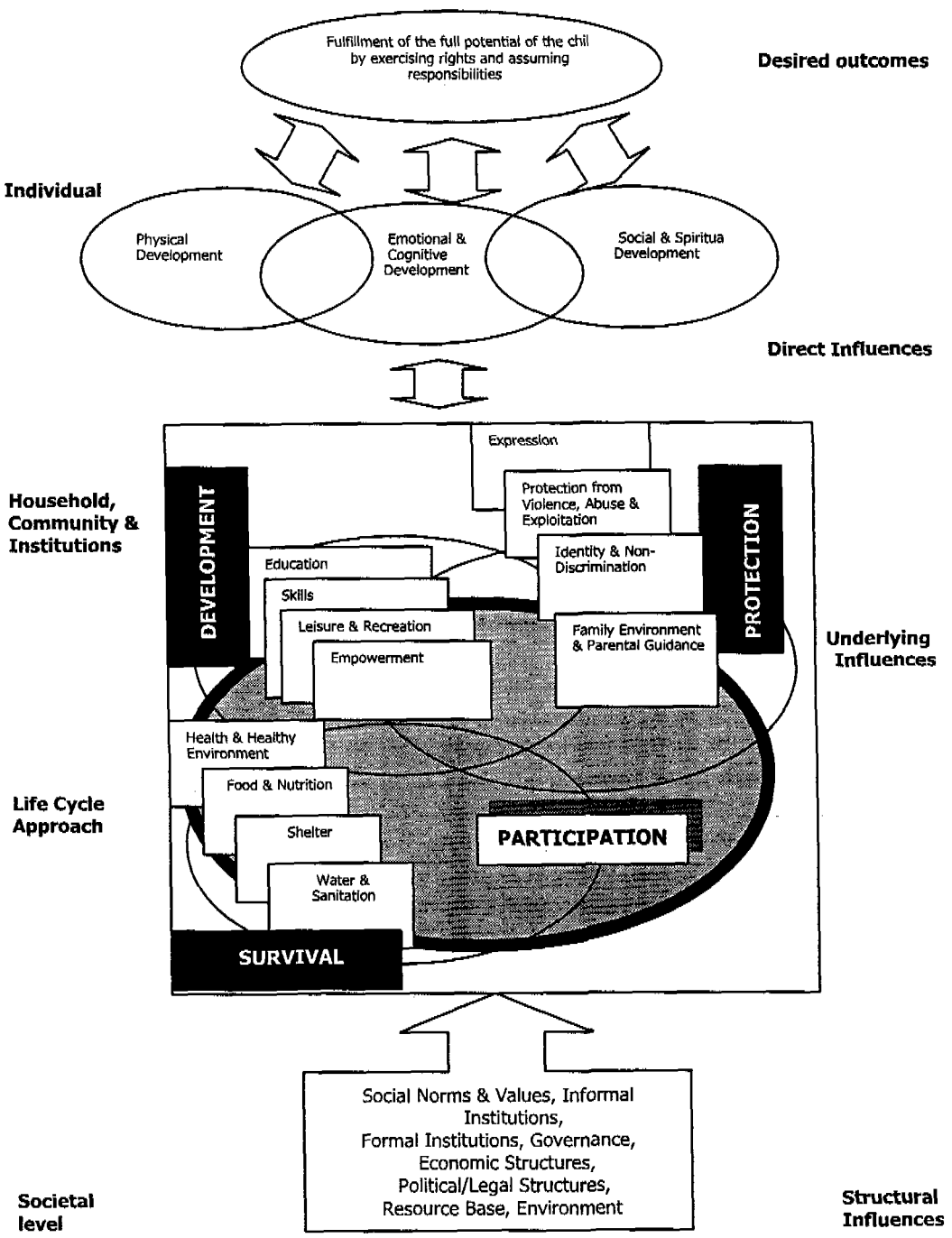
A series of orientation sessions were first held with the Technical Teams to ensure that they understood the process required to undertake the analysis. Subsequently, the Technical Teams carried out the analyses.

A number of case studies were prepared related to each cluster of rights, to add a "human" dimension to the quantitative analysis, for e.g., child sex workers, acid victims, child domestics etc. These will add a "child-friendly" perspective and would provide human dimension in the situation assessment and analysis. The results of the situation assessment and analysis are captured in Chapters 4, 5 and 6.

The identification of problems and their causes through the SITA-A will provide a basis for developing strategic intervention areas for UNICEF-BCO. The outcome of the SITA-A will determine the strategies for sustainable social and economic development initiatives benefiting children and will form the basis for the type of programmes for children that UNICEF will support. The strategic actions identifies would be set in terms of fulfillment of rights - best interests of the child. They would also balance content and process, short-term and long-term, and addressing immediate underlying and structural causes. In any interventions developed, priority would be given to disparity reduction, marginalized poor children and other vulnerable groups and to empowerment of children and their caretakers. At the same time, it will be necessary to strengthen GOB to fulfill their obligations.

SITA-A go beyond UNICEF programme design, since it provides much-needed source of information on children. One important aim of the SITA-A is to help increase the awareness of problems affecting children and to transform it into a national dialogue through a thorough consultative process.

FIGURE 1 CONCEPTUAL FRAMEWORK FOR SITUATION ASSESSMENT & ANALYSIS (SAA) FROM A RIGHTS PERSPECTIVE



PART TWO

ASSESSMENT AND ANALYSIS

CHAPTER THREE

CHAPTER THREE

The National Context

3.1 HISTORY AND CULTURE[1]

Documented history of what now constitutes Bangladesh is traceable from as early as the fourth century BC at the end of which period it formed the eastern-most province of the ancient Buddhist empire of Asoka[2].

A deltaic country of 147,570 sq. km., Bangladesh lies in the north eastern part of South Asia. It is bounded on the west, the north and the north-east by India, on the south-east by Myanmar and on the south by the Bay of Bengal into which flows a network of some 230 rivers with a total length of 24,140 km. The country is divided into three broad physiographic units of which floodplains occupy about 80 per cent, hills about 12 per cent and terraces about eight per cent of the land area. With a population density of 854 persons/sq. km., Bangladesh is one of the most densely populated countries in the world.

The diverse mixture of religions and cultural traditions among its population has led to the development of a rich cultural heritage in Bangladesh, in terms of art, music, theatre, poetry and literature. Elements of both Islam and Hinduism can be found in the daily lifestyles of Bangladeshis. The area is also known for greater religious tolerance than many other parts of the region. Society is conservative with respect to the status of women however, and a combination of factors including poverty, and cultural values, which value men and boy children more highly relative to women and girls, act to create a situation of considerable inequality between the sexes.

In its new existence, Bangladesh has spent much of the time under martial law, and democracy is still a relatively new experience for the country. This has implications for the development of political culture and conduct as well as popular perceptions of politics and politicians in Bangladesh.

3.2 GOVERNANCE

3.2.1 The State Institutions and Some Relevant Governance Issues

A parliamentary form of government governs Bangladesh. The Prime Minister is the chief executive of the country. She/he is appointed by the president from the majority party leader. She/he is assisted by a council of ministers.

There are some 68,000 villages in Bangladesh, and for the first time in more than a century, local government elected bodies, the *Gram Parishads*, will soon be established at the village level. These villages administratively fall under 4451 unions where local governance is entrusted to elected bodies called *Pourashavas* in urban areas and

1 Unless otherwise stated the source of this section is *Discovery of Bangladesh: Explorations into Dynamics of a Hidden Nation*, Akbar Ali Khan, UPL, 1996.

2 *The National Conservation Strategy of Bangladesh* (first draft), MoEF, 1991.

Union Parishads in rural areas. The unions fall under 464 thanas, each thana being headed by a Thana Nirbahi Officer. The local government body at this level is the *Thana Parishad*. The thanas fall under 64 zilas each of which is headed by a Deputy Commissioner, the local government body being the *Zila Parishad*. The zilas fall under six divisions each placed under a Divisional Commissioner. The Deputy Commissioner and the Divisional Commissioner are usually recruited from the administrative cadre of the Bangladesh Civil Service.

The Bangladesh Constitution provides for a unicameral legislature which is called the *Jatiya Sansad*, or the national parliament. It comprises 330 members of which 300 are directly elected by adult franchise, and 30 are female members elected by the *Jatiya Sansad*. Election to the current and Seventh *Jatiya Sangsad* was held on June 12, 1996. The need to strengthening the Jatiya Sansad and the parliamentary practices for effective governance has been recognized by all.

The Supreme Court, the highest judiciary in the country, is headed by the Chief Justice, and comprises the Appellate Division and the High Court Division. Special court or tribunals such as labour courts and family courts exist for adjudication of relevant disputes. There are Metropolitan Magistracy for the four major metropolitan areas of Dhaka, Chittagong, Rajshahi and Khulna. Criminal and civil courts operate at the zila level and Grameen Courts are in the process of being instituted at the village level.

Bangladesh's judicial system is seriously constrained in its ability to respond to many contemporary needs, particularly those related to commercial and financial transactions and contract enforcement. Commercial and financial laws are not fully sufficient to meet the demand of the present day need. The court system is overloaded. Court procedures are cumbersome, institutional capacity is limited, and like other government agencies, the judiciary is poorly paid,[3] resulting in eroding ethical standards and judicial capacity. Poor judicial training facilities and inadequate infrastructure further aggravate these structural weaknesses. These weaknesses have resulted in a huge backlog of cases and substantial transaction cost to the clients. The process of legal and judicial reform has been initiated and should accelerate. [4]

The police is another public institution that needs to undergo massive reforms in order to ensure good governance. Inadequate training, poor salary, and low job security contributes to a low level of motivation and morale among the police force. These factors have also resulted in a police force which lacks accountability.[5] Bangladesh presently has a total police strength of about 93,000 personnel in 530 thanas. About 65 percent of the police is engaged in maintenance of public order, 20 percent in investigation and inquiry and 4 percent in traffic. About 75 percent of the force are at levels of constables, while less than 1 percent is at the supervisory level.[6] Allocations for training only includes 0.5 percent of the police budget. Few are made aware about human rights issues during the training. A study finding reveal that out of 100 responding police officers, 95 said that they had not received any training focused on human security issues; only 9 could speak about freedom of movement and only 8 about the rights of freedom and security.[7]

Bangladesh's planning and budget system continues to remain beset with a number of deficiencies, which diminishes the transparency and accountability of how public funds are allocated and spent. The budget is not framed within a consistent macroeconomic and medium term framework, which de-links the level and composition of expenditure and financing of deficit from other macroeconomic aggregates. The development (ADP) and recurrent budget are prepared and approved on parallel tracks and compartmentalization creates a mismatch between investment

3 The judiciary poorly paid, although compeer to other government agencies it is better off.

4 Key Challenges for the Next Millennium, World Bank, April 1999.

5 Various surveys have repeatedly identified the police as one of the most corrupt arms of the government.

6 Ensuring Human Rights Security in Bangladesh: A Precondition for democracy and Development. United nations Development Program, 1998

7 ibid.

program and recurrent budget. The recurrent budget is formulated on an incremental basis causing an automatic upward ratcheting. The sectoral strategies in the ADP are so broad that almost every project that is presented meet the criteria and scarce resources are spread thin across a large number of the projects. Shortcoming in cash expenditure monitoring inhibits cash management and deficit control and causes month to month fluctuations in Government borrowing. Furthermore, policy and expenditure evaluation is minimal. Very little attempt is made to assess impact or service delivery. [8]

3.2.2 Gender

The Gender-related development index (GDI) ranks Bangladesh at 140th position out of 174 countries[9]. The main causes for this low index value are low literacy rates and very low share of earned income of women compared to men. It has been estimated that in 1995 female literacy rate was half that of men, and where in least developed countries the average female share of earned income was more than 34 per cent, in Bangladesh it stood at only 23 per cent [10]. The fact that Bangladesh is a patriarchal, patrilocal and patrimonial society has a lot to do with the position of women and their access to resources, employment, opportunities to improve their situation. There is an interesting paradox regarding gender relations in the country. Mothers are held in high respect and at the individual level the women are not discriminated. However, at the societal level, the status of women still remains low. The issue of early marriage and social security still remain as the major impediments.

Recent years have seen an attempt to bring women more effectively into the mainstream of events in Bangladesh. Although women constitute 49% of the population, their numbers are not reflected in the decision-making structures of the country. Currently, the Prime Minister and Leader of the Opposition are female, but at the senior levels of the executive, legislature and judiciary, the numbers of women are strikingly few. Apart from the 10% of reserved seats for women in Parliament, only seven women have been directly elected as members of parliament. This is partly due to the reluctance of political parties to field women candidates, because women are often at a disadvantage in both social and economic terms in comparison to their male counterparts. This disadvantage has been partially redressed in the recent Union Parishad (UP) elections, which provided for direct election of women to one quarter of the seats at the local level. This means that there are now 12,828 female members[11], of whom 20 are chairpersons of their Union Parishad[12]. Around 10% of judges in the subordinate courts are women[13]. However, there are no female judges in the Supreme Court, and less than 5% of senior positions in the civil service are held by women.

In terms of ownership of land and assets, men at all levels of society are better off than women. It is estimated that a significant majority of the people living in absolute poverty is women, and women headed households are among the poorest in the country with 45% of female-headed households living below the poverty line[14]. This situation is perpetuated by sociocultural norms, which favour men in matters related to inheritance and other financial dealings, and promote the giving of dowry,[15] by women's families at the time of their marriage. The discrimination faced by women and girl children means that their access to resources such as education, health and

8 Key Challenges for the Next Millennium, World Bank, April 1999.

9 *Human Development Report 1998*, UNDP.

10 UNDP 1998, *op.cit.*

11 Ain O Salish Kendra et al (1997) Human Rights in Bangladesh; UPL: Dhaka

12 UNDP (1999) National Gender Profile; UNDP: Dhaka

13 Figure provided from Gradation List prepared by MLJPA by Mr. Hassan Shaheed Ferdous, Judge and Deputy Director Training, Judicial and AdministrativeTraining Institute

14 UNDP (1999) National Gender Profile; UNDP: Dhaka

15 Recently, the giving of dowry at the time of marriage has been declining.

finance is restricted throughout their life cycle; this reinforces the position of disadvantage they find themselves in relative to men. The fact that Bangladesh is one of the very few places in the world where women have a lower life expectancy than men is an indicator of how pervasive discrimination against women is.

Gender discrimination from birth leads to 17% of mothers being with a very short statue (less than 145cm tall) and 52% of mothers being underweight (Body Mass Index less than 18.5). Though all pregnant women are at risk of developing obstetric complications, women with short stature, anaemia, and low BMI are at greater risk of maternal death. The low status of women also contributes to the delays in accessing to maternal care services, which would lead to maternal deaths. Globally the maternal mortality rate is seen as an indicator of the overall status of women of a country. The maternal mortality rate in Bangladesh is 4.5, maternal deaths per 1000 live births compared with 0.8 in Sri Lanka. Violence against women is a critical public health problem in the country.

In general, women's contributions to the economy are invisibilised because much of their activity consists of non-market work. In rural areas, women do not have access to markets, and find it harder to obtain income-earning work. Some of the microfinance schemes provide women with opportunities for self-employment, but market access remains a persistent problem. Most women working in the market economy operate in the informal sector, where their wages are lower than those of their male workmates. Even in the garments sector, which has been the fastest growing sector of the economy in recent years, although the majority of the workforce is female, the conditions are often in violation of legislative provisions, and female workers are perceived to be less demanding; the senior management in the factories remains a male preserve.

Women's workloads are frequently heavy, leading to the concern about the "triple burden" they carry in terms of market and non-market productive activity, as well as reproductive responsibilities and child rearing. Within the family, women are rarely in a position to participate in decision-making with regard to important matters such as children's education and marriage. This has been changing somewhat in recent years, as more women have entered the market economy, and social structures are gradually changing as a result of this. However, for the majority of women in Bangladesh, the inequitable inheritance laws, as well as social perceptions and cultural practices with regard to dowry and divorce, combine to make their position in society subordinate to that of men. This is the situation that currently prevails, even though the constitution of Bangladesh formally provides for equality between citizens irrespective of gender.

3.2.3 Civil Society[16]

The development of civil society in Bangladesh has its roots in the many self-help and affinity groups that evolved from people sharing common challenges. Since independence, this development has been marked but not linear, with stop-go periods.

Today, the spirit of self-help and social resilience was nowhere better demonstrated than in the manner in which communities coped with the massive 1998 flood – the worst in a century.

Increasingly, citizens groups are beginning to grapple with issues in the public forum encouraged in part by a vigorous newspaper sector that spans the spectrum of opinion. Initiatives by state actors to include these groups in policy making have increased. Recently there has also been an upswing in the area of public interest law and actions launched by legal activists.

16 The main sources for this section include *Concept Paper on Good Governance* by Hasnat Abdul Hye, and *Civil Society and Good Governance: Relevance for Bangladesh* by Jeffery E. Key, papers presented at the International Conference on Good Governance, Dhaka, August 1998, MoLGRD&C/UNDP; and *The State of Civil Society in Bangladesh* by Dilara Chowdhury, *The Daily Star*, 5 November 1998.

All this is against a backdrop of active NGO involvement in development activities such as health, gender, micro-finance, education, agriculture and environment. In many cases, the NGOs work on projects that are complementary to state programs or as part of the state program (e.g. approximately 400 NGOs help the GOB to deliver adult education programs).

In several areas, Bangladesh NGOs are recognized globally as "trailblazers" and have received recognition worldwide. This is especially true of micro-credit, women's empowerment and non-formal education programs.

Based on the Islamic practice of Zakat, many people make contributions of their family income on a regular basis to those less fortunate. This practice is also reflected in the work of several private sector companies who have well developed projects that reach out to others. The role of the Bangladesh Garment Exporters and Manufacturers Association (BGMEA) as co-partners with UNICEF and ILO in an imaginative project to make the sector child labor free was noted worldwide and served as a model for subsequent actions elsewhere (e.g. with the football production in Sialkot, Pakistan).

3.2.4 The Chittagong Hill Tracts and Minorities

Situated in the southeastern part of Bangladesh, the Chittagong Hill Tracts comprises three districts- Rangamati, Khagrachari and Banderban. The ethnic population of the three hill districts comprises as many as 14 tribes each having its own distinct dialect, culture, practices and rituals. The three largest tribes among them are the Chakma, the Marma and the Tripura. In 1991 the total tribal population in the CHT was estimated to be about 500,000[17]. This progress in the social and economic development of this part of the country has been slower than the national average, mainly due to the long history of conflict and the difficult terrain. Both of these factors present additional challenges to ensuring adequate service provision.

Because of their pattern and style of *jhum* or shifting cultivation, some tribal people do not hold any formal ownership of land. But, large numbers of them have formal title to the land they are having as their homestead and plough cultivation, horticulture land etc. None of the tribals and non-tribals has any formal rights on USF (Unclassified State Forest) where the tribal most practice *jhum* or shifting cultivation. In some cases, settlers received settlement in USF land. When large-scale insurgency and counter-insurgency action started, many tribals left for India leaving their homes and settled lands. Finding good land vacant, settlers occupied these lands and many subsequently received formal title to these lands. Some tribals who did not leave for India also occupied the land of their fellow tribals who left for India. However, it has resulted in the ownership of the land being disputed between the settlers from the plains and the tribal community. This is being probed by a Task Force headed by a tribal M.P. and some 3,000 cases have been identified.

On 2 December 1997, a Peace Accord was signed between the Government of Bangladesh (GoB) and the Parbattya Chattagram Jana Sanghati Samiti (PCJSS) ending more than two decades of conflict in the Chittagong Hill Tracts (CHT).

Following the signature of the Accord, GOB initiated consultations with its development partners on how best to meet the immediate support requirements that are to underpin the implementation of the Accord. The Special Affairs Division (SAD) in consultation with the Economic Relations Division (ERD) compiled an initial portfolio of project interventions that was shared with a number of donors on 22 February 1998. At this meeting it was decided to establish a joint GOB-donor working group that was to agree on parameters and process requirements for identifying and elaborating immediate and medium support measures in respect of CHT. UNDP was requested to facilitate co-

17 Estimated from the 1991 census figures in the Statistical Yearbook of Bangladesh 1997.

ordination among donors and to fund a needs assessment mission. The Mission was fielded on 5 April 1998 and completed its work on 15 May 1998[18].

The Interim Regional Council, which took over on May 27, 1999, has the responsibility to initiate development options in consultations with the UN agencies.

3.2.5 Recent Developments in National Policy

The **Nation Plan of Action** was approved by the Cabinet (1999) and will be signed by the Prime Minister shortly. Building on the success and the initiatives already taken there is a sense of urgency in the government to accelerate the pace of development activities and services to ensure that children enjoy the rights as embodied in the CRC and the National Children Policy, and improve the opportunities for and living conditions and quality of life of all children. The National Plan of Action is the response to the urgency of giving children their rights, developing a culture of recognizing children as having rights of their own and nor just recipients of favour, and more importantly develop the services needed to ensure Survival, Protection, Development and Participation of children and thereby improve the quality of their life, and giving the an edge in shaping their own future to cope with the requirements of the new millennium.

The **National Children Policy (1994)** was approved by the Government and stipulates importance of ensuring security, welfare and development of children in the national agenda. The policy highlights the importance of providing adequate services of children, including health, nutrition and education. It also stipulates that a "proper family environment" is one of main preconditions for proper development of a child. The policy indicates identifies the need for assistance to children in difficult circumstances, and ensures that the legal rights of children are within the national, social and family context. Lastly, the policy clearly stets that the Government has adopted the principle of Best interest of the Children-that is, that in all national, social, family or personal situations, the best interest of the child will be held paramount.

In the **National Health Policy**, recently approved by the Cabinet, Primary health Care has been accepted as the method of health care delivery system to render comprehensive and cost-effective health services. Emphasis has been given to preventive and promotive strategies with "Health for all" as the fundamental objectives. The aim of the policy would be to provide better health to the maximum number of people with minimum input. Curative and rehabilitative services should be satisfactorily ensured. Drug policy is being liberalized and upgraded in accordance with the National Health Policy to meet the requirement of the health services. Epidemiological surveillance system is an important integer of the disease control programme of the government. Appropriate and adequate Human Resource Development system is under consideration to reap maximum benefits of human knowledge and skills. Participation of the community including the local government in the organization of health care delivery system at all levels has been emphasized as an important precondition to the goal of Health For All. Nutrition and health education is being given proper and due emphasis and is treated as the core of all health and family welfare activities. Private entrepreneurs and NGOs are now encouraged, with active support of Government, to complement efforts in the health service delivery system. Inter-sectoral collaboration and co-ordination has been established and strengthened for tapping the resources of other sectors for enhancing the cause of health.

The Fourth Five-Year Plan document, for the first time, included a chapter on **nutrition.** Two national documents on nutritional assessment, analyses and plan of action have been prepared as "The nutrition program and action plan in the 1990s" in the light of the "World Summit Declaration" and the other as "The Bangladesh Country Paper for the International Conference on Nutrition" (1992). The National Plan of Action for Nutrition (NPAN) has also been prepared (1997).

18 UNDP Mission, Findings and Recommendations, May 1998, Dhaka, Bangladesh.

A national policy on **education** has been prepared and is awaiting Cabinet approval. The Fifth Five-Year Plan (1997-2002) outlines the education strategy of the government. The declared policy of the government is to achieve Education for All by the year 2000. The strategy places the highest emphasis on primary education; namely to bring all villages and mahallas (in urban areas) under the cover of compulsory, uniform and free primary education. Massive and continuous training of teachers at primary and secondary levels within the country will be undertaken. Local government bodies will be increasingly involved in the management of primary and secondary institutions. Appropriate steps will be taken to reduce drop-out rate and minimize its incidence at the primary and secondary levels. Actions will be taken to reduce the gender gap and regional imbalances. Efforts to enhance participation of women in every sphere of education as well as to reduce the gap between facilities provided for male and female education.

The National Policy for **Safe Water Supply and Sanitation** (1998) outlines the following principle objectives: facilitate access of all citizens to basic level of services in water supply and sanitation; bring about behaviour change regarding use of water and sanitation; reducing water borne diseases; building capacity in local governments and communities. The following principles have been adopted as the basis for policy formulation: recognize the value of water and that it is a basic need, importance of participation of users, especially women; the need for capacity-building and taking an integrated, holisitic approach, promoting the involvement of the private sector; and ensuring environmental integrity and adequate emergency response. Within the overall objectives the following specific goals will be targeted for achievement in phases in the near future:

i. Increasing the present coverage of safe drinking water in rural areas by lowering the average number of users per tube-well from the present 105 to 50 in the near future.
ii. Ensuring the installation of one sanitary latrine in each household in the rural areas and improving public health standard through inculcating the habit of proper use of sanitary latrines.
iii. Making safe drinking water available to each household in the urban areas
iv. Ensuring sanitary latrine within easy access of every urban household through technology options ranging from pit latrines to water borne sewerage.
v. Installing public latrines in schools, bus stations and important public places and community latrines in densely populated poor communities without sufficient space for individual household latrines.
vi. Ensuring supply of quality water through observance of accepted quality standards.
vii. Removal of arsenic from drinking water and supply of arsenic free water from alternate sources in arsenic affected areas.
vii. Taking measures in urban areas for removal of solid and liquid waste and their use in various purposes. Ensuring the use of waste for the production of organic fertilizer (compost) in the rural areas.

Bangladesh ratified the UN convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in November, 1984. Within the overall framework of the CEDAW and as a follow-up to the United Nations Fourth World Conference on Women held in 1995, The government adopted a National Policy for **Women's Advancement**. It sets the goal of eliminating all forms of discrimination against women by empowering them with the ability of being equal partners of development. The national policy aims at promoting and protecting women's human rights; ensuring equal rights to have access to politics, administration, sports, culture and socio-economic activities; reflecting positive image of women in the media; eradicating persistent burden of poverty on women; ensuring equal access to health and nutrition care; prioritizing education and skill training for women; emphasising protection from environmental hazards; supporting measures for the security of abandoned, deserted women in need of special protection measures including elimination of trafficking of and violence against women, and rehabilitation of women affected during national calamities; and facilitating participation of women in all the national and international bodies and fora.

3.3 THE ECONOMY

The macro-economic situation in Bangladesh during the 1990s shows two different and contrasting trends: on one hand it reflects the gains that can be made by adopting good policies; and on the other, it highlights the negative effect of slow progress in policy reforms with respect to the state-owned enterprises.

The healthy increase in the growth of real per capita GDP from 3.8 in 1994 to 5.6 in 1998 has been attributed to the improvement in Government policies. The impact of this improvement in policies would have been higher were it not for the setback faced during the devastating floods of 1988 and 1998 (Table 6.1). The GNP per capita has also shown a steady rise from US$ 279 in 1990 to US$ 350 in 1998[19].

Table 3.1: The Macro Economy

Indicator	1990	1992	1994	1996	1998
GDP Growth Rate	7.0	5.0	3.8	5.0	5.6
GNP Per Capita (in US$)	279.3	279.3	293.6	341.2	350.1
			(Per cent age of GDP)		
Savings					
Domestic Savings	11.4	14.1	14.2	13.1	15.1
National Savings	13.7	16.9	18.8	16.7	19.0
Investment					
Gross Investment	18.9	18.8	19.0	20.8	20.2
Public	7.3	7.0	6.7	6.4	6.6
Private	11.6	11.8	12.3	14.4	13.6
Budget					
Total Revenue	6.9	8.3	9.3	9.1	9.6
Tax Revenue	5.8	6.7	7.2	7.3	7.6
Total Expenditure	12.8	12.8	13.9	13.5	13.9
Overall Budget Deficit	-5.8	-4.5	-4.6	-4.5	-4.2
Balance of Payment					
Current Account Balance	-5.2	-1.9	-1.3	-4.1	-1.2
			(In Per cent)		
Debt Service Ratio	20.9	9.0	12.9	10.7	7.9
Rate of Inflation	3.9	4.6	3.3	6.7	7.0
Exchange Rate (Tk./US $)	32.9	38.2	40.0	40.9	45.4

Source: Annex 3, p. 65, World Bank (1999).

The economy is slowly but steadily shifting its emphasis from agriculture to the manufacturing and service sectors, the share of agriculture in GDP has dropped from 28 per cent in 1990 to 23 per cent in 1998 (Table 6.2). The corresponding change has been a three per cent point rise in manufacturing and a two per cent point rise in the service sectors.

19 Unless otherwise stated the source of data in this section is *Bangladesh: Key Challenges for the Next Millennium,* the World Bank, 1999.

Within the agriculture sector however, there has been significant diversification. In 1990 the sub-sectoral shares stood at 67 per cent from crops, 15 per cent from animal farming and 11 per cent from fishing. In 1998 whereas the share from crops dropped to 53 per cent, that from fishing nearly doubled to 21 per cent, and the share of animal farming registered a three per cent point increase to 18 per cent.

Table 3.2: Per cent age Distribution of GDP of Bangladesh at Current Market Prices

Industry	GDP (%)	
	FY 1990	FY 1998
GDP at Current Market Price	100	100
Agriculture	28	23
Manufacturing	15	18
Mining/quarrying	1	1
Service	56	58
Electricity, Gas and Water Supply	1	1
Construction	7	7
Wholesale and Retail Sale	13	15
Hotel and Restaurant	1	1
Transport, storage & communication	12	6
Financial Intermediations	1	1
Real Estates, Renting and Business	8	9
Public Administration and Defense	2	2
Education	1	7
Health and Social Works	1	1
Community, Social and Personal Service	9	8

Source: Compiled from *Bangladesh: Key Challenges for the Next Millennium,* the World Bank, 1999

The increase in manufacturing is largely attributable to the readymade garment and knitwear industries, which have displayed significant growth, exports from these sub-sectors increasing more than threefold from 1183 million US dollars in 1992 to 3784 million US dollars in 1998.

Most of the contribution is however from large and medium scale enterprises, small-scale[20] enterprises answering for less than 30 per cent of the sectoral income, there being no change in this distribution in this period. The major portion (90 per cent) of the investment in the manufacturing comes from the private sector, the domestic private sector contributing more than 60 per cent to this investment (Table 6.3).

These improvements in the economic performance are partly the outcome of improved macroeconomic management as discernible by the General Macro Performance Index[21], which has risen from a lowly 2.5 in 1984 to a somewhat respectable 4 in 1998[22]. The Government has achieved this by adopting sound macro management measures during

20 BBS defines large scale enterprises as those engaging 50 persons or more; medium scale enterprises as those engaging 10 – 49 persons; and small scale enterprises as those engaging less than 10 persons.

21 World Bank (1999), Bangladesh: Key Challenges for the Next Millennium, Dhaka.

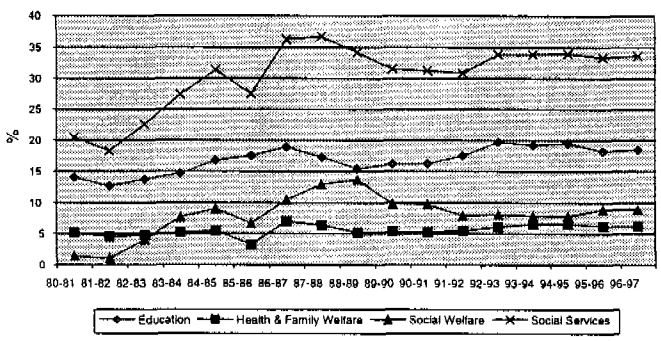
22 Judged against a scale of 1 to 6 with a score of 1 suggesting poor policies over an extended period and a score of 6 suggesting good policies for an extended period.

the 1990s, to reduce fiscal deficits, contain rates of inflation, correct the distortions in the exchange rates, and promote export-led growth.

3.4 INVESTMENT IN HUMAN DEVELOPMENT[23]

Impressive gains in budget allocations for the social services have been achieved in Bangladesh, particularly during the 1990s. Significant proportion of this increase was accounted for by basic social services from the poor benefits most.

Figure 1 Current Expenditures (Social Services)



The share of social sector spending in ADP almost doubled during the period 1990/91 to 1996/97 from 12.5 percent to 24.2 percent. The share of social services in the current expenditure of the central government rose modestly from 30.8 percent to 33 percent, in the corresponding years. These figures represented substantial increases from the period 1980/81 to 1984/85, as the share of social spending in ADP and the recurrent budget averaged just 10 percent and 25 percent respectively.

Within the social sector, spending on education increased from 14 percent of recurrent budget in 1980/81 to 18.4 percent in 1996/97. This is matched by similar increases in the development budget from 4.1 percent in 1980/81 to 13.5 percent in 1996/97. Spending on health and family welfare increased from 5.2 percent of total recurrent expenditures in 1980/81 to 6.2 percent in 1996/97. In the development budget, the corresponding increase was from 5.7 percent to 9.2 percent. (See Figure 1)

Further analysis using the expenditure ratios provides an interesting picture of investment in human development.[24] The public expenditure ratio, i.e., share of public expenditure in the GDP remains almost unchanged around 17 percent from 1980/81 to 1996/97. However, in terms of the social allocation ratio, i.e., the share of social sector budget in the public expenditure, it doubled from 15 percent in 1980/81 to 1996/97. Social Priority Ratio is the ratio of the allocation to basic social services in the social sector budget. This has fluctuated and is around 50 percent in 1996/97.

23 *Dr. Nasreen Khundker & Dr. Reza Kibria,* "Aid and Budget Restructuring in Bangladesh (The 20/20 Study)", *April1999*

24 *See UNDP Human Development Report, 1991 for description of these ratios.*

Table 3.3 Expenditure Ratios

Year	Public Expenditure Ratio	Social Allocation Ratio	Social Priority Ratio
1980/81	17	15	53
1981/82	18	15	53
1982/83	16	17	NA
1983/84	18	16	57
1984/85	15	21	59
1985/86	16	19	56
1986/87	16	22	53
1987/88	16	24	57
1988/89	16	25	63
1989/90	16	24	61
1990/91	16	23	62
1991/92	17	24	62
1992/93	18	26	56
1993/94	18	27	57
1994/95	19	29	56
1995/96	17	29	55
1996/97	17	30	46

In terms of the share of Official Development Assistance to social sectors, it has increased over the years and is over 20 percent since 1992/93.

There is scope for inter-sectoral restructuring of current expenditures by containing further growth of military expenditures, which since 1980/81 absorbed 18.5 percent of the recurrent budget. On the other hand there is little scope for intra-sectoral restructuring in the health and education sectors.

Despite shortcomings in the planning and implementation of social sector spending programmes and the cost-effectiveness of such programmes, Bangladesh is one of the developing countries, where increases in government spending have been reflected in corresponding improvements in social indicators.

3.5 POVERTY[25]

The most recent estimates of the Human Poverty Index (HPI) for Bangladesh show that the HPI has decreased from more than 61 in 1981-83 to about 40 in 1995-97[26]. This is reconfirmed by findings that while poverty remains endemic, aggregate poverty has declined from 59 per cent in 1983-84 to lie in the range 45-53 per cent in 1995-96 (tables 3.5 and 3.6).

25 Unless otherwise stated, the source of this section is from *Poverty Issues in Bangladesh: A Strategic Review*, H.Z. Rahman, DFID, 1998.

26 BIDS/UNDP (1999) op.cit.

Extreme poverty has also decreased in this period from 41 percent to 23-35 per cent[27]. Rural poverty has dropped from 53 percent in 1991/92 to 51 percent in 1995/96, urban poverty experiencing a higher drop from 34 percent to 26 percent[28].

Table 3.4 Trends in Poverty Incidence in Bangladesh

Source	Extreme Poor (% of population)		All Poor (% of population)	
	1991-92	1995-96	1991-92	1995-96
HES 1995-96				
Rural	28.3	23.3	47.6	45.4
Urban	26.3	26.4	46.7	48.5
World Bank/BBS 1998				
National	42.7	35.6	58.8	53.1
Rural	46.0	39.8	61.2	56.7
Urban	23.3	14.3	44.9	35.0
CIRDAP/BBS 1999			**1996**	**1998**
Rural			47.9	47.6
Urban			44.4	44.3
BIDS 1995	1987	1994	1987	1994
	25.8	22.5	57.5	51.7

Source: Compiled from H.Z. Rahman 1998, *op. cit.; Poverty Monitoring Survey in the Urban and Rural Areas*, CIRDAP/BBS 1999.

Note: Estimation method is headcount index using direct calorie intake.

The decline in the incidence of poverty over the decade of the 90s has however, been at the very modest rate of less than one per cent point a year so that in 1996 some 60 million people remained below the poverty line of 2100 - 2200 Kcal. with nearly 40 million being extremely poor[29] who do not meet even a daily energy intake of 1,805 calories.

27 H.Z. Rahman (1998) *Poverty Issues in Bangladesh: A Strategic Review* (unpublished).

28 BIDS/UNDP (1999) op.cit.

29 The extreme poor are also referred to as the very poor, the hard core poor, and the poorest of the poor.

Table 3.5 Poverty Trends 1984-85 to 1995-96

	Very Poor					Poor				
	'83-84	'85-86	'88-89	'91-92	'95-96	'83-84	'85-86	'88-89	'91-92	'95-96
Headcount										
National	40.91	33.77	41.32	42.69	35.55	58.50	51.73	57.13	58.84	53.08
Rural	42.62	36.01	44.30	45.95	39.79	59.61	53.14	59.18	61.19	56.65
Urban	28.03	19.90	21.99	23.29	14.32	50.15	42.92	43.88	44.87	35.04
Poverty gap										
National	10.42	6.85	9.89	10.74	7.89	16.52	12.27	15.35	17.19	14.37
Rural	10.51	7.36	10.76	11.73	8.90	16.83	12.50	16.01	18.06	15.40
Urban	6.53	3.70	4.20	4.89	2.75	14.26	10.85	11.06	12.00	9.19
Squared poverty gap										
National	3.69	2.14	3.43	3.86	2.59	6.61	4.20	5.77	6.76	5.36
Rural	3.88	2.31	3.78	4.25	2.95	6.72	4.27	6.07	7.15	5.74
Urban	2.29	1.04	1.21	1.53	0.80	5.78	3.81	3.83	4.43	3.44
Gini Index										
National	25.53	25.66	27.94	27.15	31.01	25.38	24.73	27.02	25.92	29.34
Rural	24.33	23.80	25.96	25.06	26.43	24.62	23.58	25.71	24.34	26.47
Urban	29.46	29.87	31.09	31.09	36.03	29.31	29.34	31.35	30.68	35.38

Source: World Bank (1998). BBS (1997) for 1995-96 estimates.

Other poverty-significant evidence that corroborate the reduction in the levels of poverty include the decrease in the proportion of rural population without access to basic clothing from 15 to four per cent in the period 1990-95; and the decline in the proportion of rural households living in extremely vulnerable types of housing from nine to two per cent in the same period. Again, the incidence of malnutrition was the lowest in end 1996[30] and real wages increased by about seven per cent between 1991/92 – 1996, especially in the agriculture and manufacturing *sectors*[31].

However, the burden of poverty continues to fall disproportionately on women in areas of nutritional intake, access to gainful employment, wage rates, and access to maternal health-care. Not only are female-headed households (estimated to be between five to nine per cent [32] of rural households) the worst-off group among the poor, but also households dependent on female earners (estimated to be 20 per cent of rural households) have a higher incidence of poverty than those dependent on male earners.

Poverty has declined more in urban than in rural areas and the rates of decline have been more pronounced in the case of extreme poverty which halved since 1983-84. The situation in the urban slums and fringes however, still remains precarious. Rural aggregate poverty also declined by some 15 per cent age points in that period (Table 4.2). Urbanization, which has increased at a very fast pace from 12-13 per cent in the early eighties to 22-23 per cent in the mid-nineties, has thus benefited both the moderate and the extreme poor.

30 Cited in D. Mitchell's *Promoting Growth in Bangladesh Agriculture*, 1998, the World Bank, Washington, D.C.

31 CIRDAP 1997, *Structural Adjustment Policies and Labour Markets.* Monitoring Adjustment and Poverty Policy Brief 11, Dhaka.

32 *Female Headed Households* by S. Hamid in Rahman and Hossain (eds.) *Rethinking Rural Poverty*, 1995, Sage publications.

It is a matter of concern however, that in spite of the positive economic growth and reduction in poverty, inequality as measured by Gini Index based on consumption levels, has registered an increase. Overall inequality has increased faster in the 1990s than in the 1980s, and is more pronounced in the urban than in rural areas. Inequality is also more pronounced for the very poor than for the poor. The slow reduction in poverty in an environment of relatively high economic growth has been attributed to this rising inequality rather than to increase in population.

There is also regional variation in poverty levels that cuts across both rural and urban areas. The disparity is more prominent in urban than in rural areas, possibly because of the skewed urbanization process. Thus urban poverty in the major cities of Dhaka and Chittagong at 29 to 34 per cent is about half that in Khulna and Barisal where it is estimated to be 48 to 54 per cent . While regional disparity in rural poverty is more muted (lowest 47 per cent , highest 61 per cent), there are localized pockets of extreme distress in the ecologically vulnerable low-lying belts along major rivers and the coastal areas.

Poverty in Bangladesh is however not static. There are five critical process dimensions, which perpetuate the situation. These are natural disasters, illness-related expenditure, insecurity, dowry, and death of the main income earner in a household. Natural disasters include floods, cyclones and riverbank erosion; illness-related expenditure includes expenses incurred for illness of family member or livestock; insecurity includes loss from theft, dacoity, eviction from land, litigations, physical threats, extortion, police harassment, legal expenses, rape and abandonment of women, and general absence of law and order; and dowry expenses are incurred on daughter's marriage.

Of these process dimensions illness-related expenditure routinely affect about 40 per cent of rural households while crisis arising from insecurity dimensions affect some 15 per cent annually. Dowry expenses create crisis situation for about four per cent of the households and death of main earner affects another two per cent . The magnitude of the income erosion arising from these five dimensions is estimated to be nearly 8,000 taka annually or nearly 16 per cent of the average rural household income.

Seasonal dimensions also exacerbate the poverty situation. While traditionally there have been two major periods of seasonal deficit in rural Bangladesh, the widespread expansion of winter rice production has significantly reduced the impact of the March – May lean season. The September – November lean season however continues to a food deficit period for many households, whose fluctuations in income and consumption are not captured by standard poverty measures.

Such seasonal deficits are mainly experienced by rural households whose principal occupations are wage labour and petty trade[33] who were also found to be the most severely affected by the famines of 1943 and 1974[34]. This unequal impact is due to fall in wage employment opportunities and in earnings from trade during the month of October: wage employment declines by as much as 62 per cent and average wage levels fall by 20 to 50 per cent depending on the region. More than 40 per cent of the petty traders suffer fall in their daily earnings. Such drop in income levels leads to reduction in food intake, asset depletion and increased indebtedness.

The poor in Bangladesh are not homogeneous and fall into three distinct groups:

- The extreme poor households (22.7 % of rural households) lie clearly below the poverty threshold and have a daily per capita intake of < 1800 Kcal; own =0.15 acres of land; have annual per capita income of 3757 taka; and suffer chronic food deficit.
- The moderate poor households (29.2% of rural households) lie around the threshold of the poverty boundary and have a daily per capita intake of <2112 Kcal.; own =0.50 acres of land; have a per capita annual income of 6287 taka; and are occasionally food deficit.

33 Rahman, H.Z. (1995) *Mora Kartik: Seasonal Deficits and the Vulnerability of the Rural Poor* in Rahman and Hossain (eds.) Rethinking Rural Poverty: Bangladesh as a Case Study. UPL, Dhaka.

34 Amartya Sen

- Tomorrow's poor (21% of rural households) currently lie above the poverty threshold but are vulnerable to income erosion pressures and consequent descent into poverty. They own =1.5 acres of land; have a per capita annual income of 8368 taka; and are neither food deficit nor food surplus.

3.5.1 The Role of Microfinance in Poverty Reduction

Currently 9.5 million people in Bangladesh have access to microfinance services under programmes run by the Grameen Bank, BRAC, Proshika, ASA, and other NGOs. Of these 86 per cent are women. Total cumulative loans disbursed as of June 1998 stands at 152 billion taka, 64 per cent of which have been disbursed by the Grameen Bank alone. Most of the disbursement has been in rural areas, less than two per cent being directed at urban areas. Members' savings total nearly 12 billion taka[35].

While many factors have contributed to the appreciable though modest reduction in poverty, a target approach to poverty alleviation through provision of credit by programmes such as the Grameen Bank, BRAC, and BRDB RD-12 have been found to be conducive to reducing the extent and depth of poverty. This approach has also managed sustain household welfare on a longer-term basis. Recently, PKSF has been formed to disburse funds to NGOs to provide credit.

Thus moderate poverty has been found to be appreciably lower (62 per cent) among Grameen Bank members than among non-members who fulfil the eligibility criteria[36] (72 per cent). Also, moderate poverty in villages not covered by any credit programmes is higher among those who are eligible (66 per cent) for microcredit programmes [37].

Table 3.6 The Impact of Grameen Bank Credit on Poverty Reduction

Type of Group	Headcount ratio for moderate poverty	Headcount ratio for extreme poverty	Poverty Gap Index	FGT Index
Grameen Bank Villages				
Eligible and participating	61.61	10.32	13.18	2.82
Eligible but not participating	71.54	17.07	17.83	4.45
Not eligible and not participating	43.06	9.72	9.28	12.00
Total	58.94	12.90	13.60	3.03
Non-programme villages				
Eligible	65.59	9.72	15.47	3.65
Not eligible	51.11	11.11	11.45	2.56
Total	58.51	10.21	14.84	3.48

Source: Adapted from Khandker and Chowdhury 1996.
Note: FGT Index = Foster-Greer-Thorbecke measures the severity of poverty among the poor.

35 *Microfinance Statistics of NGOs and other MFIs*, Volume 6, June 1998, Credit and Development Forum, Dhaka.

36 The criteria to be fulfilled in order to be eligible for loans at entry point include: landownership not exceeding 0.5 acres of cultivable land; value of assets not exceeding the value of one acre of medium quality land; main occupation is wage labour; must belong to a group.

37 *Target Credit Programmes and Rural Poverty in Bangladesh*, S.R. Khandker and O. H. Chowdhury, World Bank Discussion paper No. 336, 1996.

In spite of these encouraging trends, no significant variation has been observed in the incidence of extreme poverty between members and those fulfilling eligibility criteria in villages not covered by credit programmes, the headcount ratio for extreme poverty in both cases being around 10. On the other hand, headcount ratio for extreme poverty among eligible non-members in villages covered by Grameen Bank stands at 17 which is very high compared to all other groups.

This confirms other findings[38], which point out that credit programmes in general, have not been successful in reaching the poorest of the poor. Some of the main causes for this shortcoming include self-exclusion of the poorest; the group self-selection process[39]; location because the very poor are often concentrated in difficult to access regions, which increases the credit delivery cost for the institution. Also another shortcoming of these programs is that the attitude of the target beneficiaries in some highly vulnerable ecological disaster prone areas has become habituated to receiving humanitarian relief.

3.6 THE HUMAN AND NATURAL ENVIRONMENT

3.6.1 The Population

The population density in Bangladesh is one of the highest in the world. Even with a steady decline in the fertility rate with accelerated state efforts to attain a replacement fertility rate, the country's population is expected to reach 170 million, and population density 1200 persons per sq. km by 2010[40]. The majority of the population resides in rural areas, and the poorer sections are often marginalised into inhabiting environmentally degraded or resource-exploited zones. The linkage between poverty and environmental condition is complex and intricately intertwined in Bangladesh, with increasing numbers of people being exposed to ecologically fragile or environmentally unsound situations, which are not conducive to longer-term sustainable livelihoods.

The current population of Bangladesh is estimated to be about 126 million, with a population growth rate of 1.5 prevalent in 1996[41].The pressure of population on the existing resource base, and the disparities in income distribution and ownership of assets and production systems has led to a situation where 48%[42] of the population live below the national poverty line. In addition, the strains created by attempts to sustain a large population has contributed to fragmentation of land holdings, increasing landlessness, deforestation and degradation of the physical environment through pollution and over-use.

Although the population growth rate has shown a marked decline in the decade of the nineties, falling from 2.0 in1991 to 1.8 in 1996[43], the size of the population base means that Bangladesh will continue to experience a high population growth in absolute terms for decades to come. By 2015, the population is estimated to rise to 162.7 million[44]. The massive expansion in the population in the last twenty-five years has ensured a high proportion of

38 *Sustainable Banking with the Poor: A Case Study of Grameen Bank*, Hashemi and Schuler, 1997, mimeo, Dhaka.

39 Hashemi et. al. (1997) however finds that a relatively small proportion of women is excluded for this reason.

40 UNDP (1999) Environmental Overview of the Country Programme, Dhaka (unpublished)

41 World Bank (1999) Bangladesh: Key Challenges for the Next Millennium; World Bank: Dhaka

42 UNDP (1998) Human Development Report; UNDP: New York

43 World Bank op.cit.

44 UNDP (1998) Human Development Report; UNDP: New York

younger people amongst the population, with 43% being below the age of 15[45]. The proportion of elderly (60 years and above) is low at less than 6 per cent, the proportion of males being marginally higher because of the higher life expectancy rate.

Although the male:female life expectancy ratio has shown positive trends, rising from 56.5:55.7 in 1991 to 58.1:57.6 in 1996[46], the population remains male-biased with 49 per cent of the population being female. Bangladesh is one of the very few countries in the world where the women have a lower life expectancy than men, as the natural tendency for women to have greater longevity is reversed.

The fertility rate dropped from 4.3 in 1991 to 3.4 in 1996[47], which is due to a combination of factors, including the increase in contraceptive prevalence rate from 40 per cent in 1991 to 52 per cent in 1997[48], the increase in the mean age at first marriage from 18 to 20 years for girls, increased female literacy and higher female labour force participation [49]. Maternal mortality rate has nearly halved since 1990 but still remains high at 4.3-4.4 per 1000 live births in 1997[50]. Among the reasons for the high maternal mortality rate are the low nutritional status of pregnant women and the lack of health care, only 18 per cent of births in 1997 being attended by skilled health personnel[51]. In addition, a significant proportion of maternal deaths, around 14%, is associated with violence[52].

3.6.2 Natural Resource Base

Bangladesh extend from the Bay of Bengal in the south and merges into the highlands of India under the foothills of the Himalayas in the north. The largest delta in the world it makes up 8 per cent of the 600,000 sq. m. Ganges-Brahmaputra-Meghna basin, and funnels nearly all the outflow to the Bay of Bengal[53]. This brings with it a yearly cycle of floods and silt loads which constitute the natural base of soil revitalization, traditional agriculture and fisheries. The country is predominantly flat, 80% of total land area, having highland tracts in the upper middle, south-eastern and north-eastern sections, parts of which are covered by forests. Almost half of the country has an elevation of less than 10 meters above sea level. The agro-ecological environment is broad and is classified into 30 zones with some 88 sub-zones[54]. Apart from the regional diversity, there is considerable variation in type, moisture regime and temperature of its soil.

Tropical cyclones or hurricanes, accompanied by storm surges regularly hit the coastal areas of Bangladesh. In rural areas the poor depend on common property resources such as open water fisheries, wetland based flora and fauna, government land and forests for a significant part of their livelihoods. More than 15 per cent of the income of a rural household can be accounted for by such activities as foraging for food, fodder and building materials[55]. Some

45 Estimated from Statistical Yearbook of Bangladesh 1997, BBS 1998.

46 BBS 1998 op.cit.

47 World Bank op.cit.

48 Common Country Assessment Indicators

49 UNDP (1999) National Gender Profile; UNDP: Dhaka

50 CCA indicators, UNICEF.

51 Common Country Assessment Indicators.

52 Ministry of Health and Family Welfare (1998) The Women Friendly Hospital Initiative; MOHFW/UNICEF: Dhaka

53 SEHD (1998) Bangladesh environment: Facing the 21st Century, Dhaka

54 *The Statistical Yearbook of Bangladesh 1997*, BBS.

55 UNDP (1998) Bangladesh Human Development Report, Dhaka

80 per cent of the total population depend to some extent on the utilisation of natural resources or on processing the resultant products. This access is however getting more and more restricted as traditional partners of resource use and management disappears in the face of increasing commercialization and resource exploitation.

Water Resource Management

Increased and conflicting needs by different water-using sectors strain the country's water resources, especially during the dry season. During the wet season on the other hand, the combination of high rainfall and peak flows from the Padma, Brahmaputra and Meghna rivers cause floods that can affect more than 55 per cent of the total land. Exacerbating the situation are man-made interventions to control floods or develop irrigation, which are perceived to have negative impact on the environment. Inadequate planning of flood control, drainage, and irrigation interventions are thought to have led to worsened off-site flooding, drainage of wetlands, and increased waterlogging and salinization. Moreover, some water development projects have caused disproportionate hardship on displaced populations who were not adequately compensated at the time of relocation.

Government polices, such as the Flood Action Plan, have moreover been characterized by a definite top-down approach that exacerbates environmental problems. Recently however, the Government has initiated steps towards a more comprehensive plan starting with the Bangladesh Water and Flood management Strategy.

The Government has taken some institutional initiatives by enhancing the environmental responsibilities of the Water Resource Planning Organisation. WARPO however can be effective only if it has the capacity to generate and implement technical knowledge on the design of environment-friendly water structures and can implement participatory policies in the design or restructuring of water projects.

Arsenic Contamination

Much of the country's groundwater is contaminated with arsenic and more than 21 million people are potentially at risk of arsenic poisoning due to drinking water from tubewells that contain arsenic level higher than the nationally accepted standard. The Government is implementing various programmes aided by donors to provide relief to the most affected population and find long term, sustainable solutions to the problem. (See chapter 3 for more details).

3.6.3 Disaster Vulnerability and Preparedness[56]

Bangladesh is one of the most disaster-prone countries of the world. Because of its geographical location and other environmental reasons, the country is frequently exposed to various types of natural disasters such as cyclones, floods, riverbank erosion, tornadoes, droughts and earthquakes. It has been estimated that while only about four per cent of global cyclones make landfall in Bangladesh, the loss of lives and damage to the country is about 90 per cent of the world estimate. The cyclone that struck the coastal areas of Bangladesh in November 1970 caused over 300,000 deaths and US$ 2.5 billion worth of damage to property. In the recent floods of 1998 damages were estimated to be two to three billion US dollars.

56 Unless otherwise stated the source of this section is UNDP document BGD/92/002 Comprehensive Support for Disaster Management.

Table 3.7 Bangladesh: Major Natural Disasters

Year	Type of Disaster	Deaths
1822	Cyclone	40,000
1887	Cyclone	100,000
1898	Cyclone	175,000
1943-44	Drought, irregular rain, transport dislocation and War (includes West Bengal)	3,000,000
1957		
1960	Cyclone	11,149
1961	Cyclone	11,468
1963	Cyclone	11,520
1965	Cyclone	19,270
1970	Cyclone	300,000
1974	Floods followed by famine	30,000
1985	Cyclone	11,069
1987	Floods	1,657
1988	Floods	5,708
1988	Cyclone	2,379
1991	Cyclone	138,868
1998	Floods, lasting for nearly three months, covering 65 % of land area	1,000

Source: Comprehensive Support for Disaster Management, BGD/92/002, and UNDP.

Increases in population, and population density, and industrialization in urban areas have considerably increased the risks associated with major fires, and industrial and other accidents. Human activities such as unplanned construction of infrastructure causing closure of many natural drainage systems have also increased the frequency of flooding especially in urban areas.

Disaster management includes all aspects of planning for and response to disasters. It involves the management of both risks and consequences of disasters and includes preparedness, mitigation, protocols, emergency response and post-disaster reconstruction and rehabilitation. This broad concept is relatively new, especially in Bangladesh, where 'disaster management' has generally been understood to mean management after a disaster has occurred, particularly of relief operations.

Bangladesh has fairly well developed procedures for managing the consequences of natural disasters. It has made considerable efforts in organising disaster relief operations within the limits of the available resources. However, much of the achievements have been done on 'ad-hoc' basis with few people receiving any relevant training or following practical guidelines. While few formal evaluations have been made of the Government's disaster management activities, the various recommendations for improvement at all levels include:

- More attention to be given to preparedness and to possibilities for action to reduce risks and loses;
- Better co-ordination of activities between line ministries/departments/agencies, and between civil authorities, the Armed Forces, NGOs, and professional associations together with necessary training.

A needs assessment conducted with UNDP confirmed the previous recommendations and stated that the following need to be accomplished in order to improve disaster management:

- establish national level policies, plans and guidelines;
- strengthen existing institutions and co-ordination mechanisms in the field;
- organize extensive public education and community mobilisation activities;
- promote a number of specific, practical measures to develop and test 'proofing' techniques;
- improve warning systems;
- improved existing methodologies for the assessment of damages and needs;
- develop specific expertise and management systems for the overall management and co-ordination of emergency response operations;
- integrate the capabilities of the civil administration, the Armed Forces, NGOs, professional and other organisations; and
- promote wider knowledge of disaster risks and the possibilities to mitigate those risks.

3.7 REGIONAL ISSUES

3.7.1 Children's issues and South Asia Regional Cooperation (SARC)

The SARC has adopted a number of policies relating to children. This includes initiatives to address child labour and child trafficking. Although these initiatives are a step in the right direction, and have potential, the follow-up on the implementation needs to be strengthened.

3.7.2 Trafficking

The phenomenon of trafficking in women and children has become an increasingly urgent issue in recent years; the cross-border activity taking place makes it difficult to estimate the numbers involved. Within the region, Bangladesh (along with Nepal) is viewed as a "sending" country, while others, such as India, are viewed primarily as "receiving" countries; India is also a transit area, from where women and children are siphoned off to the rest of the world. According to one estimate, around 4500 women and children are smuggled into Pakistan alone every year[57].

The trade in human beings is the result of a complex combination of factors, including growing poverty and population pressure, cultural perceptions about the rights of women and children and the low value given to women and girl children, as well as globalisation and the demand for labour and prostitution services in the international market.

57 Bangladesh National Women Lawyers Association (1996) Movement Against Flesh Trade; BNWLA: Dhaka

Traffickers use a combination of methods to trap their victims, which range from promises of jobs and marriage to coercion and abduction. The situation is exacerbated by the existence of organised rings of traffickers, by the collusion of law enforcement personnel in the trade, and by the high profit-making potential that such activities offer[58].

Thus any attempt to address the issue of trafficking would have to be undertaken on a regional basis to maximise the effectiveness of such initiatives.

3.7.3 Migration

The oil boom in the Middle Eastern countries, and the revived industrial economy of the NICs in Southeast Asia drew a large number of temporary migrant labourers to these countries. Bangladeshi migrants to the USA and Canada are mostly skilled and professional people. It is estimated that in 1995 there were nearly 100,000 documented migrants.

Bangladeshi migrants are predominantly male, but there have been some significant female migrations for professional and semi-professional jobs especially to the Middle East. The Government however officially discourages international migration of women because of various incidences of abuses to which women migrants have been subjected. In July 1998 the Government placed a ban on foreign employment for female nurses and housemaids. The ban was lifted in October 1998 for nurses but remains in force for housemaids.

Remittances are sent both through official channels as well as through an unofficial system of intermediaries (*hoondi*) who arrange for a direct remittance of workers' wages to the families. The existence of a parallel system for transferring earnings from abroad is due to the inefficiency and corruption of the postal system and the failure of national banks to institute policies which answer the needs of migrant workers in terms of cash flow facilities and investment schemes.

The labour market conditions in the region have changed considerably over the last decade or so, with countries such as Nepal and Vietnam increasing competition through means which are detrimental to the rights and the welfare of migrant labourers. The increased labour supply , together with the deteriorating economic situation of South East Asia and the middle east, has pushed down wages by as much as 50 percent in some sectors, and has reduced employment opportunities.

The key legislation in Bangladesh on labour migration is the Ordinance on Labour Emigration 1982, but in the face of recent labour migration dynamics and the globalisation of the labour market, the legislation needs to be modernised to meet the emerging challenges. While policy makers in Bangladesh recognise the necessity to improve and strengthen the labour migration process, there remains a gap between enactment of policies and legislation and their effective implementation.

58 UNIFEM (1998) Trade in Human Misery; UNIFEM South Asia Regional Office: New Delhi

3.7 COMMITMENTS TO HUMAN RIGHTS CONVENTIONS

Bangladesh has been relatively active in the area of human rights to the extent that it has to date ratified most of the International Human Rights conventions given below.

Status of Signature/ Ratification/ Accession by Bangladesh to Human Rights Instruments

No	Convention/ Covenant	Signature	Ratification/ Accession
1	Convention on the Prevention and Punishment of the Crime of Genocide (9 December 1948)		5 Oct 1998
2	International Convention on the Elimination of All Forms of Racial Discrimination (7 March 1966)		11 June 1979
3	International Covenant on Economic, Social and Cultural Rights (16 December 1966)		5 Oct 1998
4	International Covenant on Civil and Political Rights (16 December 1966)		
5	International Convention on the Suppression and Punishment of the Crime of Apartheid (30 November 1973)		5 Feb 1985
6	Convention on the Elimination of All Forms of Discrimination Against Women (18 December 1979)		6 Nov 1984
7	Convention on the Political Rights of Women (31 March 1953)		5 Oct 1998
8	Convention on Consent to Marriage, Minimum Age for marriage and Registration of Marriages (10 December 1962)		5 Oct 1998
9	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (10 December 1984)		5 Oct 1998
10	International Convention Against Apartheid in Sports (10 December 1985)		
11	Convention on the Rights of the Child (20 November 1989)	26 Jan 1990	3 Aug 1990
12	Convention Relating to the Status of Refugees (28 July 1951)		
13	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (18 December 1990)	5 October 1998	

Source: Permanent Mission of Bangladesh to the United Nations, New York, 1999.

The swiftest ratification in the history of international conventions has been on the CRC, followed closely by the CEDAW. However, despite the high number of countries ratifying the CEDAW, it is also the Convention with the highest number of reservations.

In 1984 the Government of Bangladesh ratified CEDAW with reservations to four important provisions, namely articles 2, 13(a), 16(1)(c), and 16(1)(f). These articles relate to:

- The elimination of discrimination against women (including through progressive legislative measures, and in their national constitutions);
- The same rights and responsibilities during marriage and its dissolution;
- The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation, where in all cases the interests of the children shall be paramount[59].

On July 19, 1997, when it submitted its Third and Fourth Report to the CEDAW Committee, in compliance with Article 18 of the Convention, Bangladesh partially withdrew its reservations to Articles 13(a) and 16(1)(f). These Articles state that *the State Parties to the Convention shall take appropriate measures to eliminate discrimination... ...on the basis of equality of men and women... ...*[60]. The Government however has not as yet introduced CEDAW provisions into domestic legislation, nor has it taken any measures for eliminating legal discrimination in citizenship rights, personal rights and inheritance rights. Existing institutional measures thus do not facilitate women's access to justice or to political and public participation.

3.8 CONCLUSION

Bangladesh is an old country with a history of colonial exploitation, which did not destroy indigenous resilience for coping with adverse conditions and creating opportunities for development. Despite continuance of a military-bureaucratic rule over a long period, the democratic urge of the people prevailed. However, institutionalization of democracy in the governance of the country form the national to the local level is yet to gain its root.

Bangladeshi society is hierarchical and in recent years the economic polarisation has increased. Population pressure, shrinking employment opportunities, inequity of access to quality education has limited the impact of poverty eradication process undertaken by GoB and NGOs. Though hard-core poor are numerous in number, the number of people below the poverty line do not seem to have increased.

Recent policies to promote private initiative in areas earlier reserved for public sector seem to have created capacity for coping with natural disasters and individual initiative for becoming economically active. This has been reflected in the economic structures and economic growth rates. However, quality of life has not equitably changed or change has not come where it is most needed.

59 Ain O Shalish Kendra 1998.

60 Ain O Shalish Kendra 1997.

Th preconditions for such change is devolution of decision making power to the local level with adequate resource moblisation capacity, getting community involved in social improvement initiative, and making physical infrastructural changes that bring supportive changes through inroads of production technology and interactive mobility. Here the role of civil society is important.

The issues related gender and child survival and development have been recognized and over the years some initiative has been in place. Even then opportunity for improvement and continuity of maintenance of required intervention need appropriate attention. These relate to maternal and child health, nutrition, accesses to education, employment opportunity, and preservation of appropriate social and natural environment, reduction of gaps between socio-economic strata. Despite all efforts in the context of CRC some stand out requiring special attention, i.e. arsenic contamination, air pollution, homeless families, slum dwellers, trafficking of children, violence against children etc. These issues have been discussed in detail in the following chapters and an attempt has been made to analyze the causality and identify the responsibility of the duty bearers at all levels.

CHAPTER FOUR

Survival

4.1 KEY ELEMENTS OF SURVIVAL

Children's survival depends on meeting their basic needs for life and growth. Their needs change with their age, from life in the womb to adolescence. They need to be prepared to meet the challenges to health and well-being. In addition, a suitable environment is needed so that the children are protected from infective agents and other hazards to health and safety.

Survival are first categorized into two parts: (1) health and nutrition; and (2) water and environmental sanitation, in view of program operational point of view. Special focus has been given to two pertinent and relevant issues in the health and nutrition component of the chapter: a) women's health and
b) children in disasters.

4.1.1 Health and Nutrition

The most vulnerable time is the period before birth upto the first month of life. Since life begins in the mother's womb, it is influenced by the state of her health and nutritional status, and the care she is given or is herself taking. Many mothers are malnourished and suffer from micronutrient deficiencies-- 74% of mothers with iron deficiency anaemia, 60% being deficient in serum retinol (less than 20u/dl)[1], a night blindness rate of 3.4% (during pregnancy & lactation)[2] and 47% iodine deficient. With various factors, the 30 – 50% of newborns are with low birth weight (less than 2.5 kg). The chance to influence this situation is limited by poor attendance for antenatal care, with only about 25% of pregnant mothers attending antenatal clinic even once. However, 90% of pregnant women have tetanus immunization.

Early marriage, absence of premarital counselling, pressure on the bride to reproduce quickly, and the poor nutritional status of the mothers are among the factors leading to a poor foetal and maternal outcome of a pregnancy. The risks associated with pregnancy and delivery are not appreciated. Over 95% of deliveries occur at home mainly at the hands of untrained persons. Only 5% of the estimated number of mothers with complications seek skilled care. The maternal mortality rate is 4.3 per 1,000 live births is less than previously but the rate of improvement is slow. A disturbing finding is that an estimated 14% of deaths are related to violence. Only 1 out of 4 infants who survive their mother's death will live 12 months.

Given the untrained birth attendants, it is hardly surprising that 12 babies in every 1,000 live births die within hours of birth mainly from birth trauma. Of the 35 who die in the first week, 19 deaths are due to prematurity. Within the first month, prematurity and neonatal tetanus account for almost half (47%) of the neonatal deaths. The proportion of deaths from neonatal tetanus has decreased over the years but the 10% due to birth asphyxia and the 11% due to birth trauma remain a challenge.

1 SK Roy, et.al.,1994

2 HKI, 1998

The neonatal death rate contributes to over 50% of the infant mortality rate. IMR has shown a consistent pattern of decreasing from 94 per 1,000 live births in 1990 to 66 in 1997, a decrease of almost 30%. Rural infants are much less likely to survive than urban infants. Other than neonatal causes, acute respiratory infections, diarrhoea and measles are the most frequent causes of death.

In the Under 5 years figures, pneumonia and diarrhoea are the most common causes of death with malnutrition increasing the risk of death. There has been a fall in the U5MR of over 23% between 1991 (146 per 1,000 live births) and 1997 (112 per 1,000 live births). Again, the rural children are at greater risk of death than urban children. However, it must be noted that children living in slums in urban areas have a higher risk of death then the overall urban average.

Estimates of the deaths prevented by immunization highlight the important role played by the EPI programme. However, there has been a slow decline in this effect related to the persisting problem of high drop out rates (30-40%). This means that although more than 50% of children under 1 year are immunized, 1.0 –1.5 million children are unprotected.

Campaigns targeted had reducing death due to diarrhoeal diseases and acute respiratory illness(ARI) have also shown a fall in the case fatality rates. In 1993 the case fatality rates were 0.67 for diarrhoea and 0.44 for ARI compared with 0.11 for diarrhoea and 0.34 for ARI in 1997. There is an even more dramatic reduction in ARI fatality rate in 1998 where the larger sample size gave a fatality rate of 0.05. Low levels of knowledge and inappropriate care seeking behaviour which also shows a gender bias, contribute to this situation. Only 20 % of children with pneumonia are taken to a qualified service provider. Urban slum and rural children are the most vulnerable.

This vulnerability is related in part to the prevalence of malnutrition which is highest in urban slum children and second highest in rural children. The incidence of stunting and underweight increases in the second year of life and shows only minor changes but the incidence of wasting is highest in the second year of life. Unhygienic practices, poor weaning patterns and inappropriate living conditions especially in the slum areas result in high incidence of disease which compounds the malnutrition. Nevertheless, the ten year period 1986 –1996 has shown a 1.4% decrease in underweight prevalence and 1.7% decrease in stunting.

The various interventions such as immunization and diarrhoeal disease control have been complemented by increases in the mother's education, promotion of early and exclusive breast feeding, supplementation with Vitamin A and the use of iodized salt. Combining the supplementation of Vitamin A with the National Immunization Day has increased coverage and there is a downward trend in the incidence of night blindness in children under six years of age from 3.76 % in 1982-83 to 0.8% in 1997. However, it must be noted that recent reduction in Night Blindness prevalence in early childhood to less than 1% does not mean that the deficiency does not remain. The shift in night blindness to schooll children and to pregnant and lactating women means that this vitamin deficiency still remains an important public health issue.

Protection from iodine deficiency through the use of iodized salt has increased sharply. In 1994 less than 20% used iodized salt but by 1998 almost 80 % used it.

In the years of late childhood, from 6 –10 years, the same forces of poverty, gender discrimination and inappropriate care continue to affect the survival of children. The pattern of malnutrition continues with over 60% malnourished, 78 % of boys and 83 % of girls anaemic, and 2.1 % boys and 1.6 % girls suffering night blindness, according to the National Nutrition Survey 1995 –96. Environmental pollution results in lead poisoning and increased incidence of asthma.

Accidental deaths are an important cause of death with drowning being responsible for nearly 19 % of deaths of children 12 –59 months in a rural area[3]. In older childhood, drowning and traffic accidents are a significant cause of deaths. Many children are forced into hazardous work which increases their susceptibility to accidental death. 23% of the population of Bangladesh is aged between 10 to 19 years. Girls are particularly vulnerable at this age. They are often married and have begun child bearing with little attention to their nutritional needs during their growth spurt and their needs for care during pregnancy. The fertility rate for 15 –19 year olds is 155 per thousand and it is estimated that each year 800,000 young girls enter this risky stage of marriage and child bearing. Accidents, violence including septic abortion and suicide are responsible for about a third of the deaths of young girls of this age.

Malnutrition persists as a problem with the rural situation worse than the aggregated urban figures. Surprisingly, the National Nutrition Survey 1995 –96 shows that there is less malnutrition in the girls than the boys. 54.3 % of rural boys compared with 36.6 % of girls have low Body Mass Index scores and in the urban areas, the scores are 41.8 % for boys and 25.1 % for girls. This maybe misleading as the growth spurt at adolescence occurs earlier in girls than in boys. Yet, the figures are showing significant that a significant number of adolescent boys and girls suffer from malnutrition.

Survival for children in Bangladesh is first compromised by the lack of care given to the mother who shelters them in the womb and delivers them usually without skilled assistance. It continues to be challenged by the lack of care and proper food after birth leading to a cycle of poverty and disease producing malnourished children prey to diarrhoea and pneumonia. The interventions to ensure that the best possible start in life is given to all children are gradually making an impression but many challenges remain.

4.1.2 Water and Sanitation

Diarrhoea and dysentery are at the top of 15 major causes of death in Bangladesh. Together they account for 15% deaths in the country.[4] Prevalence of diarrhoea remains also the largest contributor to morbidity (18 per 1000) and ranks the highest (11%) among all patients showing symptoms of acute and chronic diseases.[5] The Bangladesh Demographic and Health Survey, 1996-1997, notes that there has been only a slight decline in the prevalence of diarrhoea in the country (13 percent of children under three in 1993-1994 vs. 9 percent in 1996-1997).[6] Another national level Diarrhoeal Morbidity and Treatment Survey reports a decline in the prevalence of diarrhoea among rural children under five from 23 percent in 1987-1988 to 20 percent in 1994-1995 and from 24 to 16 percent among urban children.[7]

---

3 1988-93, AH Baqui et al., Matlab, ICDDR,B

4 Bangladesh Bureau of Statistics (1996). ***Health and Demographic Survey.*** Dhaka

5 Bangladesh Bureau of Statistics (1994). ***Health and Demographic Survey.*** Dhaka

6 SN Mitra, A Al-Sabir, AR Cross, K Jamil (1997). ***Bangladesh Demographic and Health Survey, 1996-1997.*** Dhaka.

7 SN Mitra and S Islam (1996). ***Diarrhoeal Morbidity and Treatment Survey 1994/95.*** Dhaka. Mitra and Associates and Social Marketing Company.

Studies in Bangladesh and other parts of the world show that the reduction of diarrhoea and other water-related diseases as well as malnutrition and consequently the reduction of mortality of infants and children under five are possible through a combined impact of access to safe water and sanitary latrines as well as proper hygienic behaviours. A three year study by ICDDR,B in five villages of Mirzapur upazilla (Dhaka district) from 1984-1987 showed a 25% reduction in the incidences of diarrhoea (including dysentery and persistent diarrhoea) in areas where an integrated intervention of water, sanitation and hygiene education was introduced.[8] A follow up survey in 1992, five years after the intervention, indicated that the prevalence of diarrhoeal diseases among the control population was about twice that among those in the intervention area.[9] Another study in two unions of Chittagong district in 1994 also noted within one year a 34% decrease in diarrhoeal reduction due to similar interventions.[10] These studies emphasize the need to integrate water, sanitation and hygiene education to have the desired result. In the case of the study in Chittagong district, there were additional elements such as oral rehydration therapy, breastfeeding and clean environment that were combined with water and environmental sanitation interventions.

A study of ill health and its impact on nutrition found that it was the poorest households who lost most workdays to illness or injury and also most income and much the highest proportion of income. Parents and children living in the poorest quality, most insecure and overcrowded living space with the least adequate provision for water supply, sanitation, drainage and garbage collection that suffer most from environmental hazards.[11] In urban areas, the association between income levels and environmental hazards are generally strongest in regard to the quality and quantity of water, the level of provision for sanitation, drainage and solid waste collection, and the risk from floods and other natural hazards.

4.2 ASSESSMENT OF TRENDS

4.2.1 Health and Nutrition

4.2.1.1. Prenatal to 5 years: Shoishab

This is the most crucial period in the life of the child. It is the time when the child is most vulnerable and survival is threatened not only by disease but also by poverty, ignorance, gender discrimination and harmful traditional practices. It is the period which sets the scene and pattern for future growth and development of the child. The main causes and conditions that threaten this age group is shown below:

---

8 KMA Aziz, BA Haque, KhZ Hasan, MY Patwari, SRA Huttly, MM Rahaman and RG Feachem. "Reduction in diarrhoeal diseases in children in rural Bangladesh by environmental and behavioural modifications," ***Transactions of the Royal Society of Tropical Medicine and Hygiene (1990) 84, 433-438.***

9 BA Hoque, T Juncker, RB Sack, M Ali, KMA Aziz. "Sustainability of a water, sanitation and hygiene education project in rural Bangladesh: A 5-year follow-up." ***Bulletin of the World Health Organization (1996), 74 (4), 431-437.***

10 O. Massee Bateman, Raquiba A. Jahan, Sumana Brahman, Sushila Zeitlyn nad Sandra L. Laston (1995). **Sanitation and Family Education (SAFE) Pilot Project.** Report on the Monitoring and Improvement System. CARE-Banglaadesh, Dhaka.

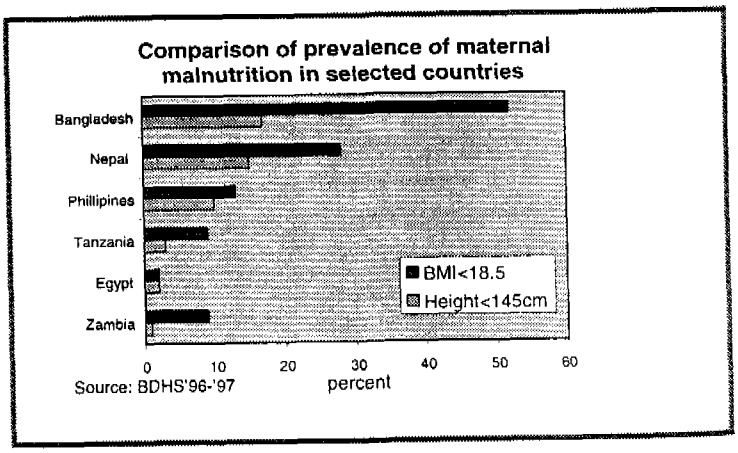
11 Pryer, Jane, (1993). "The impact of adult ill-health on household income and nutrition in Khulna, Bangladesh," **Environment and Urbanization, Vol 5, No 2, October.**

Table 4.1: Percentage distribution of apparent causes of death of under 5 years old children, by age group, 1988-93, AH Baqui et al. (based on verbal autopsy)

Cause of death	Age Group			
	Neonatal	1-11 months	12-59 months	Total (%)
Confirmed Diagnoses				
Accident:	0.0	4.4	20.9	8.8
Drowning	0.0	3.1	18.9	7.7
Others	0.0	1.3	2.0	1.1
Neonatal tetanus	14.9	0.0	0.0	5.4
Measles	0.0	0.0	1.9	0.7
Measles followed by ALRI, diarrhoea	0.0	3.6	5.1	2.8
ALRI	11.0	30.1	18.3	18.9
Watery diarrhoea	1.7	6.6	4.6	4.1
Persistent diarrhoea	0.0	4.6	3.5	2.6
Dysentery	0.0	0.9	2.4	1.1
ALRI and watery diarrhoea	1.0	5.1	2.9	2.8
ALRI and persistent diarrhoea	0.0	3.1	3.0	2.0
ALRI and dysentery	0.0	0.4	1.0	0.5
Congenital abnormality	0.9	0.0	0.0	0.3
Prematurity	0.0	0.0	0.0	0.0
Possible diagnoses				
Possible ALRI	6.3	8.6	4.0	6.1
Possible diarrhoea	0.0	5.6	8.6	4.7
Possible ALRI and diarrhoea	0.3	2.0	1.3	1.2
Early perinatal	47.6	0.0	0.0	17.1
Malnutrition[12]	1.5	6.6	8.6	5.5
Not identified	14.8	18.5	13.9	15.5
No. of deaths (unweighted)	311	232	285	828

4.2.1.1.1 Surviving to birth

As life begins and is nurtured in the mother's womb, it is also influenced by the state of her health. Many mothers are malnourished and suffer from micronutrient deficiencies-- 74% of mothers with iron deficiency anaemia, 60% being deficient in serum retinol (less than

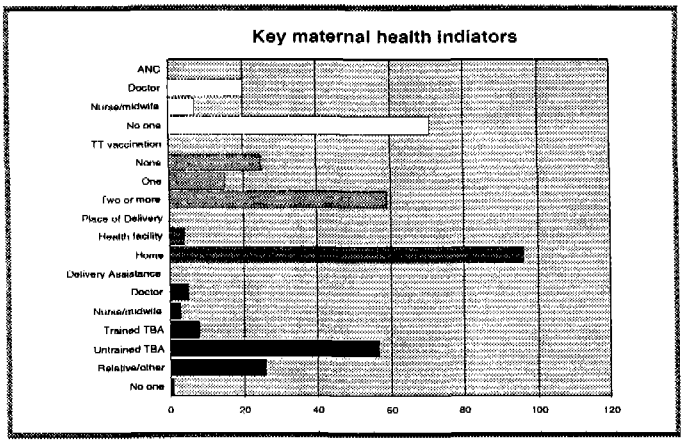


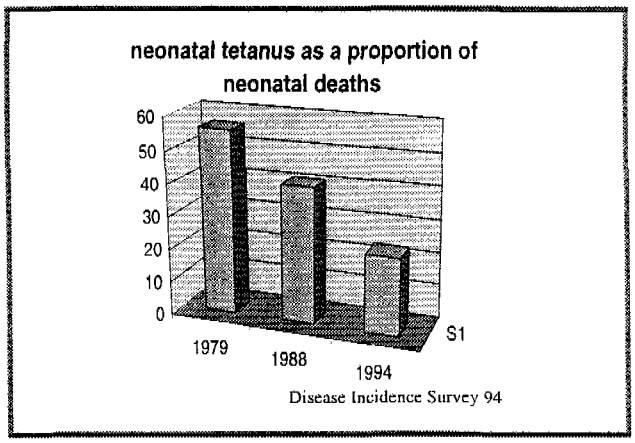
12 The rates shown here are a possible under-estimate as it is known that approximately 54% of all childhood deaths have malnutrition as an underlying cause.

20u/dl)[13], a night blindness rate of 3.4% (during pregnancy & lactation)[14] and 47% are iodine deficient. Eating habits during pregnancy further aggaravate her condition and also contribute to Low Birth Weight of the newborn.

With low uptake of ANC (about 25% at least one visit), the opportunity of counselling women & their families on proper care and preparation for obstetric emergencies is not well established. A missed opportunity, however, is the high level of TT contacts of about 90%.

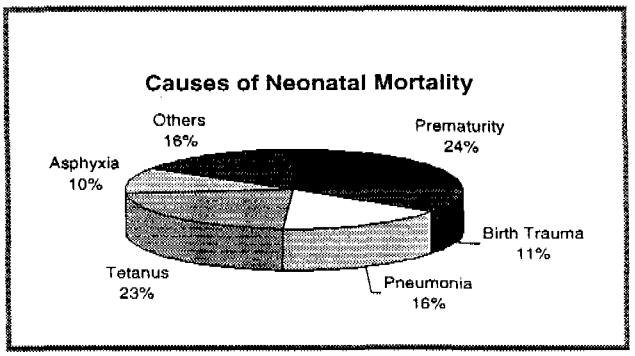
With more than 95% births taking place in the home and only about 18% being attended by any trained personnel, risk to both mother & child remains high. This, combined with only 5% of estimated complications seeking available services[15], results in a poor outcome for the neonate and the women.





Trends in MMR as reported by BBS (SVRS), though showing a downward slope are not supported with a comparative increase in utilisation of services of skilled personnel. Reduction in TFR brought about by increase in contraceptive use and birth spacing has resulted in a reduction in the total number of births, yet the risks of mortality and long term morbidity for women of reproductive age group remain.

4.2.1.1.2 Surviving the first month



Information from the early nineties showed that for every thousand children born alive, 12 died within hours of birth – 8 due to birth trauma and 3 due to prematurity. A further 23 died within the first week – 16 due to prematurity and five as a result of neonatal tetanus.

The situation, particularly in relation to neonatal tetanus has improved over the years. The'94 survey which elicited a mortality rate of 25/1000LB, showed that neonatal deaths were accounting for a progressively lower proportion of neonatal deaths. Challenges persist in reducing deaths due to birth asphyxia and trauma.

13 SK Roy, et.al.,1994

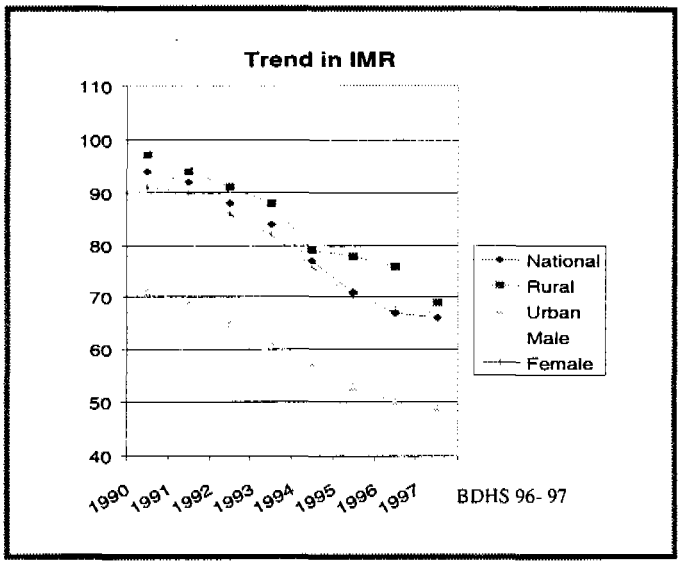
14 HKI, 1998

15 Baseline Survey of EOC Services in Bangladesh, BIRPERHT, 1995

4.2.1.1.3 Surviving the first years

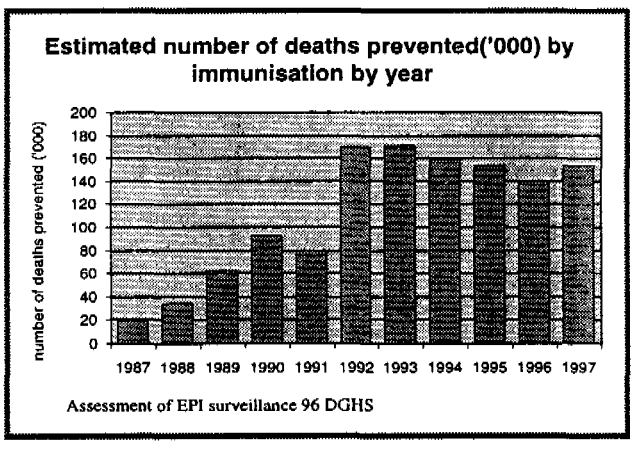
A gradually decreasing trend in Infant Mortality Rate (IMR) can be observed over the years. It can be said from the figures that IMR has decreased substantially (almost 40 percent) during 1997 (57 per 1000 live births) as compared to that of the base year 1990 (94 per 1000 live births). The urban- rural differential in IMR is significant. Rural infants are at higher risk of death before reaching their first birthday. Mother's education and knowledge of hygiene, age of mother at birth etc. are highly related factors to infant mortality rate. Most of the infant deaths are due to acute respiratory infections, diarrhoea, measles and high rate of neonatal mortality .

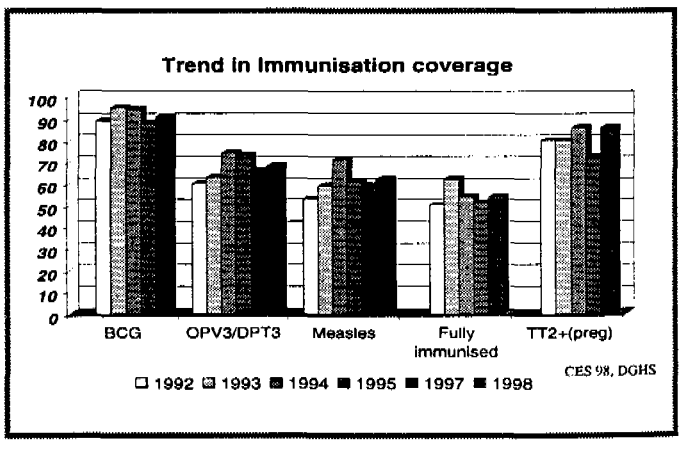
Less than 25 percent decrease in U5MR can be observed between 1997 (112 per 1000 live births) and 1991 (146 per 1000 live births. The children in rural areas are more at risk of dying before reaching their fifth birthday than those in urban areas. Pneumonia & diarrhoea are the major killers in this category and underlying malnutrition significantly contributes to the risk of fatality. Unhygienic practices and inappropriate living conditions result in high incidence of waterborne and other communicable diseases, particularly in slum populations.



Reductions in IMR and U5MR (shown above, based on BBS,SVRS) are linked to the success of the EPI and diarrhoeal disease control programme, yet while more than 50% of children are fully immunised by age one, 1-1.5 million children in the first years of life are unprotected. High drop out rates (30-40%) are a persisting problem.

One of the aggravating factors is low levels of knowledge and inappropriate care seeking practices for child illness and also elements of gender discrimination. Only 20% of children with pneumonia are taken to the qualified service provider[16]. Urban slum & rural population remains most vulnerable as seen in differential trends of key survival indicators.





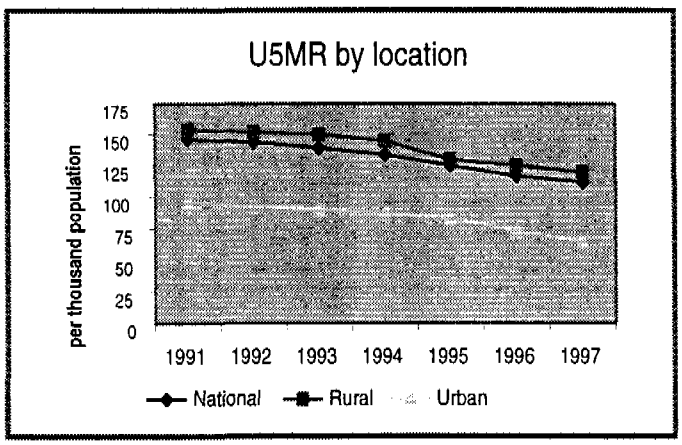
16 ARI/CDD Household Survey, 1997

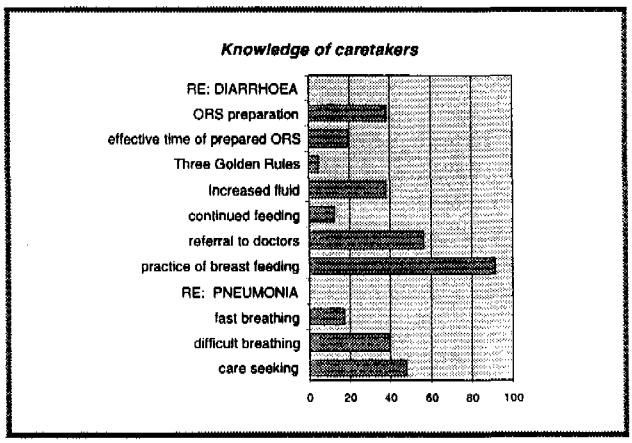
Table 4.2: Trend in disease & deaths among under 5 children

Year	Diarrhoea			ARI		
	Cases	Deaths	Case fatality	Cases	Deaths	Case fatality
1992	449,687	2,644	0.59			
1993	614,556	4,119	0.67	7,933	35	0.44
1994	345,567	1,245	0.36	37,778	158	0.42
1995	583,870	1,750	0.30	108,460	427	0.39
1996	976,106	921	0.09	288,052	985	0.34
1997	1,073,956	1,188	0.11	354,212	1,211	0.34
	CDD unit, DGHS			ARI control intervention areas		

The trends in malnutrition indicate it still remain as one of the major critical problems for human resource development and social sector in Bangladesh. Although there has been some improvements in prevalence of nightblindness among children and stunting rate. The 1995-96 nutritional status shows improvement from 1985-86 with underweight prevalence decrease by 1.4% per year , stunting decrease by 1.7% per year and wasting prevalence remaining about the same. Improved nutritional status could be associated with:

- Mothers education
- Knowledge of ORT preparation
- Treatment by trained health personnel
- Immunization coverage
- Use of safe drinking water
- Feeding colostum
- Exclusive breastfeeding
- Household income increase
- Prevalence of diarrhoea and measles
- Hygienic practice





Case Study

In spite of the regular CDD Project activities , Bangladesh government decided to launch a country wide communication campaign on ORT promotion in 1994. UNICEF came forward to support the GOB initiatives through technical guidance and mobilizing funds for the implementation of the largest communication campaign in the history of Bangladesh. To implement this communication campaign activity at the field lot of strategies has been followed of which a strategy called "Local level initiatives" was found the most effective one.. Following are the few examples:.

On the edge of the Bay of Bengal lies Patuakhali, a coastal district cris-crossed by rivers and canals. The land is fertile and fishing and rice productions are the mainstay of the local economy. Patuakhali is a poor district and infectious diseases, malnutrition and illiteracy are widespread. As in the rest of Bangladesh diarrhoeal diseases have been a leading cause of death among under-fivas in Patuakhali. A highly motivated district administrative machinery, taking its lead from the health sector of the Government of Bangladesh and UNICEF, has achieved unprecedented success with the ORT Communication Campaign. In addition to regular activities viz. Health sessions and school classes conducted using the specially designed materials, the ORT Communication Campaign has been taken into a number of original and innovative directions by local initiative.

On the Bengali New Year (April 14), at the initiative of the Civil Surgeon, Thana Health and Family Planning Officers facilitated the setting up of ORT stalls at each of 26 fairs in Patuakhali District. The eye catching red-and-yellow stalls festooned in banners, bunting and posters proved to be crowd pullers. Some people were drawn to the colorful stall by the diarrhoea doll and were fascinated to see the dehydration-rehydration cycle. Others listened to the story of Zarina and Julekha. Still others perused the collection of recommended home fluids displayed stall and asked questions of the health workers staffing the stalls. Some stalls had the added attraction of lively folk songs and dances incorporating ORT themes. Putting up and operating the stalls gave health officials a sense of mission and solidarity. It also provided a celebratory and highly visible way of demonstrating their work. The stalls captured the imagination of not only local community members but also government officials and service providers from other sectors as well as social and political leaders.

*Energized by this experience, the district administration headed by the Deputy Commissioner, came together to organize a first time event - **the ORT Long March**. With contributions, Monetary and in kind, from different government departments, local leaders and businessmen, an "ORT procession" of vehicles departed from Patuakhali to Kuakatha, 74 km away. Wearing locally designed and produced ORT T-shirts and caps, the government officials, local civil society members, NGO officials drove in vehicles draped with banners. One bus was entirely painted with ORT messages emphasizing the three golden rules. The journey to Kuakatha and back took two whole day...because the procession stopped at a total of 26 pre-selected locations and addressed groups ranging from several hundreds to several thousands. At each location local communities waited with excitement and anticipation to watch the ORT event - songs, dances, stories, plays and serious advice delivered from a red-and-yellow ORT dais..*

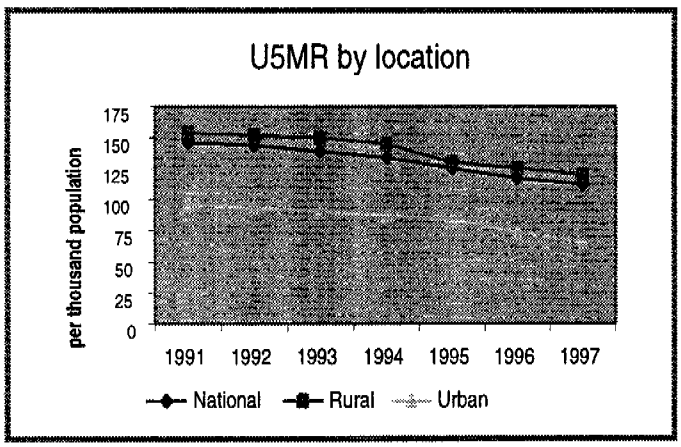
Patuakhali is truly alive with the ORTCC. In village markets - haats - it is not uncommon to see fold performers sing about the three golden rules. wall paintings of these rules in schools and hospitals are a common sight. Journalists have been writing about the issues and events in local newspapers. What is most impressive is the dedication and energy that has been generated among people both within and outside the health sector. This is social mobilization in its truest sense. Impressed by the activities in Pakuakhali, neighbouring districts want to organize their own events.. Barguna has already taken out a River March.

CHAPTER FOUR

Malnutrition the highest among children in urban slums; the second highest in rural areas; and the lowest in non-slum urban areas. There is no significant difference by sex or region; and no significant seasonal effect.

Efforts to promote exclusive breast feeding are concentrating on awareness creation, monitoring of BMS code and Baby Friendly Hospital Initiative. The activities are being coordinated by the Bangladesh Breastfeeding Foundation and the impact is yet to be reviewed.

The trend in micro-nutrient deficiency disorders has shown favourable directions. This is particularly in the case of vitamin A deficiency. The strong programmatic boost to increasing supplementation rates through organising vitamin A week, incorporating with routine immunisation measles contact and piggy-backing with National immunisation days has resulted in a very favourable downward trend



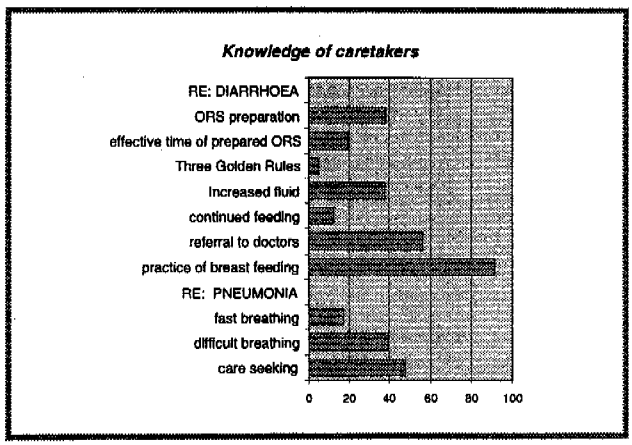
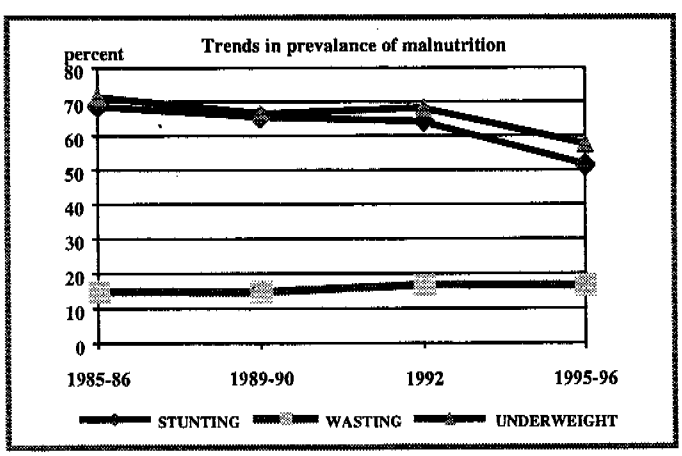
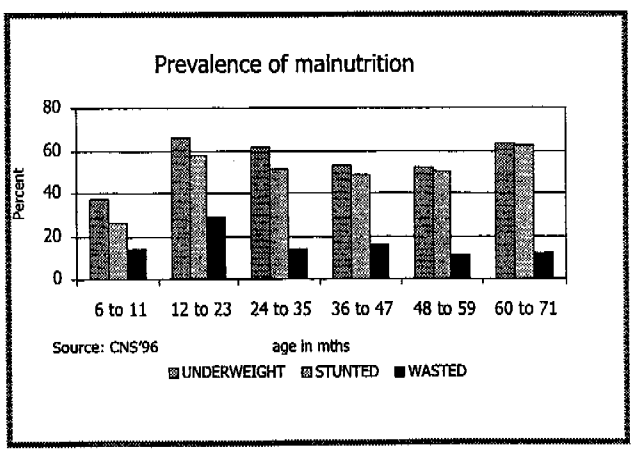


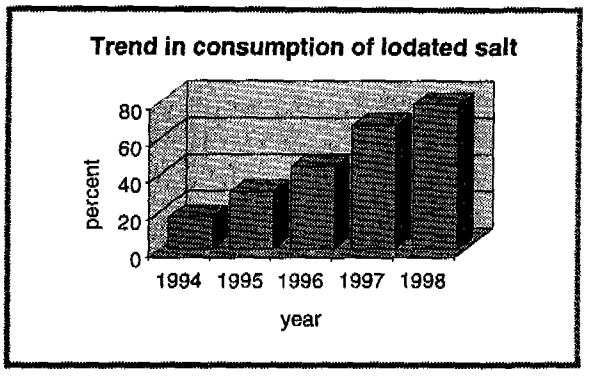
Table 4.3: Trend in night-blindness in children

Survey/Study	Year	% night blindness
Bangladesh National Blindness Study/IPHN/HKI	1982-83	3.76%
National Blindness Prevention Program Evaluation IPHN/UNICEF	1989	1.78%
National Vitamin A Survey Bangladesh, 1997		
HKI/USAID/UNICEF	1997	0.66%





Regarding iodine deficiency disorders, the utilization rate of iodized salt has increased over the years.However, a survey carried out in 1999 indicated that 30% of salt samples are within an acceptable range of value for iodine content at the salt iodisation factory level. A survey is being carried out at present to evaluate the impact of the salt iodisation programme on the prevalence of Iodine Deficiency disorders and results will be available in early 2000.



4.2.1.2 6-10 years: (Balyakal)

Poor nutritional status and vulnerability to killer diseases such as diarrhoea & pneumonia threatens survival of this age group. The report of the National Nutrition Survey '95-'96 shows that 2.1% boys and 1.6% girls of the 5 to under 10 age groups are suffering from night blindness. Also, anaemia continues to be problem for 78% boys and 83% girls in the 5-14 age group. The situation of malnutrition in this group is indicated below:

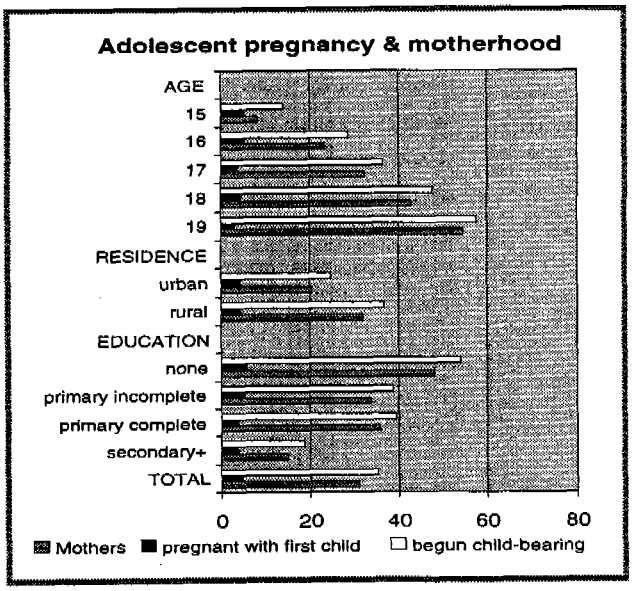
Table 4.4: Nutritional Status of children aged 6-9 yrs. using Z-score

Nutritional Status	Percentage of Children
Stunted & underweight	
Normal	34.8
Malnourished	65.2
Stunted but not underweight	5.8
Underweight but not stunted	12.7
Both stunted & underweight	46.7
Stunting & wasting	
Normal	38.2
Malnourished	61.8
Stunted but not wasted	43.4
Wasted but not stunted	9.3
Both stunted & wasted	9.8
Total Stunted	52.5
Total Wasted	18.4
Total Underweight	59.4

Situation is influenced by inappropriate care seeking behaviour, elements of poverty and gender discriminatory practices. Lack of hygiene education, unhygienic practices and inappropriate living conditions continue to result in high incidence of waterborne and other communicable diseases. Accidental deaths are an important cause of death with drowning being responsible for nearly 19 % of deaths of children 12 –59 months in a rural area[17]. In older childhood, drowning and traffic accidents are a significant cause of deaths.

17 1988-93, AH Baqui et al., Matlab, ICDDR,B

Growing environmental pollution resulting in lead poisoning and asthma is emerging as major problem. A further risk to this age group is the growing numbers who go into hazardous work/labour.



4.2.1.3 11-18 years: Koishor

The population in the 10-19 age block is 23% of the total population in Bangladesh. The greatest threat to survival in this age group is among girls and is related to early marriage and childbearing. It is estimated that Bangladesh has the highest proportion of women under the age of 20 giving birth every year with a fertility rate of 155per thousand women aged 15-19 yrs. Though mean age at marriage and age specific fertility rates show a favourable trend, it is still estimated that every year 800,000 young girls are married and have initiated child bearing. The risks of childbearing are particularly high in this age group and the situation is aggravated by maternal malnutirion and inappropriate caring practices. School & TT contacts are not being optimally utilised for supplementation, counselling and education. Situation of malnutrition is further aggravated during adolescent growth spurt as a result of improper caring practices. Another area of concern is violence and suicide acting as significant factors threatening survival.

Case Study

Bulbuli a teenage housewife became pregnant after two years of her marriage. She did not consult a health worker or visit the hospital for a check-up. Her husband X , a poor day laborer and his family members made no arrangements for dealing with pregnancy related complications. Bulbuli's labor pains were accompanied by a severe headache. Her mother-in-law tied an amulet on Bulbuli's arm and fed her holy water in order to cure her. Meanwhile Bulbuli started having convulsions. At X's uncle's suggestion a homeopathic doctor was called. The medicines prescribed by this doctor further aggravated Bulbuli's condition. X then brought a TBA to examine his wife. The TBA tried to get the baby out for a few hours and then left. Bulbuli's condition was deteriorating very quickly and she had severe convulsions. Her in laws thought she was under the influence of 'evil spirits' and left her all by herself. Bulbuli became unconscious at the end of the night.

X had wanted to take his wife to the hospital when Bulbuli's condition was deteriorating. His neighbours pressured him to stay at home and let the local women folk try to deliver the baby. The local leaders also told X since Bulbuli's parents were not present he could not take her to the hospital by himself. X was told that he would have to sign a bond if he wanted to take Bulbuli to the hospital. However, when Bulbuli's condition took a real bad turn in the morning X decided he would take his chances and take his wife to the hospital. He hired a van to carry his unconscious wife. He also called in another TBA. The van driver informed X that he has no awning and X had to pay extra money to him. The village leaders came back again to stop X from taking Bulbuli to the hospital. X's cousin and the TBA hired by X argued furiously with them and managed to set for the hospital with Bulbuli. After an hour of travelling by van, they managed to secure a lift from a person with a microbus. At the sub district hospital the doctors struggled long hours and were able to save Bulbuli and her child's life.

Surprisingly, the National Nutrition Survey 1995 –96 shows that there is less malnutrition in the girls than the boys. 54.3 % of rural boys compared with 36.6 % of girls have low Body Mass Index scores and in the urban areas, the scores are 41.8 % for boys and 25.1 % for girls. This maybe misleading as the growth spurt at adolescence occurs earlier in girls than in boys. Yet, the figures are showing significant that a significant number of adolescent boys and girls suffer from malnutrition.

Table 4.5: *Distribution of nutritional status of adolescents by cut-off points of age-groups 10-17 according to Body Mass Index (BMI)*

Category	Rural		Urban	
By BMI	Male	Female	Male	Female
Normal	45.7	62.8	55.5	71.4
Underweight				
($< 5^{th}$ percentile)	54.3	36.6	41.8	25.1
Overweight				
($> = 85^{th}$ percentile)	·	0.6	2.7	3.4

Source: National Nutrition Survey, INFS, 1995-96

Problems persisting in all age groups

Anemia is prevalent in all age groups in Bangladesh.

Table 4.6: Anemia Prevalence in rural areas in Bangladesh, 1981-82 and 1995-96

	1981-82			1995-96		
Age group	Male	Female	Total	Male	Female	Total
0-4 yr.	N/A	N/A	73.0	60.4	79.4	69.5
5-14 yr.	74.0	73.0	N/A	78.1	82.9	N/A
15 yr. +	60.0	74.0	N/A	70.8	85.2	N/A

Source: Bangladesh National Nutrition Survey, INFS, 1995-1996

Special Focus on Children in Disasters

Vulnerbilities experienced by children are both direct and indirect. While some are caused by the disaster itself, others are the result of the failure of intervention agencies to address the vulnerabilities. In some cases, they are generated by the interventions as well.

Of the vulnerabilities noted in the floods of 1998, the most common is that a child faces food shortage. This shortage is chronic but increases during the floods. While some feel that there is no clear cut case for protein supplementation and decisions to manage vulnerabilities such as Infant Therapeutic feeding should be taken carefully, lack of food is universally considered a vulnerability. The young child (0-2 years) experiences higher food related vulnerability because the parents generally practice food deprivation to feed the children which in turn reduces the capacity of mother to breast feed. Appropriate food management remains a weak aspect of the programme as blended food suitable for children is not always available.

Shortage of food is followed by health problems including those linked to malnutrition. But the process of vulnerability affecting children ranges from immediate ailments to impact of home management which affects the family care giving process and consequently further increases vulnerabilities. All records show that children experience higher incidence of diarrhoea, water borne diseases, water induced sores, bronchial problems etc. This leads to greater medical cost, greater maternal time for care giving and resultant in loss of income and income available for food and other necessities. Urban slums have no significant development programmes in general and selective relief work is carried out in these slums. The physical conditions in the slums affect the overall health and sanitary conditions very negatively.

Sadeka's Story

Ten year old Sadeka's home in Sherpur was overrun by floods within the third week of floods in 1998. Her family moved to a shelter run by a local NGO after a week living on the roof. What bothered Sadeka the most was the food shortage and the endless fighting amongst her siblings over what little they had. Her mother who is a member of an NGO did not get any help from the institution. The biggest problem Sadeka and her sisters faced were collecting tubewell water and using sanitary latrines. The sisters had to wade through water and stand in long queues and fight with the neighbours over collecting water from the tubewell. They had to wait till nightfall to row to a highland nearby and defecate.
Source: OXFAM

Camp life is another cause of vulnerability for children especially girl children. Almost every camp had a number of cases of lost children and coming from all ages. Children are certainly not fully safe in every camp. In a camp itself, girl children often experience sexual harassment and abuse. Violence is common. Life at these urban camps are by themselves very traumatic but no stress management is possible either for children or adults.

Incidents of drowning, snake bites, water sores are common in the rural areas. In extreme flood situations drowning of very small children is a life threatening vulnerability.

Female headed families have greater vulnerability than a complete family unit and girl children face even greater vulnerabilities as they need to assist their parents in survival strategies. In urban areas, girl children are encouraged to use begging skills after a flood to take advantage of any outpouring of sympathy. Children also suffer from trauma caused by the loss of control over their life including inability to go to school.

One social and personal disability which has been noted by all is the escalation of violence within and between families. The enormous stress caused by the flood, anxiety of parents over loss of income, shortage of food,

Salima's Story

Thirteen year old Salima lives in Kurigram in North Bengal. Her father decided to move to a shelter after the difficulties faced by the women became impossible to manage due to lack of latrines or any other place that can be used for defecating became impossible to find. Even though the overall health situation was a lot better at the shelter the lack of privacy at the shelter, incidents of eveteasing by the men made the girls feel very insecure. When the level of harassment rose the family was decided to move out.
Source: SCF-UK

accidents , illness etc increase tension between parents which lead to violence, both verbal and physical. This is a major negative experience which highly affects the emotional state of children.

Lack of credit and unavailability of work due prolonged flood means no work or poor work. Loss of work therefore affects the entire family as conventional food security lasts a little more then a week. Repayment programme of credit agencies increases vulnerabilities of families, which also affect children. Parents unable to feed start the trek to the city or the father moves leaving the family behind. In either case, the children of the poor lose out. Even if they survive the floods that are drowned by the post-flood scenario. It becomes more devastating than floods as the process of pauperization takes hold on a family. Migration move towards the city in post-flood situation creates vulnerabilities for the family as they are unprepared for urban life.

Women's Health

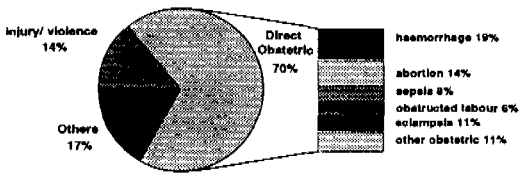
The disadvantaged situation of girls and women and their adverse social and economic status contributes to the many health and nutritional problems that they face. This often takes the form of violence. Given that many forms of violence exist ranging from denial of adequate nutrition, education and care, psychosocial oppression to physical abuse, indeed it has been found that the proportion of deaths of women due to violence is even greater than those related to pregnancy. This situation is also reflected in 14% of deaths of women during pregnancy and following child birth having been found to be related to violence and injury. This is a mere tip of the iceberg.

Causes of all female deaths .

	Cause of Death	Rural(%)	Urban(%)
8.	Pregnancy related problems	2.33	5.22
10.	Suicide, murder, burn	5.81	6.96

Source: SRS, 1992, Bangladesh Bureau of Statistics

Causes of maternal deaths .



This is an unnecessary plight of women. The same women who contribute to 42% of the labour force of a country face death and disability in the very process that brings forth life. The technical solutions to preventing death and disability due to complications of pregnancy and childbirth have been established in the past decades. Yet, today, in the forefront of the new millennium, the women of Bangladesh continue to be deprived of their right to life.

It is unconscionable that this situation is allowed to persist. Reducing maternal deaths is not possible solely through a "health" intervention/ initiative. Maternal mortality being considered an indicator of the overall situation of women

in a nation, the approach hence, needs to be of a more comprehensive nature, one of social development. The need is for *nurturing a socio-cultural movement that reduces maternal mortality as a woman's right, and also enhances women's self esteem and status.* The improvement of Bangladeshi women's health is not just a social and moral necessity, it is also an economic imperative. It is estimated that iron deficiency anemia among women alone causes losses in agricultural production to the tune of 5 billion dollars over a period of 10 years. Economic losses caused by persisting and long term complications resulting from pregnancy and child birth, though not estimated are likely to be of a much greater magnitude.

A baseline survey[18] found that only 2.2% of expected annual births were taking place in facilities. Only 5% of the expected 600,000 complications sought services of the facilities. Barriers to the provision of the expected level of services included inadequacies in availability of trained personnel, necessary drugs and equipment. Good "leadership" and management was identified as a factor which strongly influenced the utilisation of services as did the "good reputation" of the service provider/centre. Experience so far has shown that ensuring the presence of a consultant Obstetrician at the district hospital together with adequate supplies of drugs, has resulted in a doubling of the case load in some instances.

The near absence of skills and facilities to cope with obstetric emergencies is matched by a virtual absence of strategic responses and ability of the health system to respond to the dimension of violence. The stage of denial has not yet passed. The heath facilities and care providers at all levels is one place where battered and abused women come into contact with the system and effort is necessary to address the issue through this important point of contact.

Bangladesh has a fairly comprehensive physical infrastructure for the delivery of maternal health and related services. Unfortunately, these precious resources are not functionally effective. An added constraint is the existence of a split infrastructure which has an important bearing, particularly on maternal health issues. Also, the availability and quality of services between levels varies and this variation is present even within each level.

There is however the unique opportunity to build on efforts to improve obstetric services in hospitals, particularly district hospitals. *In the way that EPI took forward and built a base for outreach services, strategic responses to reducing maternal deaths can provide the entry point to improving the services in health facilities and converting them to respond to the particular needs of women.*

Given that most of the problems relevant to maternal health in Bangladesh are a function of the social standing of the girl child and woman, it is also clear that the present health and family planning system is also not meeting the expected level of function. If maternal mortality is to be considered as an indicator to reflect the general health and well being of the female population, then there is a need for reappraisal of interventions which are expected to create impact on this indicator. In the process of developing the HPSP, this aspect of the provision of health care is being analyzed and will be addressed.

18 Baseline Survey for Assesment of EOC Services in Bangladesh, BIRPERHT,1995

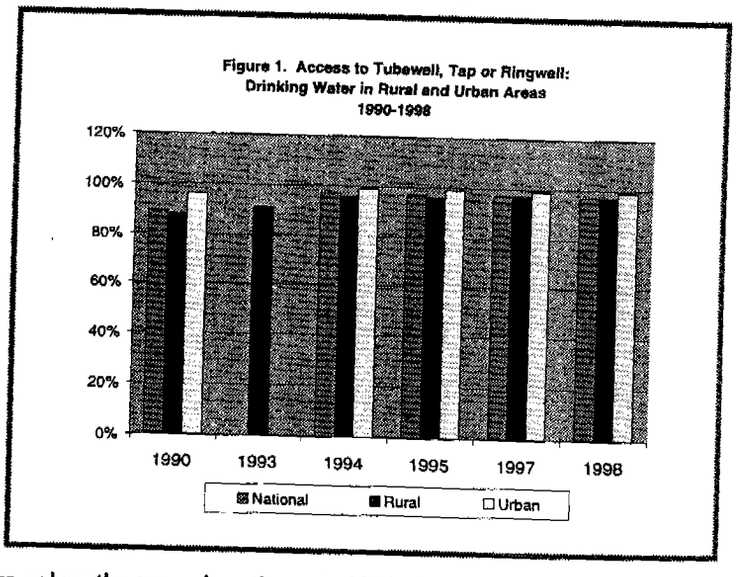
Case Study

Sahara became pregnant four years after her marriage. Her husband, Shahidul, a rickshawpuller lived with his extended family. Sahara did not consult any doctor or health workers during pregnancy. Her husband and her in laws did not take any preparations to meet an emergency situation during childbirth. When Sahara started having contraptions she was fed holy water and homeopathic medicine. Two untrained TBAs were called for assistance. The TBAs failed to get the baby out and they told the family that a doctor should be called. Shahidul brought in the village doctor who gave Sahara IV injections. After that Sahara had severe convulsions and the TBA present asked Shahidul to take Sahara to the hospital which was six kilometers away. She told them that the baby was stuck inside the birth passage and only doctors would be able to help. Sahara's mother in law refused to let Sahara be admitted to a hospital as she would be treated by a male doctor.

Meanwhile Sahara's father came and requested the mother in law to let his daughter be taken to a hospital. But his request was turned down. A TBA from the next village was brought in who pulled the baby out by force. By now Sahara was bleeding severely and condition deteriorated. Her father called a rickshaw to take her to the hospital but her in laws refused to let her go. After the neighbour's intervened the in laws agreed on one condition that a male doctor would not treat her. Sahara became unconscious due to heavy bleeding and died on the way to the hospital.

4.2.2 Water and Sanitation

4.2.2.1 Safe Water Use



In 1971, there were about 168,000 tubewells in rural areas, each providing drinking water to approximately 325 people.[19] A vast majority of the population in remote areas used surface water for drinking and other domestic purposes and consequent outbreak of cholera, dysentery, diarrhoea and other water borne diseases took a heavy toll of life of both adults and children. Most rural households today have access to tubewells within 150 meters. More than 97 per cent of the population in rural areas and 99 percent in urban areas drink tubewell water. Progotir Pothey data[20] show that the trend has remained more or less the same since the early 1990s (see Figure 1). A small percentage of population still use surface water for drinking purposes.

19 Awal, Abdul and A.S.Azad (1998). ***Project Completion Report. DPHE/UNICEF Rural Water Supply and Sanitation Programme, 1972-1997.*** report submitted to Danida, Danish Ministry of Foreign Affairs.

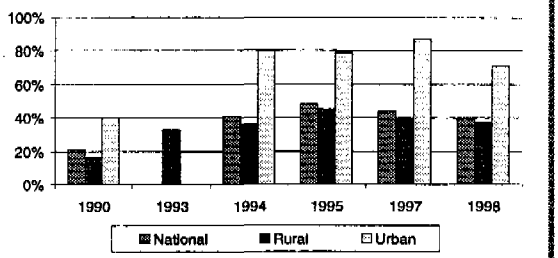
20 Bangladesh Bureau of Statistics and UNICEF. ***Progotir Pathey***: 1993, 1994, 1996, 1997, 1998. Dhaka

Four other emerging trends are of special relevance as they impede the progress in safe water use. These include: ground water contamination due to arsenic contamination; saline water intrusion in the Coastal Belt, lowering of ground water table during the dry season, and special problems in the rocky and hilly areas. These are taken up separately below in section 4.3.2.

4.2.2.2 Sanitary Disposal of Human Excreta

Access to hygienic latrines by households has increased remarkably from only 1 percent in 1971 to 16% in 1990 to 40 per cent in 1997. Such increase has been possible through collective intervention of the government and NGOs and also due to integration of the new social mobilization and hygiene education components in the rural sanitation programme. The trend seems to have, however, leveled off since 1993 and the use of sanitary latrine has remained between 30 and 40 per cent. The percentage of population using hanging latrine or resorting to open defecation has also remained unchanged (see Figure 2). The trend suggests that those motivated and were able to afford a sanitary latrine have already installed one, any further increase will require an intensive mobilization and motivational intervention targeting the poor using multi media communication campaign and involving various partners and allies.

Figure 2.
Hygienic Latrines in Rural and Urban Areas
1990-1998



4.2.2.3 Problems at different age groups

Shoishab: Prenatal to 5 years

The morbidity of the infant and young child as they learn to crawl and then walk, and the natural curiosity of a healthy child, is attributable to the risk from environmental hazards in poor quality housing and living environments. From the time that an infant first learns to crawl, through childhood and adolescence, a home with inadequate provision of sanitation and personal hygiene increases greatly the risk of the child ingesting faecal pathogens. Objects with faecal matter on them may be found on the floor or around the house and which the child puts in its mouth. Or a young child's hands may be contaminated with faecal matters as it plays in the area around the house and also put hands in the mouth.

Diarrhoea is one of the pressing health problems for infants and children and is usually caused by one of a number of food and water borne pathogens. In Bangladesh, Over the past 7 years diarrhea mortality has decreased significantly, from 260,000 annual deaths of children under the age of 5 years to 110,000 in 1996. However, the diarrhea morbidity still remains high. The annual average annual incidence of diarrhea among children under five years of age is 3-5 episodes. Each episode may last from 2-3 days up to 2 weeks or more, resulting in severe dehydration, malnutrition and sometimes death.

A secondary analysis of *Progotir Pathey* data [21] from different years shows strong correlation between diarrhoeal prevalence and malnutrition vs. the use of sanitary latrines as well as use of water from tubewells for household

21 Bangladesh Bureau of Statistics and UNICEF. ***Progotir Pathey 1995, 1996, 1997.*** Dhaka.

work.[22] The logistic regression analysis confirms that younger children of 12-23 months are more prone to diarrhoeal incidences than children of 4+ years. Also households that do not use sanitary latrines are 15% more prone to suffer from diarrrhoea and those that do not use tubewell water for household work are more likely to get diarrhoea by 40 to 67%. This is significant because households that do not use tubewell for household work are also the ones that that are less likely to wash hands using soap, ash or soil after defecation and store drinking water in such a way as to increase the pathogen load over time.

It is a matter therefore of serious concern that about 20,000 metric tones of human excreta everyday contaminate land and water bodies with harmful bacteria, thus contributing to an unhealthy environment. There is also a mistaken belief that children's excreta are not harmful. The unfortunate consequence is that disposal of children's (under five) faeces into latrines is done by only 10% of the households in rural areas and only 50% even in the non-slum urban households is based on the prevailing belief that children's excreta is not harmful. Defecation in open areas by children is an accepted practice and very common in the rural areas.

Balyakal: 6 to 10 years

The area where the environment exhibits a profound impact on child health and development is the quality of the older child's living environment – both in and out of the home and school. Most schools are overcrowded and most have inadequate provision for defecation and personal hygiene. At their most extreme, hundreds of children have to share a few latrines which are themselves poorly maintained and with little provision of hand washing. There are children in need of special protection that face particular environmental risks. For instance, street children generally have very poor quality accommodation (often sleeping in the open or in public places) and great difficulties in getting access to places to wash, obtain drinking water, latrines and health services.

Lack of hygiene education, unhygienic practices and inappropriate living conditions continue to result in high incidence of waterborne and other communicable diseases. Nearly 50% of the Government and registered primary schools do not have drinking water and sanitation facilities. Where they exist, one study shows that only 70% are used regularly by boys and girls; 40% are not cleaned properly; 18% are locked up for primary use by teachers only.[23] Experience from the DPHE/UNICEF pilot project on school sanitation and hygiene education shows that the construction of the WATSAN facilities leads to an average of 10% increase in the attendance of girl students.[24]

Koishor: 11 to 18 years

Adolescent girls and boys play a significant role in water provision and in cleaning sanitation facilities. They are responsible for fetching water for domestic purposes, taking care of their siblings, disposing children's excreta, washing soiled clothes, and keeping the household living environment clean.

Access to latrines is severely constrained by socio-cultural expectations. The incidences of urinary tract infection are considerably higher among poor rural and urban women, who have less access to facilities offering any privacy, yet for whom it is not acceptable to be seen to defecate. As a result, poor women are forced to rise early in order to perform toilet functions before daybreak. This can be extremely stressful particularly for adolescent girls during menstruation.

22 D Bajracharya, M Shuaib, M Shahidullah and M Mazharul Islam et al (1998). "Reducing Diarrhoeal and Malnutrition through WATSAN" paper presented at the 1998 WEDC Conference, Islamabad.

23 UNICEF (1998). Report of a Comparative Study between SMC and DPHE Contractor Constructed Facilities under School Sanitation Programme in Noakhali District. Dhaka.

24 UNICEF (1994). Evaluation of the use and Maintenance of Water Supply and Sanitation System in Primary Schoold. Phase-I. Dhaka.

According to one study, adolescent girls in the 11-20 years' age group contribute 27% of their time collecting about water (see details in Table 4.19). It is important to note that 26% of the women collect drinking water from a distance of over 200 meters and about 8% women spend over 3 hours per day during the dry season in this activity (the percentage of women goes up to 18% during the rainy season). It is also observed that about 21% male collect water occasionally to supplement female collection.[25]

Table 4.19. Water Collection Pattern in Rural Bangladesh

Age Group (girls or women)	% Contribution Water Collection	Water Collection (Hrs per Day)	% Dry S.	% Wet S.	Distance to Water Source (meters)	%
◆ 0 - 5	0	◆ less than 1	58	39	◆ less than 100	46
◆ 6 - 10	7	◆ 1 - 2	34	43	◆ 100 - 200	28
◆ 11 - 20	27	◆ 3 - 5	7	11	◆ 200 - 500	22
◆ 0 - 5	0	◆ 5 +	1	7	◆ 500 +	4
◆ 6 - 10	7					
◆ 11 - 20	27					
◆ 21 - 30	35					
◆ 31 - 50	25					
◆ 51 +	6					

4.3 MAJOR MANIFESTATIONS OF PROBLEMS AND GROUPS AFFECTED

4.3.1 Health and Nutrition

The persisting problems of disease and health seeking behaviour continues to affect the most vulnerable groups – children and women. The manifestation is particularly acute in children under the age of five years, pregnant and lactating women. The situation of rapid urbanisation which has not been supported in terms of ensuring healthy living environment has resulted in poor situation of slum dwellers. In comparison with substantial attention that has been paid to the nutritional status of children after birth, less attention and resource input has been made for the prevention of low-birth weight and women/adolscent girls' malnutrition that could be key points to break the inter-generational cycle of malnutrition. Lack of child friendly focus in planning and implementing disaster management strategies and interventions has increased children's vulnerability during natural disasters. (See the following table for the summary)

25 VHSS (1995). **Women in the Context of Sanitation, Water Supply and Hygiene: A village based study."** Report submitted to UNICEF, Dhaka

Assessment of trends & major manifestations of problems by life cycle

Shoishab (prenatal to 5 yrs.)	Balyakal (6-10 yrs.)	Koishor/Jubokal (11-18 yrs.)
◆ In the most vulnerable period of life, U5MR remains high at 112 and IMR has steadily declined over the years with life expectancy at birth having a much more modest increase ◆ Neonatal mortality rates has also reduced less dramatically and this is associated with low rate of institutional delivery (2-5%), low attendance of deliveries by skilled personnel (10-15%), LBW (40-50%) and poor ANC (25%) ◆ Early marriage, absence of pre-marital counselling pressure on women/girls to reproduce early in the marriage and existing malnutrition contribute to poor foetal and maternal outcome. ◆ Maternal malnutrition, LBW, improper feeding and caring practices result in failure to thrive in 62% of children by the age of 2 yrs. ◆ Unhygienic practices and inappropriate living conditions result in high incidence of waterborne and other communicable diseases ◆ While more than 50% of children are fully immunised by age one, 1-1.5 million children in the first years of life are unprotected. High drop out rates (30-40%) are a persisting problem ◆ Discriminatory practices towards women and girl children contribute to the poor situation ◆ Contacts with target groups are not being utilised optimally—TT coverage of pregnant women is around 80%, yet ANC coverage is as low as 25% ◆ Appropriate care seeking for emergency situations remains unsatisfactorily low—5% for obstetric emergencies, 17% for pneumonia ◆ Urban slum & rural population remains most vulnerable as seen in differential trends of key survival indicators	◆ Poor nutritional status and vulnerability to killer diseases such as diarrhoea & pneumonia threatens survival of this age group ◆ Situation is influenced by inappropriate care seeking behaviour, elements of poverty and gender discriminatory practices ◆ Lack of hygiene education, unhygienic practices and inappropriate living conditions continue to result in high incidence of waterborne and other communicable diseases ◆ Environmental pollution is leading to an increase in morbidity due to asthma and lead poisoning	◆ The greatest threat to survival in this age group is early marriage and childberaing ◆ Though mean age at marriage and age specific fertility rates show a favourable trend, it is still estimated that every year 800,000 young girls are married and have initiated child bearing ◆ The risks of childbearing are particularly high in this age group and the situation is aggravated by maternal malnutirion and inappropriate caring practices. ◆ School & TT contacts (??%) are not beeing optimally utilised for supplementation, counselling and education ◆ Situation of malnutrition is further aggravated during adolescent growth spurt asa result of improper caring practices ◆ Violence and suicide are also significant factors threatening survival. ◆ Drugs and substance abuse is threatening the longterm survival, particularly in urban areas

Case Study

The Bangladesh Integrated Nutrition Project (BINP) was first designed in 1991 as a comprehensive nutrition intervention package mainly for rural area. BINP has three components: (1) Community-base Nutrition Components (CBNC) that covers growth monitoring and supplementary feeding to malnourished children less than 2 year old, and pregnant and lactating women, with various IEC activities; (2) Intersectional Nutrition Activities that consists of home gardening, poultry, national IEC promotion, other intersectional areas; and (3) Strengthening Existing Nutrition Activities, e.g., on-going micronutrient supplementation and fortification activities and breast feeding promotion and protection.

After an intensive field testing in one thana to develop the most feasible operational strategy, in 1995 the field intervention started in 6 thanas with a unique collaboration between the Government and NGOs. As of July, 1999, BINP has expanded to 40 thanas and is expected to cover additional 20 more thanas by end of 2000. BINP implementation was coordinated by the Ministry of Health and Family Welfare, in collaboration of Ministries of Agriculture, Fishery and Livestock, Information, and other partners, with support from the World Bank and UNICEF. Also, the cooperation between the World Bank and UNICEF in BINP has developed a unique inter-agency cooperation system.

Another unique aspect of BINP was that Community Nutrition Promoters, female members who are selected by community members, organize all field activities covering a catchment area of Community Nutrition Center with about 1,500 population with support of Village Nutrition Committee. Also, Nutrition Committee was established at Union and Thana level, respectively.

The Mid-Term Review of BINP conducted in March, 1999 indicated that there was a reduction in severe malnutrition (under weight) among the children in the treatment area due to BINP intervention. Effect of the intervention on weight gain during pregnancy and proportion of low birth weight babies is to be examined.

4.3.2 Water and Sanitation

4.3.2.1 Ground Water Contamination due to Arsenic

The cause, origin and extent of arsenic contamination are just beginning to be understood. Based on the *Groundwater Studies for Arsenic Contamination in Bangladesh* by the British Geological Survey[26] and the DPHE/UNICEF analysis of 30,000 field test results[27] of tubewells around the country, arsenic contamination above 50 parts per billion (microgrammes per litre) has been detected in 44 districts of the country. The percentage of tubewells contaminated varies, however, from one district to another (see Table 4.7). Preliminary estimates show that about 21 million people are potentially at risk due to arsenicosis; although it is yet unknown how many are actually affected.

26 British Geological Survey and Mott Macdonal International (1999). ***Groundwater Studies for Arsenic Contamination in Bangladesh, Phase I, Rapid Investigation Phase.*** *Main Report.* Dhaka, UK Department for International Development.

27 DPHE/UNICEF (1999). ***An Analysis of Field Kit Data: UNICEF/DPHE Arsenic Testing Programme.*** *Interim Report.* UNICEF, Dhaka.

Table 4.7. Population at Risk due to Arsenic Contamination

%of TWs with As > 50 ppb	No of districts	Population at potential risk (million)	% of population at potential risk
0	20	0	0
01-20%	19	3.1	15
21-40%	15	8.3	39
41-60%	6	4.8	23
61-80%	2	1.7	8
81-100%	2	3.2	15
TOTAL	64	21.2	100

In terms of the geographic spread, Chittagong and Khulna Divisions, as shown in Table 4.8, are the worst affected with 8.6 million and 5.2 million people or 36% of the population within the Division at potential risk of arsenicosis. Dhaka Division also has about 4.4 million people at risk.

Table 4.8 Distribution of Population at Risk in Different Administrative Divisions

	Division characteristics		Population at risk		% Population
Name of division	No. of districts	Population (million)	No. Affected districts	Population (million)	at risk within the Division
Barisal	6	8.4	1	0.7	8
Chittagong	11	23.9	7	8.6	36
Dhaka	17	37.9	13	4.4	12
Khulna	10	14.4	10	5.2	36
Rajshahi	16	29.9	10	1.4	5
Sylhet	4	11.3	3	1.0	9
TOTAL	64	122.1	44	21.2	17

As a result of arsenic contamination, the percentage of people with access to safe water has been significantly reduced in many districts. Altogether, 24.4 million people or 20% of the total population now do not have access to water that is safe from contamination due to arsenic and pathogens.

Table 4.9. Population without Access to Safe Water

% Population With Access to Safe Drinking Water	No of Districts	Total population (million)	Population Without Access to Safe Drinking Water	
			Million	%
01-20%	2	3.8	3.4	88
21-40%	5	7.0	4.7	67
41-60%	7	10.3	5.0	49
61-80%	16	26.9	7.9	30
81-100%	34	74.1	3.4	5
TOTAL	64	122.1	24.4	20

The distribution of these people by administrative Divisions shows that Khulna and Chittagong Divisions are the worst off, followed by Sylhet, Barisal and Dhaka. From the perspective of arsenic contamination, Rajshahi Division is the best off, with 95% of the population still having access to safe water. However, there are other hydrogeological reasons, as will be described below, which make Rajshahi Division vulnerable (see table 4.10).

Table 4.10 Distribution of People without Access to Safe Water in Different Divisions

Name of Division	Total Population (million)	Population without access to safe water (million)	% Population without access to safe water	No of districts where less than 80% population have access to safe water
Barisal	8.4	1.2	14	2
Chittagong	23.9	9.4	39	9
Dhaka	37.9	4.4	12	8
Khulna	14.4	6.5	45	8
Rajshahi	29.9	1.5	5	1
Sylhet	7.7	1.5	19	2
TOTAL	122.1	24.4	20	30

In spite of the severity of the problem, the awareness about the arsenic problem is at present extremely low. The 1998 Baseline Survey of Awareness of 'Facts for Life' Messages indicates that only 7% of the 1,839 women interviewed had heard of arsenic (5% in the rural areas and 20% in the urban areas) and 4% knew that diseases caused by arsenic can be prevented by using water from sources that have safe levels of arsenic.[28] A report by

28 Mitra and Associates (1998). ***Baseline Survey of Awareness of 'Facts for Life' Messages: Final Report.*** Dhaka

Asiatic Social based on group discussions and interviews among about 700 respondents (representing a wide variety of target groups) provides further insights into the challenges of communication.[29]

- While there are wide variations in what people knew about arsenic contamination and its consequences on health, awareness levels are very low.
- The level of awareness is relatively higher in those areas where some arsenic mitigation activities have been conducted.
- The predisposition to behaviour change is relatively higher in those areas where there are known cases of arsenicosis.
- The differentiation between pathogen free and arsenic free water was not clearly understood.
- There is a general resistance to change water consumption and water management behaviour.

4.3.2.2 Saline Water Intrusion in the Coastal Belt

Intrusion of saline water into the aquifer is a special problem in the Coastal Belt in relation to access to safe drinking water. 16 districts in four Divisions have in particular some parts where this poses a problem. 10.4 million people are thus affected. The percentage of people affected within a district varies widely. All six districts in Barisal Division have some portion affected by salt water intrusion, thus necessitating 60% of the total population (5 million) to rely on tapping deep aquifers, filtering pond water or collecting rain water. In other divisions, the proportion is relatively smaller, although in Chittagong Division, the number of people thus affected adds up to nearly 4 million.

Table 4.11. Population Affected by Salt Water Intrusion

Name of Division	No of Districts with DTW area	Total Population in the Districts	Population in the DTW area	% Population in the DTW area
Barisal	6	8.4	5.0	60
Chittagong	5	13.2	3.8	29
Dhaka	3	3.4	0.5	15
Khulna	2	4.0	1.0	26
TOTAL	16	29.0	10.4	37

A pattern is apparent when disaggregating the districts by percentage of population affected by salt-water intrusion (called "deep tubewell area," DTW, for convenience). Where the proportion of DTW area is very high (i.e., above 90%), nearly 4 million people live in highly diarrhoea prone areas. An average of 24% of the population suffer from diarrhoeal prevalence in such an area as opposed to the 16% national average as reported in *Progotir Pathey 1998.*

29 Asiatic Social (1999). ***Annesha: Formative report conducted to formulate an arsenic communication strategy.*** Submitted to the Department of Public Health Engineering and UNICEF. Dhaka.

Arsenic Contamination in Samta Village

Samta Village, located in Sarsa thana of Jessore district, represents a case where the problem of arsenic is very severe, more so than in many other parts of Bangladesh. Nationally, according to preliminary test results, an average of 22% tubewells might be contaminated with arsenic above the national standard of 50 parts per billion (ppb). In marked contrast, 90% of the 282 tubewells in this village of 3,533 people (682 households) contain arsenic above the acceptable limit. Forty-four tubewells (16%) in the southern part of the village contain arsenic above 500 ppb, ten times higher than the acceptable limit.[30]

A study by members of the Asia Arsenic Network shows that symptoms of arsenic poisoning have been noted in 152 households (22%of the households) among family members, ranging in age from 6 to 70 years (average age of male patients, 34.8; female patients, 33.1). Seventy-seven households had one who showed signs of arsenicosis. In 3 households, all seven members of the family in each showed signs of arsenic poisoning. The most severely affected patients are concentrated in the south-central part of the village. In general, the distribution pattern of patients is consistent with that of arsenic contaminated tubewells. However, discrepancies are noticed, which suggest that there are other factors, such as nutrition and income levels, which may accelerate or slow down the effects of arsenic.

As part of the mitigation effort, the Department of Public Health Engineering has installed 7 deep tubewells in the village. In addition, AAN has helped towards the installation of one pond sand filter. The feasibility and acceptability of rain water harvesting is also being investigated.

Focus group discussions carried out by Asiatic Social reveals many aspects of the complexity of dealing with arsenic poisoning.[31]

- *People are on the whole aware that they must not drink water from "red" (contaminated) tubewells. However, knowledge about different facets of arsenic poisoning is extremely limited. The observation by one villager is representative of the overall impression: " We don't know much about arsenic. But we know, as we were told, if we consume the red tubewell water, we will have skin lesions."*
- *There is no sense of urgency in people's mind that compels them to seek actively for alternatives to arsenic free water for drinking. "I know my tubewell water is contaminated but I keep on drinking that water because I don't want to go far to fetch arsenic free water. Moreover, my tubewell water is more tasty than that arsenic free water." Another villager remarked; "For how many days should we keep on going out to fetch water?" He expected that solutions should be provided to the village by agencies outside the village: "You had better mend all the tubewells in the area." There was little sign of their own motivation to seek for or contribute towards finding the alternatives.*
- *On frustrated villager said: "No matter how seriously and passionately you try to persuade them not to drink arsenic contaminated water, it just won't work if you don't provide them with sufficient number of alternate sources of water."*
- *Social workers in the village believe that change in people's behaviours is urgently needed but it is not easy to change them quickly. Nevertheless a general feeling of hope exists, as remarked by one villager: "It may take time but it is going to happen if measures are taken carefully and effectively."*

The experience from Samta shows the need for motivating people to change their water consumption behaviour. It also shows that knowledge, attitude and practice as well as response to stimuli is better here than in other areas where similar programmes do not exist. Massive and comprehensive programme towards mitigation should be pursued on an urgent basis. Simultaneously, communication campaign to educate and motivate people towards action should also be instituted.

Table 4.12 Diarrhoea Incidence and Private TW Installation in Deep Tubewell Areas

% DTW Area	No of Districts	Population	% Diarrhoea Incidence	% Privately Installed TWs
91-100%	3	3.9	24	38
21-50%	7	5.4	18	65
11-20%	6	1.1	16	85

The technology most popularly used is the deep tubewell with a No. 6 pump head. Pond sand filters have also been constructed in some places. However, only half of those installed function effectively, the other half having problems of maintenance. Rain water collection is a possibility, although it is yet to gain the popularity for wide scale adoption. The deep tubewell is at least eight times more expensive than a shallow tubewell. An affordable technology that is also socially acceptable (in a similar way as what the No.6 pump for shallow tubewell has become) is yet to be found. The implication is that the technology remains out of reach for most of the poor, unless constructed with financial and technical assistance by DPHE. Currently, the average number of people per deep tubewell is 1 37. And most of these deep tubewells are installed by DPHE. The proportion of private TWs is much smaller in the DTW districts. According to the MICS survey data, 62% of the TWs in these districts are installed as part of the GoB programme, as opposed to the national average of 24%. In the distribution of the public tubewells, it is usually the relatively better off who are able to provide the high contribution money and wield their political influence to have them sited close to their households and treat them as privately-owned. The access by the poor, as a result, is limited, if not denied.[32]

4.3.2.3 Lowering of Groundwater Table during the Dry Season

Nearly 55 million people living in as many as 36 districts of the country suffer from the difficulty in accessing tubewell water during 3-4 months of the dry season when the water table drops to more than 7 meters below the ground level.[33] The problem of ground water lowering is compounded by the extensive use of pumps to draw large quantities of water for irrigation. Tubewells attached with Tara handpumps have been introduced in the area since the mid-1980's for supplying drinking water from water tables that are upto 15 meters below ground level. The average number of people served by a Tara tubewell is at 419 a very high ratio, indicating that millions of people are still deprived of having a water source that is capable of supplying water all year round. This contributes to diarrhoeal morbidity peaks in the Low Water Table (LWT) area during the dry season as people walk longer distance for fetching water and use water from surface sources (such as streams) that contain harmful pathogens.

30 Asia Arsenic Network (1999). ***Arsenic Contamination of Groundwater in Bangladesh: Interim Report of the Research at Samta Village.*** Miyazaki, Japan

31 Asiatic Social (1999). ***Annesha: Formative Research Conducted to Formulate an Arsenic Communication Strategy.*** Report submitted to the Department of Public Health Engineering and UNICEF, Dhaka.

32 DENCONSULT and NIRAS (1999). ***Evaluation of Rural Water Supply and Sanitation Programme, Bangladesh.*** Report prepared for DPHE, DANIDA, SDC and UNICEF. Dhaka.

33 Engineering and Planning Consultants (EPC) and Mott MacDonald Ltd (1994). ***Study to Forecast Declining Groundwater Level in Bangladesh.*** Final Report submitted to UNICEF and DPHE. Dhaka

Table 4.13 Distribution of Tara Tubewells in Low Water Table Area

% LWT Area	No of districts	Total Population	LWT Population (million)	No of Tara (thousand)	TWs People/ Tara TW
81 - 100	16	29.2	27.6	73.3	377
61 - 80	7	24.9	17.5	29.9	586
41 - 60	5	10.9	5.6	17.3	324
21 - 40	5	10.2	3.0	6.1	492
11 - 20	3	5.6	1.0	2.4	417
TOTAL	36	79.7	54.1	129.1	419

The disparity in the distribution of pumps is apparent from the average number of people served by Tara tubewell, ranging from 324 in districts where 41-60% of the area falls under LWTA to 586 where the districts are 61-80% LWTA (see Table 4.13). In terms of the administrative divisions, Rajshahi Division is best off as the ratio of people per Tara TW is 327 compared to 440 in Dhaka Division. Since the LWT population in Chittagong and Khulna Divisions is smaller, they have received much less attention in terms of Tara TW installation (see Table 4.14).

Table 4.14 Tara Tubewells in Low Water Table Area of Different Divisions

Name of Division	No of districts	Total Population	LWT Population (million)	No of Tara TWs (thousand)	People/ Tara TW
Chittagong	3	9.5	4.2	4.5	933
Dhaka	14	34.5	23.6	53.6	450
Khulna	6	9.1	6.5	9.9	649
Rajshahi	13	26.5	19.9	60.9	327
	36	79.6	54.1	129.1	419

A preliminary DPHE estimate shows that the distribution of Tara tubewells is highly skewed within the districts. The results compiled from 108 thanas indicate that 13% of the villages (that contain at least 150 people) in the LWTA do not have any Tara TW. Using 350 people per Tara TW as the reference, 28% of the population remain unserved.

The installation of the Tara tubewell is three times more expensive than the No.6 hand pump. In much the same way as the deep tubewell as mentioned above, Tara tubewells are also installed under DPHE auspices. The popularity of the No.6 pump is evidenced by the proliferation of private tubewells in the country. As indicated in Table 4.14, 75% of tubewells on average are installed privately (based on 1997 and 1998 multiple indicator cluster surveys conducted by BBS with UNICEF assistance). This pattern is observed in most parts of the country except

in the Barisal division where as already mentioned above, the districts lie primarily in the coastal belt and where deep tubewells or pond sand filters need to be installed to avert salt water intrusion into the aquifer. Other districts where the pattern is at variance are in the Chittagong Hill Tracts, the haor area (e.g., Sunamganj, Kishoreganj, Netrokona, Moulvibazar), as well as Natore and Chapai Nawabganj in Rajshahi Division. This is also true in the metropolitan areas where water supply authorities use the centralized distribution system.

Table 4.14 Proportion of Private Tubewells in Different Administrative Divisions

(Unit: % HHs)

Division Name	Rural	Urban	Metropolitan	
			Slum	Non-Slum
Barisal	48	38	-	-
Chittagong	76	68	56	66
Dhaka	82	62	79	54
Khulna	74	51	-	31
Rajshahi	80	83	-	55
Sylhet	60	73	-	-
National	75	65	73	54

An evaluation of the Bangladesh Rural Water Supply and Sanitation Programme suggests that the Tara tubewell has a double problem.[34] On the one hand, the social acceptability of the Tara tubewell is questionable. A survey suggests that complaints about direct action in Tara pumps (as opposed to lever action in No.6 pump) are voiced by 20% of the respondents.[35] On the other hand, the distribution of the Tara and deep tubewell ends up to a large extent in favour of the relatively wealthier and more influential members of the community. This is mainly due to the cost factor so that the contribution money from the beneficiaries is usually provided by those that can afford them. This, compounded by the political influence exercised by them, means that the siting of the tubewells end up being close to their households, if not in their private plots. Neighbours who are often poor families therefore have only restricted access, at best to collect water for drinking at their consent.

4.3.2.4 Water Supply in the Chittagong Hill Tracts

According to *Progotir Pathey*, access to safe drinking water in the three districts of Chittagong Hill Tracts (CHT) is among the worst in the country: 37% in Rangamati, 56% in Bandarban, and 72% in Khagrachari. Considering that the data is collected mostly from the relatively more accessible areas, the situation is likely to be even worse than what the data suggests. The topography and hydrogeology of the CHT requires more varied and innovative solutions to problems of water supply and sanitation than in the rest of Bangladesh. Tubewells are appropriate in

34 DENCONSULT and NIRAS (1999). *Evaluation of Rural Water Supply and Sanitation Programme, Bangladesh.* Report prepared for DPHE, DANIDA, SDC and UNICEF. Dhaka.

35 Center for Management Development (1995). *Report on Evaluation of Tara-II Hand Pump with NO.6 Pump Head and Tara Dev. Head at Mymensingh and Chapai Nowabganj District.*

less than 40 percent of the area, mainly in the settlements along the valley floors. Current technologies to extract groundwater do not always seem to be appropriate for the specific hydro-geological conditions. Because of the rocky layer and hard clay, drilling of wells needs higher capacity tools. The DPHE has provided tubewells and ringwells but the shortage of good underground aquifers and poor construction has rendered many tubewells non-operational.

The people in the hill areas generally collect drinking water from rivers, springs and lakes, where the potential risk of contamination is very high. Due to the lower population density, however, the actual risk may be low, as evidenced by the relatively low incidence of diarrhoea in the region. Low cost technology alternatives to these polluted surface water sources are required for the scattered settlements along the hills, in rocky areas, or those adjacent to the lake, such as ring wells, rainwater harvesting, infiltration galleries with handpumps and gravity piped systems. Most of these are known in the CHT but previous examples have been of inadequate quality. Hence, there is a need for an R&D programme to help provide simple, robust, cost effective and sustainable solutions according to hill context.

4.3.2.5 Unsanitary Excreta Disposal

At the national level, hygienic latrines are used by 40% of the households, 37% in the rural areas and 71% in the urban areas. Within the urban areas, however, they are used by only 23% in the metropolitan slums, worse than in the rural areas. Several other points are notable from Table 4.15.

- Disposal of children's (under five) faeces is given very little attention: 10% in rural areas and only 50% even in the non-slum urban households disposed children's faeces in latrines.
- Homemade pit latrines constitute 80% of the hygienic latrines used in rural areas and urban slums.
- Use of hanging latrines is as extensive as that of hygienic latrines in the rural areas (39%) and overwhelming larger in the urban slums (77%), an indication of the need of latrines for purposes of privacy and convenience (especially of women), although the users do not necessarily recognize it as a health hazard.
- Defecation in open areas is also very extensive in the rural areas, an indication of the availability of space for such purpose and the lack of any social pressure or other compelling reason (such as health hazard or privacy) for construction of the latrine as it does in the urban areas.

Table 4.15. Status of Excreta Disposal, 1998

(Unit: % Households)

Locality	Use of Hygienic latrines				Disposal of Children's faeces in latrines	Use of hanging latrines	Open Defecation
	Total	Water-sealed latrine	Home -made pit latrine	% HPL of the Total			
National	40	11	29	72	14	38	27
Rural	37	7	30	81	10	39	30
Urban	71	46	25	35	44	26	4
Pourashava	70	41	29	41	41	24	8
Metro Slum	23	5	17	74	33	77	0
Metro Non-Slum	81	58	23	28	50	20	1

Compared to other Divisions, all the districts in Khulna Division and four of the six districts in Barisal Division have made remarkable improvement in increasing the coverage of hygienic latrines (greater than 50%). This demonstrates that the possibility exists in replicating similar success in other areas, only if social mobilization is complemented by programmes that are appropriate under local context (see Table 4.16).

Table 4.16 Status of Excreta Disposal in Different Divisions

Division Name	% HH using hygienic latrines			% HH using hanging latrine	% HH doing open defecation
	Water sealed latrine	Home-made pit latrine	Total		
Barisal	4.2	41.4	45.6	50.7	10.9
Chittagong	6.6	25.5	32.1	60.3	9.7
Dhaka	6.5	26.0	32.5	46.7	26.9
Khulna	12.6	44.1	56.7	20.9	29.0
Rajshahi	7.4	26.0	33.4	16.7	55.2
Sylhet	7.5	29.6	37.1	56.2	15.9
NATIONAL	7.4	29.5	36.9	39.0	29.7

The *1998 Baseline Survey of Awareness of 'Facts for Life" Messages* shed light on some important aspects of people's knowledge and attitude. Men and women are by and large aware that germs spread from human faeces (see Table 4.17). A large number of them believe that they are spread through flies and but not so much through water, food, hands or plates and glasses. As a consequence, people see greater importance in keeping food clean and covered rather than using sanitary latrines and keeping these clean and covered as well.

Table 4.17 Awareness of Sanitation Messages

Messages	Men	Women
Germs spread from human faeces	93	84
Faeces of adults and children are equally harmful	44	45
Germs spread from faeces through:		
• Water	12	15
• Food	12	3
• Hands	65	12
• Plates and glasses	21	20
• Flies	7	53
To prevent spreading of germs from faeces, a family should:		
• Use sanitary latrines	46	37
• Dispose children's faeces in latrine or bury it	14	17
• Clean and keep latrines covered	29	36
• Keep dungs away from house and water sources	5	4
• Install latrines away from house and water sources	11	9
• Keep food clean and covered	64	60

4.3.2.6 Development of Hygienic Behaviours

Hand washing after defecation is practiced by an overwhelming majority (see Table 4.18). Only about 27% are, however, particular in terms of what rubbing agent they use (i.e., soap, ash or soil). The remaining people wash hand and use a rubbing agent of one kind or another, but much less particular about their hygiene habits. The issue in this respect concerns more about the proper way of doing it (i.e., both hands) and using soap or ash as a preferable rubbing agent as opposed to soil.

For household work, other than drinking, tubewell water is used by only about 34% (Progotir Pothey, 1998) of the population in the rural areas. In the urban areas, the use of tubewell or tap water is practiced by more than 80%, although the pattern in the pourashavas is similar to the one in the rural areas. This is in part due to limited awareness of the health hazard related to the use of ponds or rivers for household purposes, but is also dependent on how far the water source is. Unless it is close enough, it is extremely unlikely that people would use the tubewell for all household purposes. As already mentioned, the secondary analysis shows that the correlation between diarrhoeal incidences and the use of unsafe water for household work is very strong. This is a strong indicator of the need for the improvement of various hygienic behaviours in order to reduce diarrhoeal incidences.

Table 4.18 Indicators of Hygienic Behaviours

(Unit: % Households)

Indicators	National	Rural	Pourashava	Metropolitan	
				Slum	Non-Slum
Hand washing after defecation with:					
• water and soil	15	16	8	5	8
• water and ash	3	3	2	1	2
• water and soap	9	6	37	8	50
• water and any rubbing agent	76	75	87	54	84
TW/tap water for household work	38	34	74	82	87

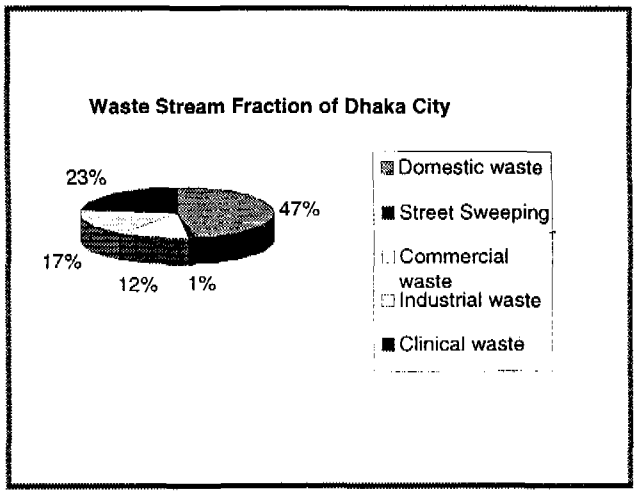
There is also a big difference between what people actually do, compared to what they know should be done. The *Baseline Survey of Awareness of 'Facts for Life'* shows that two-thirds of the people interviewed, for example, are aware that after defecation, one **should** wash hands with water and soap as shown below. In real fact, only about 9% actually do so.

After defecating, one **should** wash hands with:

	Men	Women
water and soil	18	15
water and ash	14	14
water and soap	65	69

4.3.2.7 Solid Waste Management

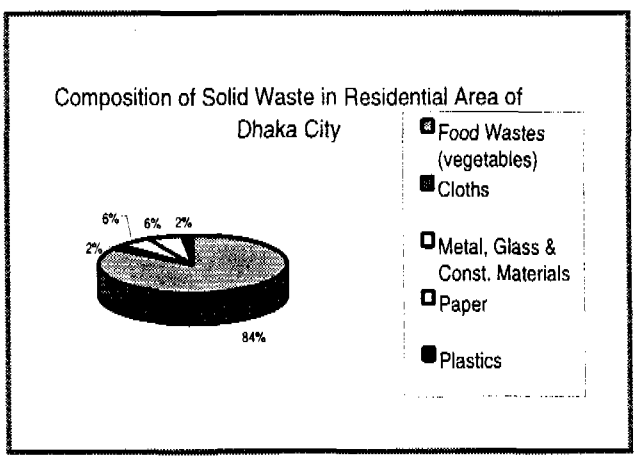
Solid Waste Management (SWM) is one of the most serious environmental problems for urban cities. Inadequate collection, disposal and unhygienic way of recycling of solid waste are the main reasons for environmental degradation and health risks in the fast growing metropolis. It is found that 49 vector borne diseases are directly and indirectly related to solid waster pollution. According to World Bank report, in urban areas of Bangladesh only

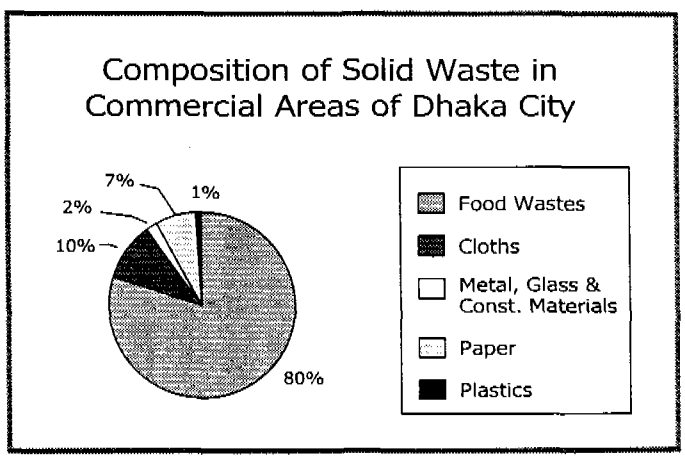


40-50% of the total generated solid waste is collected per day while the rest remaining uncollected obviously degrades the environment creating health hazards.

The waste generation rate in per person per day in Dhaka is 0.5 Kg. According to Dhaka City Corporation (DCC), the solid waste generated in Dhaka is estimated at 3,000 tones, considering an urban population of 6 million. It has been found that most of the inorganic waste materials of urban cities are recycled, but the organic are left unutilized which create disposal problem.

Major problems of Solid Waste Management and recycling in urban cities are: (i) Inadequate financing, (ii) operational inefficiency, (iii) lack of proper utilization of formal and informal sector in solid waste recycling; and (iv) inadequate final disposal facilities of solid waste.





Environmental problems due to improper solid waste management:

- Foul odor near bins, which are collected inadequately
- Blocking of drains
- Untidy streets resulting from litter and dumping of domestic waste
- Ugly sights of scavenging birds and animals near uncollected dumping sites
- Pollution of water courses and ground water
- Land pollution resulting from untreated or inadequate treated industrial waste containing toxic substances and heavy metals
- Hospital waste containing pathogenic bacterial and virus which may lead to spread of diseases
- Breeding vectors such as insects, rats etc, which transmit diseases

The most promising approaches to improve the collection coverage is the introduction of community based waste collection schemes which involves the local community in the collection. Operational efficiency of solid waste services can be improved by increasing the participation of private sector/NGOs/CBOs. At present, about 105 agencies are involved in collecting household garbage in cities and pourashavas of Bangladesh following community

managed solid waste disposal system "Kalabagan Model". The amount of waste transported and disposed of in land-filling is a ;key issue in SWM in city corporations and pourashavas, Therefore, more emphasis will have to places on recycling of organic fraction which accounts for the main portion of the Municipal's solid waste produced in the urban areas of Bangladesh.

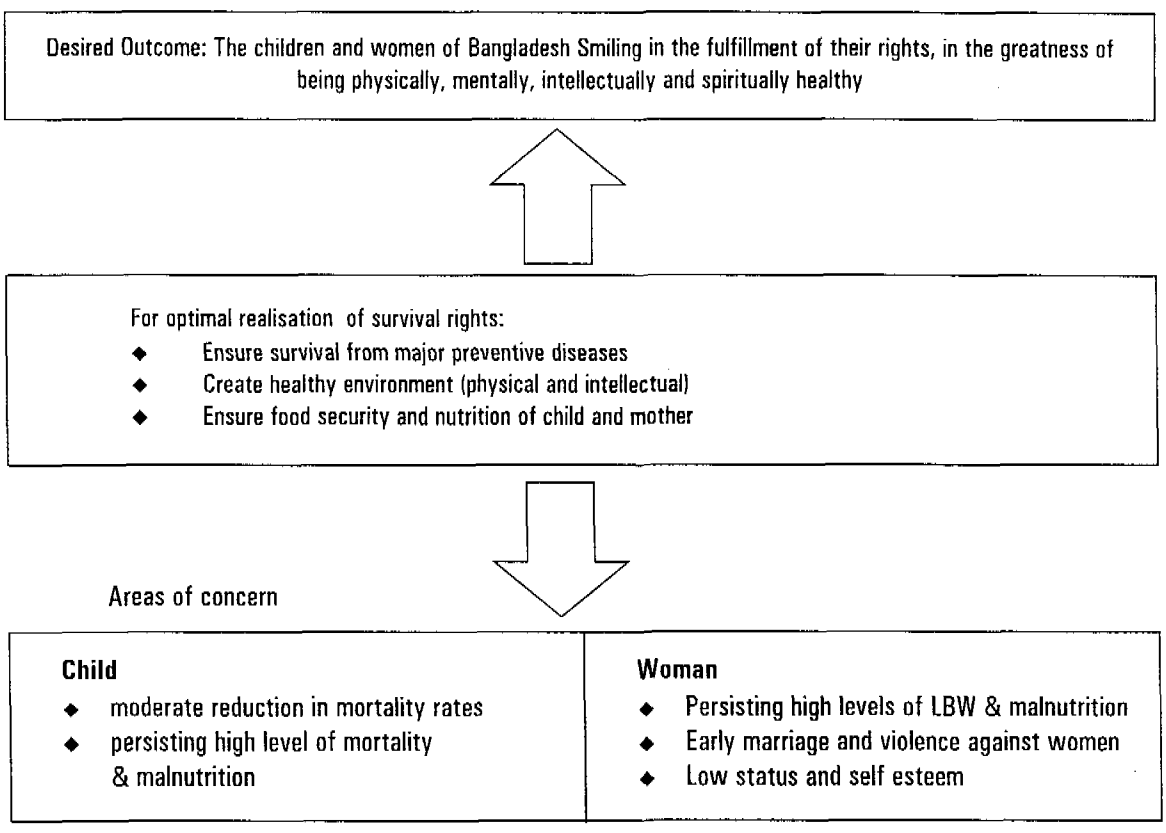
Composting of Municipal solid waste in decentralized and small-scale communal plants is a viable options for the Pourashavas of Bangladesh. National Policy of Safe Water Supply and Sanitation, 1998 of GOB has also put emphasis on recycling of waste materials as mush as possible.

4.4 ANALYSIS OF CAUSATIVE FACTORS

4.4.1 Health and Nutrition

Based on the review of key elements, assessment of trends and major manifestation of problems, key areas of concerns and unrealized survival rights are presented in the following diagram.

Overview of areas of concern and causality analysis



Following is a summary of obligations borne by key groups of duty bearer's responsibilities for fulfilling the survival rights of children. These obligations were identified through review and analysis of the situation of children at various stages of childhood.

Women/Family	Community	Service Providers	Policy Makers
◆ Being Informed ◆ adequate food and nutrition ◆ Putting knowledge and in practice ◆ gender equity among children for health care & education ◆ equitable opportunities for rest or recreation ◆ protection against violence and neglect within the family ◆ To make her a partner in decision making ◆ Seek appropriate preventive and curative care ◆ Allocate family resources ◆ safe environment ◆ intellectual development support	◆ Informing/educating community members ◆ monitoring role ◆ encourage and support health seeking behavior ◆ safe environment for children ◆ support to existing intervention programme ◆ awareness of existing condition, assess and take appropriate action ◆ resources to ensure woman-child friendly environment ◆ forming support groups ◆ mediation of violence and neglect	◆ appropriate equality/ services ◆ treat all women to respect and dignity ◆ linkage with relevant services and referrals ◆ Monitoring ◆ Ensure access and availability ◆ motivate and build awareness ◆ linkage between policy makers and the community (forward and backward inter-sectoral ◆ appropriate utilization of available human resources	◆ assessment of needs and defining policy: ◆ equitable allocation of resources ◆ enforcement of existing legislation ◆ monitoring health & nutrition status of children & women ◆ intersectoral linkages ◆ national level advocacy ◆ Effective coordination of RND ◆ gender sensitive policy

The technical advisory groups identified a number of **obstacles** that constraints the duty bearers in fulfilling their obligations. These have been categorized as immediate, underlying, and basic /structural ones.

Women/Family	Community	Service Providers	Policy Makers
IMMEDIATE			
◆ Narrow/isolated communication networks ◆ Fora for women's' voices ◆ Landlessness ◆ Low income ◆ Restricted mobility ◆ Intergenerational transfer of male dominance and violence ◆ Not looked at as an equal family member	◆ Backward with traditional beliefs regarding women, ◆ Highly hierarchical status relations ◆ Local concept of religious piety ◆ Community involvement in local level planning not adequate ◆ Lack of forum to engage in consensus ◆ No mechanism for Community involvement in Health Service Delivery ◆ Lack of appropriate monitoring mechanism of the community level interventions ◆ No knowledge of available interventions and establishing linkages	◆ Skilled based training for SP not properly given ◆ Inadequate supervisor/ monitoring of H. staff ◆ Resource constraints to provide need based services ◆ Inadequate salary for service provider and facility ◆ No relevant services (e.g. trained counselors for VAW) ◆ Lack of timely supplies ◆ No data and no action ◆ Administrative problems ◆ Bureaucratic ◆ Lack of Adequate support/Supervision	◆ Gap between stated and actual commitment ◆ Policy implementation is not monitored regularly ◆ Include lower level managers in the policy making ◆ Sometimes "too rapid" turnover of policy makers who could make a difference ◆ Insufficient allocation of resources to Health ◆ Lack of consideration in sustainability/repricabilit y of nutrition programs for expansion at national level ◆ Poor planning for optimum utilization of national resources to priority sectors ◆ Intersectoral linkage not well delineated (weak linkages with other sectors)
UNDERLYING			
◆ Lack education ◆ Lack of awareness among women about their health needs and rights ◆ Expecting women to take care of the needs of entire family ◆ Lack of awareness of child rights ◆ Poor understanding of factors affecting health ◆ Stress and stresses contributing to family inability's to cope with basic need requirements ◆ Competing Priorities ◆ Household/family level care givers are not properly empowered	◆ Limited of community responsibility ◆ Limited understanding of Health Issues ◆ Not aware about Child Rights ◆ Lack of adequate information/knowledge about health care facilities/availability of services ◆ Lack of sense of participation of community work ◆ Non cooperating of the public representatives ◆ Corruption	◆ Lack of justice and honesty in implementing programs/ projects ◆ inadequate training to provide quality services ◆ poor commitment & accountability ◆ Lack of resources and facilities ◆ Lack of Professionalism and corruption ◆ Poor job Satisfaction ◆ Lack of awareness of child rights ◆ Limited autonomy & manage/improve services ◆ Not oriented to customers needs ◆ Insufficient financial incentives and salaries for Government Workers + inefficient bureaucracy	◆ Poor research and information in some areas ◆ Lack of well delineated and articulated assignment of responsibility ◆ inadequate commitment to women's issues ◆ Systems for dialogue consensus are not encouraged ◆ Sectors other than Health not engaged in health issues

Women/Family	Community	Service Providers	Policy Makers
STRUCTURAL			
◆ Early age at marriage ◆ Low mobility, expectations & self-esteem ◆ Not treated as an equal family member ◆ Religious beliefs ◆ Traditional role play (socio-cultural definition of women) ◆ Culture of "acceptance" ◆ Frequent Natural Disasters ◆ Illiteracy and Poverty ◆ Population Pressure ◆ Patriarchal structure of family ◆ Superstition and traditional practice in community/HHs and misbelieve	◆ Leaving domestic problems to individual family (lack of intervention when needed) ◆ No effective community structure ◆ Population Pressure ◆ Frequent Natural Disasters ◆ Competing Resources minimize collective support ◆ Conservatism and prejudice ◆ Passive attitude just to wait for services to be provided by Government Or NGOs ◆ Lack of resources for community level interventions	◆ Client oriented service is not available ◆ No accountability ◆ Culture of informal payments ◆ Expectation pressure ◆ Geographical inaccessibility ◆ Frequent natural disasters ◆ Lacking of Infrastructure ◆ Lack of resources	◆ Political sensitivities ◆ No accountability to citizens ◆ Donor driven actions ◆ Lack of Political will to keep "Children First" ◆ Lack of leadership ◆ Population Pressure ◆ Commitment and lack of funds ◆ Lack of resources ◆ Defective resource allocation and wastage of resources ◆ Rapid urban population increase and lack of urban policy and interventions ◆ Inadequate and reform ◆ Back dated thinking

4.4.1.1 Lessons Learned

A variety of initiatives have been undertaken by GO and NGO in promoting health care, child care and women's health in respect of ensuring child rights of survival. Specific interventions in the first few years of life with a focus on child survival needs and rights are quite recent and mainly limited in scope.

The technical team members from their knowledge and experience identified a number of key approaches about intervention to ensure survival rights.

- It is possible to increase the number of coverage, continuance of coverage, awareness and knowledge about health care, child care, nutrition, healthy environment through involvement and participation of the target beneficiaries in planning, implementing and monitoring of such services at community level.
- Informed families, particularly mothers could be the basic actor in ensuring survival rights of the child not only at normal times but also in disaster periods.
- Integration of several activities for ensuring survival rights, covering pre and antenatal care, immunization, vitamin A supplementation at the family level, safe water and solid waste management at the community level could provide opportunity to enlarge coverage effectively and efficiently.
- Decentralization of responsibility with attendant resource availability along with accountability in administration including accountability to the community is likely to ensure sustainability of programs.
- Effective advocacy, information and communication along with enabling legislation and its proper enforcement is helpful to sensitize the target groups of their rights and obligation and to overcome structural and other obstacles.

- Community monitoring and supervision through VO and local government institutions is more effective than centralized reporting system.

4.4.1.2 Strategic Directions

Based on the survival rights of the child, their needs and past experiences the technical advisors identified some principles for identification of intervention and program strategy.

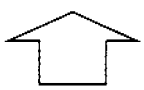
- The concept of rights being new, it is necessary to create a culture of rights and obligation in the family, at the community level, and in the administration of services by the GO and NGOs.
- The survival rights of children are multi-sectoral in nature and thus a coordinated multidimensional approach involving various channels at different levels is essential to ensure child survival rights. This will require a consultative and interactive process in identification and implementation of intervention programs.
- Capacity building at family and community level is as important as is capacity building of service providers and policy makers. such capacity building need include behavioral change, attitudinal positivism, and problem solving skill.

4.4.2 Water and Sanitation

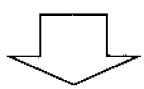
Having considered the key elements, assessment of trends and major manifestations, key areas of concern and unrealized survival rights in the context of healthy environment is presented in the following diagram.

Overview of areas concern and causality analysis with respect to water, sanitation and solid waste management

Desired Outcome: Survival of the child to achieve full potential in an environment that ensures better better hygienic conditions and practices reducing parasitic and vector borne morbidity.



For optimal opportunity for enjoyment of survival rights
- ensure access to pathogene and arsenic free safe water through better water management.
- ensure better hygienic practices in the household and public places through construction and maintenance of sanitary facilities.
- ensure proper solid waste management in the household and community through improved collection , classification and recycling of solid waste.



Areas of concern

- Access to safe water equitably for all types of usage has decreased due to arsenic contamination, saline water intrusion, lowering of ground water table resulting in morbidity due to contaminated water use.
- Existing unsatisfactory situation with respect to excreta disposal and personal hygienic behavior.
- Inappropriate solid waste disposal creates polluted environment resulting in health hazards.

Following is a summary of obligations borne by the family, community, service providers, policy makers for fulfilling survival rights of the child with respect to water, sanitation and solid waste management. These obligations were identified through review and analysis of current situation in these areas.

Family	Community	Service Providers	Policy Makers
-Construct and properly maintain sanitary latrines. -Educate the family members including domestic help, particularly the child in hygienic practices including toilet training at early age and safe disposal of infant excreta. -Ensure adequate supply of safe water for various uses, particularly for drinking, food preparation and related purposes. - ensure household and environmental cleanliness in the family and proper solid waste disposal facility including garbage and these be separated in bio-degradable and non-bio degradable.	- Construct and maintain sanitary latrine in public places (e.g. schools etc). - Construct and maintain community latrine in slum and crowded places through social mobilization. - Advocate, support and monitor compliance with respect to sanitary latrine and hygienic practices. - Mobilize and organize for safe water supply and create awareness about consequences of unsafe water use. - Create awareness about proper solid waste management and organize as well as support initiative for creating facility for garbage disposal in a properly classified way.	-Educate and mobilize community to adopt technologically appropriate sanitary excreta disposal system. - Establish production center and supply sanitary latrines to households through active network. -Monitor coverage of sanitary excreta disposal. -Mobilize community resources through awareness creation for demanding safe water supply and ensuring its regular supply which is tested at regular intervals. - Ensure water security through protection of water quality. -Initiate, promote and coordinate solid waste disposal at a place in a differentiated packs through information dissemination drives. - Promote private initiative for SWM wherever possible on cost-sharing basis.	-Make existing regulations enforceable for excreta disposal and set necessary obligatory standards in this regard and ensure compliance through local government machinery. - Provide incentive for 100% sanitation coverage for UP and ward commissioners are instituted. -Allocate resources for sanitation for high risk areas on priority basis. - Use public media for awareness creation about safe hygiene practices. - Develop effective policy and institutions for sustainable supply of safe water through urban and regional planning on a long term basis. - Update conservancy laws and legislate for phasing out of toxic mater use. - Develop guidelines for SWM for all areas including under-served areas.

The technical advocacy team identified a number of obstacles that constrain the duty-bearers in fulfilling their obligations. These have been categorized as immediate , underlying and structural in the following table.

Family	Community	Service Provider	Policy Maker
IMMEDIATE			
-Lack of space in slums and shared households. -Limited supply of inexpensive latrines. -Sanitation is not a priority concern. -Lack of knowledge regarding the Linkages between hygiene and good health. -Lack of alternative source of water supply. -Absence of proper waste collection system.	-Poor logistics -Lack of awareness and initiative and proper organization. -Insufficient cooperation amongst stakeholders due to community structure. -Lack of resources. -Lack of institutional mechanism. -Lack of education about the value of proper sanitation, safe water use and proper SWM.	-Lack of commitment. -Lack of training for creating awareness. -Lack of incentive for effective work. -Lack of coordination. -Lack of accountability -Poor management. -Lack of supervision. -Weak R& D support for safe water supply. -Lack of training for testing contamination in water.	-Lack of concrete guideline and action plan. -Lack of institutional capacity to translate policy into action. -Low priority accorded to these sub-sectors.
UNDERLYING			
-Poverty causing resource constraint for latrine construction -Lack of hygienic awareness about the benefits of sanitary latrines. -Prevalence of unhygienic practices due to culture of poverty. -Lack of knowledge about proper SWM.	-Inadequate scientific information on water quality, environmental pollution and SWM. -Prevalence of misconception, misinformation and wrong attitudinal practices. -Lack of integrated approach about water, sanitation and waste disposal.	-Limited research and development for appropriate hygienic option about water, sanitation, and SWM. -Lack of information and education for service providers for dissemination and multi-sectoral coordination.	-Lack of commitment to enact laws and regulations. -Inadequate and in appropriate planning of sanitation, safe water and SWM. -Lack of clear vision about value and importance of such services. -Lack of IEC and inter-sectoral coordination.
STRUCTURAL			
--Dependence on external support agencies for safe water, sanitation and proper waste disposal in urban and absence of such agencies in rural areas.	-Weak community structure to take action on safe water supply, sanitation, and waste disposal. -lack of appropriate initiative in slums and rural areas.	-Service providers have limited focus and being dependent on external finance , do not exhibit continued commitment for improvement of water and sanitation and SWM programs	-Lack of political commitment resulting in inadequate resource allocation and inefficient use of available resources. -lack of inter-sectoral coordination.

4.4.2.1 Lessons Learned

- A pilot project in 20 thanas carried out by the NGO Forum for Drinking Water and Sanitation during 1994-1996 demonstrates that it is possible to raise the use of latrine to greater than 90%. This is attributable to the communication and social mobilization programme that includes courtyard sessions involving grassroots workers; production of latrine parts closer to the community; and training on how to make sanitary latrines (including home-made pit latrines), keep them clean, and what to do when full.[36]

- The need for latrines, from the standpoint of privacy and convenience (especially for women), is evident from 39% hanging latrines used in rural areas and 77% in urban slums. There is the potential to make a major breakthrough by helping households to take decisions about converting hanging latrines to hygienic latrines.

- Homemade pit latrines constitute about 80% of the latrines in rural areas and urban slums. Field reports suggest that the major constraint is the transportation of latrine parts from production centres that are located far away from the house. There are also indications that production centres get established in response to demand created in the community.[37] There is therefore a need to create a conducive environment to encourage private entrepreneurs in the community to establish either latrine production centres or distribution centres close to the community. At the very least the awareness campaign needs to concentrate on how to help households make decisions about safe pit latrines.

- The programme activities targeting the Union Parishads and UWCs have been few and weakly implemented. Neither the Union Parishads nor the UWCs have played the intended key role in mobilizing the rural population and promoting personal hygiene and environmental sanitation. Also, the assumption that local political leaders, school teachers and imams will voluntarily use their time and act as "agents of change" has been vulnerable. Targeting the rural population through these intermediaries have clearly turned out to be a weak link in the social mobilization project, not only because they are busy people with other equally important tasks, but also because they lack the necessary incentives and professional dedication to disseminate health and hygiene messages. In addition, there has been little support from DPHE field staff to maintain hygiene and environmental sanitation on the local political agenda and to encourage and assist the politicians, school teachers and imams to carry out mobilization activities.

- Experience from the DPHE/UNICEF pilot project on school sanitation and hygiene education shows that the construction of the WATSAN facilities leads to an average of 10% increase in the attendance of girl students. Based on the 1995 experiment in Moulvibazar district, the programme now relies on the School Management Committee members and teachers to take responsibility for planning and construction[38]. The results are positive, with the work completed to specifications and on time. A recent study in Noakhali shows that local-level management was working well:[39]

- In more than 90% of cases, the quality of construction was good.

- In more than 70% of cases, both latrines (one for boys, one for girls) are used regularly by students.

---

36 NGO Forum for Drinking Water and Sanitation (1997). *Study Report on Lessons Learnt from Social Mobilization for Sanitaiton.*

37 DPHE-UNICEF (1994). *National Survey on Latrine Producers and Market Situation, Final Report.* House of Consultants Limited.

38 UNICEF (1995). *A Study on The Implementation of Latrines and Water Supply System in Primary Schools Through School Management Committee: An Experience in Moulovibazar.*

39 UNICEF (1998). *Report of a Comparative Study between SMC and DPHE Contractor Constructed Facilities under School Sanitation Programme in Noakhali District. Dhaka.*

- Regular cleaning of latrines is still a problem - only about 60% latrines are cleaned regularly.
- IEC materials sent to schools are used in about 85% of cases.
- More than 80% of students interact with their parents on their newly acquired knowledge of the benefits of sanitation and hygiene practices.
- More than 80% of teachers, 65% of students and about 43% of families in the school area have sanitary latrines while sanitation coverage for Noakhali is 22% in total.

4.4.2.2 Strategic Directions

1. The new National Policy on Drinking Water and Sanitation sets a new tone for future directions addressing many of the challenges posed by the situation analysis above. There is now general agreement among all concerned stakeholders about the major principles to be adopted for the future undertakings. Future provisions need to consider strong partnership with NGOs and the private sector in responding to the expressed needs and priorities of the households. DPHE should increasingly take on the role of coordinator, facilitator and supervisory role in ensuring the quality of services provided by others. In this connection, the implementation responsibilities must be allocated according to the proven capabilities. The DPHE has worked rather well within its traditional areas of responsibilities when they have been well motivated and as long as they have been able to work as engineers without political interference in their work. If new responsibilities are added to an organization in order to achieve the development objectives of a programme, a careful stakeholder institutional capacity analysis must be undertaken.

2. A more focussed poverty oriented strategy must be followed to ensure that the poorest of the poor get realistic options for using safe water for all purposes as well as construct sanitary latrines and adopt hygienic practices for improved health. For this to happen, it will be necessary to design an implementation strategy that empowers the poor financially as well as politically.

3. Gender sensitivity in programme design and implementation has been extremely poor in the past. Due to the lack of foresight in siting of the wells, for example, there are many instances when women cannot access the facilities. Often distances are prohibitive to their using safe water in larger quantities and for personal hygiene such as bathing and washing clothes. Carrying water over long distances, even during pregnancies, often cause health hazards such as backaches, leading to miscarriage etc. Similarly, the involvement of women in site selection committees has only been tokenistic. Women members of the WATSAN Committee, for example, do not usually attend the meetings; if and when they do, on special occasions, they play an extremely passive role. Very few of them have any idea regarding their roles and functions as WATSAN Committee members. Discussions show that they have not received adequate orientation or guidance in this matter.

4. The implementation strategy must also emphasize cost-effectiveness, replicability and sustainability of service delivery of the responsible institutions as well as the sustainability of the benefits to the target group. A pre-requisite in this connection is to pursue a demand-responsive approach. This could for instance mean going beyond the concept of cash contribution for TW installation or requiring a specific number of latrines to be constructed before a TW application could be approved. Field observations clearly indicate that although people have contributed in cash, they do not necessarily have a sense of ownership or maintenance responsibility. Most beneficiaries say that the TW belonged to the government and that it is basically the government's responsibility to maintain it.

5. With respect to the water supply programme, water quality monitoring has been unsatisfactory due to lack of institutional capacity. The assumption that tubewells provide safe water for drinking water is no longer valid. The recent discovery of arsenic in ground water is a good pointer to how wrong this assumption has been. Also the bacteriological contamination of some wells (mostly private ones that do not have platforms, but also some public ones close to unsanitary latrines) is the consequence of poor guidance and supervision of construction. Water quality surveys prior to choice of water resource and continuous water quality monitoring (chemical) of water produced is an important component that must be incorporated into any future water supply programme. This would also imply the need to build up adequate laboratory facilities and developing testing procedures for the supply of safe water.

6. Much more attention needs to integration of behavioral development for sanitation and hygiene at the household level and enabling members of the household to take their own decisions. This is no doubt a long term process and will require genuine community participation. In the past, there has often been an inherent conflict between increasing community involvement and the desired speed of implementation. It will be no longer acceptable for the programme to maintain its speed of implementation, at the cost of community participation. Effective advocacy, information and communication will still remain the key towards correct behavior development and change in individuals, families, communities, service providers and policy makers.

7. Efforts in capacity building and training at all levels must include those that will address the societal and basic rights of children and women including development of correct attitudes towards the beneficiaries; monitoring of quality of services being provided and accountability towards those they serve

CHAPTER FOUR

CHAPTER FIVE

Development

5.1 KEY ELEMENTS OF DEVELOPMENT

Child development is the front end of human development. From this fact comes the vision of a realigned framework for all development activity and support—from caring practices to resource allocations. Focus is placed on the development to the full potential of the child, through the exercising of rights and assumption of responsibilities, as the path to fuller human development, national growth, prosperity and equity as a whole.

Recent scientific findings confirm the crucial importance of child development to individuals and societies alike, particularly during the first years of life. However, in all countries, including Bangladesh, a child's development is challenged by various degrees of multiple poverties, in care, support, services and leadership.

In assessing child development needs and rights in Bangladesh, focus was placed on obtaining and analyzing available data and information in the areas of child development listed below. This was done for each of the three key stages in a child's life: from the prenatal period to 5 years; from 6-10 years, and from 11-18 years of age.

- Mental development (cognitive and emotional)
- Physical development (growth, motor skills and coordination)
- Ability to interact successfully in social relationships
- Ability to interact successfully with the physical environment

The Convention on the Rights of the Child states that a child has a right to develop to "the maximum extent possible" (Article 6). It also says that States Parties should "...render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children." (Article 18.2) It includes the "right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development" (Article 27) and the "right of every child to education, with a view to achieving this right progressively and on the basis of equal opportunity." (Article 28)

This assessment and analysis of the development rights of children seeks to articulate the key elements and trends affecting these rights, the major manifestations of problems, noting the main groups affected, and the causes of problems and barriers which constrain the duty bearers in fulfilling their responsibilities, and the obligations and responsibilities that caregivers, family members, communities, service providers, and policy makers have towards children, during each of the three key life stages of their childhood. Based on consultation with technical advisers and a review of programmes promoting child development, lessons learned from past experiences are also noted and some strategic directions for future initiatives suggested.

5.1.1 Prenatal to 5 years – Shoishab

Bangladesh is a demographically young nation, with annually two and a half million births. Out of a population of 128 million, there are 21.5 million children under six years of age, who thus represent over a sixth of the population. Out of this is a growing population of urban poor children aged 0-6, currently close to 2 million in number.

The period before birth through five is defined as early childhood, or *shishukal*. The quality of these critical first years in a child's life and the experiences to which the child is exposed from birth set the stage for life-long health, learning and behaviour.

This period may be roughly divided into three key stages: before birth; from birth to age three when a child's brain development is most intense; and age three up to six when early socialization and foundations for learning are laid. At every stage, the child's physical growth, cognitive, mental and emotional development, development of motor skills and coordination, evolving capacity to interact in social relationships, and increasing ability to interact successfully with the physical environment are intertwined.

5.1.2 6-10 years - Balyakal

For children ages 6 to 10 experiences both inside and outside school are important for their growth and development. As with the other stages of childhood, an environment which is both secure and stimulating is essential for development of their full potential. Structured learning, which may take place in formal schools or non-formal learning centres, is one component of the support children need at this stage.

There are nearly 20 million children aged 6 to 10 in Bangladesh. The majority live in rural areas, but there is a growing number in urban areas, particularly in the urban slums. About 18 million children are enrolled in formal primary schools, while at least another 1.5 million attend nonformal learning centres. However, while there are children below age 6 and above age 10 in primary school, nearly 4 million children of the 6 to 10 age group are not currently enrolled in primary school.

5.1.3 11 to 18 YEARS—KOISHOR & JUBOKAL

The transition from childhood to adulthood is difficult in any culture. Adolescents are no longer children but they are not yet considered by society to be fully adult. In Bangladesh, there is also a paradox as children's childhood differ on the basis of social class and income. Adolescents from the very poor families shoulder some adult responsibilities from very early ages by working either at home or outside for wages in kind or cash. However, with respect to a voice in the family, they must be subservient to their parents and especially their fathers. Middle class children have more sheltered lives, but they too face intense pressures of expectations built around a competitive examination system that is seen to determine their options for life. In both cases, the pressure of working full time to contribute to family survival or cramming to pass exams and to fulfil parental and societal obligations there is scant time for enjoying childhood or meeting the complexities of adolescence with some support mechanisms.

And so it is not surprising that in many focus group interviews with the children, adolescents in Bangladesh feel that there is not sufficient recognition of their special needs. Given its population structure, young people from 10 to 19 form some 23 percent of the population – not an insignificant group. In absolute terms the number in this age group was 27 million in 1995 and is projected to rise nearly 30 million by the year 2000.

Table 5.1: Total Population and Adolescent Population in Bangladesh : 1961-2010

Population	1961	1974	1981	1991	1995	2000	2010
Total (in'000)	55223	76398	89912	11145	11973	12924	146381
Adolescent (in '000) (age 10-19 years)	9290	16139	20550	22943	27060	29467	31765
% total population	16.8	21.1	22.9	20.6	22.6	22.8	21.7

Source: UNFPA, Bangladesh Country Paper for South Asia Conference on the Adoloscent, July 1998. (Note: Population of 1961-1995 are adjusted census population and population of 2000 and 2010 are projected)

What is the nature of the group? About 50 percent of female adolescents are illiterate and only 23 per cent of women 15 to 19 years old have had more than 7 years of schooling. Some 45 per cent of this group have no access to media, which can be a powerful tool for change. Young themselves, they are also becoming mothers at a very young age with its attendant problems. In South Asia, Bangladesh has the highest proportion of women – 66 percent – below 20 giving birth each year, compared to 49 percent in India and 30 percent in Pakistan. In 1997, some 940,500 children were born to adolescents aged 15 to 19, and the fertility rate at 55 births per 1000 women is the highest in the world. Incidentally, this bears comparison with Sri Lanka where the rate is five times lower and participation rates of adolescents in education is much higher.

Even when adolescent girls can access work in the formal sector, like the export garment industry in Bangladesh, with more than 44 percent illiterate, this blunts their capacity to access higher level skills for higher value added work. In a global economy that is increasingly knowledge based, the need for flexible, well educated labour force that can quickly deploy to master new skills and processes will be critical, there is much to be done in Bangladesh to equip a larger labour force with these tools.

As the World Bank's draft Education Sector Review states:

"One of the main development challenges for Bangladesh is to provide employment for the entrants into the labour force... the composition of labour demand in the medium term is to shift in favour of a more literate and numerate labour force as the structure of the economy moves towards a more global market oriented manufacturing and services sector."[1]

Education is the key variable that affects mortality, fertility and migration as well as livelihoods, it impact is also co-dependant on both the social and cultural frameworks of any society. Education is a key factor in sustainable development and as such education plays a critical role in the process of building a culture of human rights as well as the development of human capital. It is both a mechanism for replicating and for changing human culture and for affecting human behaviour.

To cite a 1998 UNFPA theme paper from a conference on Adolescence, "since education is inversely correlated with fertility levels, it is evident that globally and within South Asia, the education that adolescents receive will affect their reproductive behaviour and will, in turn, have a significant impact on present and future societies in which they live. Given the already well established correlation between education and demographic and social changes, the quality and quantity of the education adolescents receive up to the secondary level, particularly for girls, emerges as a priority concern."[2] The report also goes on to call for a widening access by girls and women to secondary and higher levels of education as well as to vocational education and technical training.

1 World Bank, Education Sector Review, June, 1999 (draft)

2 UNFPA, Bangladesh Country Paper for South Asia Conference on the Adolescent, July 1998

In Bangladesh the provision of secondary education is both an area of concern as well as hope. Nearly 8 million students are enrolled in the secondary stage with gross enrolment rates of 44% for grades 6-8, 27% for grades 9-10 and 16% for higher secondary (grades 11-12).[3] Due to an innovative secondary school stipend program the number of girl students as a percentage of the total enrolment in grades 6-8 (54%) is impressive but this decreases to 41% for grades 9 and 10 and to only 34% for higher secondary. [4]

5.2 ASSESSMENT OF TRENDS

5.2.1 Prenatal to 5 years – Shoishab

While data and information on the situation of child development in Bangladesh are limited, some indicative research has already been carried out in both rural and urban areas, often qualitative in approach, providing insights into caring practices as well as general knowledge levels of child development. The data and available information is also overwhelmingly on the care given by family members, which highlights the need for further research on the potential, opportunities and support provided by communities, service providers and policy-makers, as well as their perceptions and expectations of each other.

5.2.1.1 Knowledge of child development

A 1998 survey[5] carried out in both rural and urban areas and in all six divisions of Bangladesh found that general awareness of the full range of needs of children for their proper development, based on the content of the messages of *Facts for Life,* was generally low, with only one out of four women and men considering attention and care from parents as necessary for good mental/cognitive development of children under two, compared to 73% of men and 69% of women knowing that nutritious food is important. However, even in this area, the knowledge of what constitutes good nutrition was limited: only 2% of men and 3% of women knew that iodine is important for mental/cognitive development, while slightly more knew the benefits of breastmilk: 13% of men and 16% of women.

Table 5.2: Awareness of messages on child development, and components of child development support

Message: For good development of under-two children are necessary:	Women %	Men %	Local Communicators %	Media Personnel %
Attention/care from parents	25.2	24.2	34.4	42.9
Affection/love	9.6	6.7	12.6	18.2
Iodine	3.4	2.4	13.2	14.6
Breastmilk	15.9	12.8	25.2	23.0
Nutritious food	68.6	73.4	80.8	81.6

3 World Bank Education Sector Review, June 1999 (draft)

4 Ibid.

5 Mitra and Associates, "Baseline Survey of Awareness of Facts for Life Messages". UNICEF, 1998.

However, in certain areas, knowledge and values were firmly established: 91% of women and 86% of men knew that play is important for a child's development, and 95% of both women and men believed that physical punishment is bad for a child's development.

Yet the interviews revealed that parents did not generally consider anything apart from play with toys/objects as being beneficial to a young child's cognitive development. In response to the question, "What types of play help the development of intelligence among children under two years of age?" very few people mentioned pretending games, counting games, or singing/rhyming.

Women in general were aware that physical punishment is bad for children, but most did not know the harm that physical punishment can cause to children. According to another survey, approximately 30 percent of the female respondents said that physical punishment renders a child "scared," 20 percent said that it makes a child "stubborn" and about 4 percent believed that it makes a child "ferocious." (Mitra and Associates 1998)

Some variations in knowledge levels between rural and urban populations suggest that urban people had relatively greater exposure to messages on child development than their rural counterparts. Compared to 24% of rural women, 33% of urban women knew that for their proper mental development children need affection and attention from their parents. Similarly, 45% of urban women versus 25% of rural women were aware that parents should take part in their children's play and that they should encourage children to try new things in their play (26% versus 17%).

Compared to the women and men interviewed in the household sample, both local communicators and media personnel had relatively higher knowledge levels of child development. Yet there are still apparent gaps: only 43% of media personnel and only 34% of local communicators were aware that young children need affection and attention from their parents for proper mental/cognitive development.

5.2.1.2 Beliefs and perceptions of child development

There are many traditional beliefs and practices, both positive and negative, which serve as guidelines for child caregiving. Various studies[6] have identified certain beliefs in certain areas, which can have an impact on children's development and opportunities offered to them, such as:

1. The umbilical cord twisted around the baby is considered a sign of good luck;
2. The first child, irrespective of sex, is a simpleton (saral);
3. A child brings its own sustenance, as God controls the four main aspects of living—life, death, wealth and sustenance;
4. A delay in a child's learning to talk can be cured by putting lead in the mouth, using sacred water (pani pora), feeding puffed rice, etc.
5. Exposure of a baby to an "evil eye" causes loss of weight and ill health;
6. Child care is primarily a women's responsibility, even when she is working outside the home and is supporting her family;
7. Pregnant women and lactating women should not eat all types of foods—e.g. pineapple, mutton, small fish, and prawns are strictly prohibited, as are eggs, as they are believed to increase the chances of a baby's catching a cold; and
8. Babies "need" sugar water in addition to breastmilk.

6 Monir, Shahnaz. "A Study on Child Caregiving Practices of Rural Bangladesh", SCF (USA), 1994;
Ahmad, Nilufar, "Report on Social Assessment of One BINP Thana", World Bank, 1998;
Sen, Rita, "Social Assessment for the National Nutrition Program (NNP)", World Bank, 1998; and
Cameron, Sara, Kandula, Namratha, and Leng, Jennifer. "Urban Child Care in Bangladesh". SCF (USA), 1998.

Identification of primary caregivers

Through a study on child caregiving practices in rural Bangladesh sponsored by Save the Children (USA)[7], it was found that the primary responsibility of raising a child under five lies with the mother. Fathers play a minor role in child caregiving. The second most important group of caregivers is grandmothers in the extended family, and siblings in nuclear families.

In rural settings, even in situations where the mother is the primary caregiver, the provision of care is shared in a fairly seamless way: a "child of *shishu* (early childhood) stage spends most of her/his time with the mother or at least in the care of an elder sibling or other relative. The baby is constantly held, cuddled, and talked to and, at a sign of distress, picked up immediately."[8]

The patterns and roles of caregiving show marked differences in family arrangements of working and non-working mothers in poor urban families in Bangladesh. In the study on urban child care, also sponsored by SCF (USA)[9], it was found that the availability of adequate child care support was one of the factors determining whether or not women worked in the first place. The survey established that working mothers are highly dependent upon their own families, rather than their husband's families, for child care support. About a "fifth of children under age five had been forced to live away from their parents, apparently due to the absence of child care support in the city. The majority had been sent to live in their mother's home village and were being cared for by their maternal grandmothers."

Maternal grandmothers were also the most common caregivers for children living in the city. About 42% of children were provided care by grandmothers, two-thirds by maternal grandmothers. One child in six was provided care by a sibling under 14 years of age. Other relatives, servants or neighbours cared for the remainder. Fathers provided care to a small proportion.

Again, as in the rural settings, the study found that there is a fluid sharing of responsibilities according to need: "in most households, whether the mother was working or not, child care was shared by several individuals in addition to the principal caregiver. Fathers, aunts, sisters, siblings and others routinely took over".

It should be noted that the responsibility older children have in providing care for young siblings has an impact on their development as well: while acquiring certain life skills and a sense of responsibility for young children, many children, particularly girls, are also unable to attend school because of this duty. Most of these caregivers interviewed in the study had received less than two years of formal education. Older caregivers were the least likely to have attended school. Only half the caregivers reported that they felt confident about their ability to provide proper care but more than 80% expressed interest in learning more.

5.2.1.4 Child care practices in cognitive development

The SCF study in rural child care practices in Bangladesh found that close to two out of three mothers were making efforts to have contact with and interact with the child and initiate learning by the age of six months; one out of three through physical contact; and 15% showed the child things that were known to her/him. An overwhelming 92% of mothers said that they had tried to make the child smile in various ways.

---

7 Monir, Shahnaz. "A Study on Child Caregiving Practices of Rural Bangladesh", SCF (USA), 1994.

8 Aziz, S. and Maloney, C. "Life stages, gender and fertility in Bangladesh" ICDDR,B, 1985.

9 Cameron, Sara, Kandula, Namratha, and Leng, Jennifer. "Urban Child Care in Bangladesh". SCF (USA), 1998

Almost all mothers babbled with their child. Close to half of the mothers interviewed said that most children start to babble at three to six months of age, and close to half again said that this helps the child to learn how to make similar sounds.

However, children are not always encouraged to speak and talk in front of elder members of the household, and mothers prefer children to remain quiet when they are working, upset or tired. Yet three out of four mothers like to have a conversation with a child when she is at leisure, and two thirds saw children's asking questions as one of the ways for a child to learn.

By the ages of one to two years, two-thirds of children were taught to identify people, and half could identify objects by their names. It was found that most caregivers teach children to identify people and objects by pointing to a person or an object, drawing the attention of the child, and telling the child who or what it is. But when mothers were asked about the ways through which a child learns language, the answer was that a child's overall language development occurs by imitation rather than direct interaction between the caregivers and the child.

5.2.1.5 Child care practices in physical and motor skills development

The same SCF study showed that, in most cases, it was mothers who were responsible for taking care of the needs that contribute to the physical growth and development of the child, including feeding and bathing, as well as providing reassurance and safety. Siblings, cousins, aunts, uncles or children from the neighbourhood also play important roles in the physical development of the child.

Over 70% of the children studied had toys to play with to develop motor skills and a sense of physical mastery. The fathers were the main providers of toys. In observation, however, it was seen that children played more often with objects they have gathered themselves from their surroundings (such as leaves, clay, water etc.) which were not purchased by the caregivers. Over half of the mothers interviewed had given young children under one year of age toys to hold/suck. 37% of mothers reported that they allow a child of two to three years of age to explore things by touching and playing with those objects.

Babies are well protected from physical danger—they are carried or held close to a caregiver day and night and any sign of discomfort is attended to quickly. Close to half of children observed were protected from danger mostly by their mothers, followed by grandmothers. However, the risk of danger increased when the child learned to walk and when another (young) child acted as a caregiver. In observations, one quarter of children was never protected from physical danger by caregivers, nor received any admonition for dealing with hazardous objects.

Nutrition plays a key role in the physical development of children. The Bangladesh Integrated Nutrition Project (BINP) social assessment found that there are gaps between nutrition and health-related knowledge and practice. Although people knew of the similar nutritional needs of girls and boys, quite a few women admitted that other members favoured boys much more than girls. At the thana level, officials reported that among educated families, the "time given for the care of a boy is generally double that of a girl", and that among the uneducated, the "gender discrimination in child care is even more alarming."

The SCF study on urban child care also showed that nutrition is an area of potential vulnerability for children of working parents. Findings included that over 40% of working mothers said that they had given up breastfeeding because of "work." Children of working mothers were more vulnerable to malnutrition when their (other) caregivers were involved in food preparation. About 70% of caregivers prepared food for children in their care, 70% of whom showed signs of chronic (low weight for age) malnutrition. Poor nutrition was much less marked in the 30% of children whose food was always prepared by their mothers.

High rates of illness were found in this urban poor population: the study found that more than 70% of children of both working and non-working mothers had been ill during the previous month. Two thirds had experienced a respiratory infection; the remainder had mostly suffered from diarrhoea. About three-quarters of working mothers had sought treatment for their children, compared with less than 60% of non-working mothers.

Although working mothers were more likely to treat illness in their children, they were less likely to seek qualified medical attention. They were more likely to go to a pharmacy and pick up medicines without consulting a qualified health worker. The reverse was true for non-working mothers.

5.2.1.6 Childcare practices in social and emotional development

Childcare practices in the early years of a child's life are crucial in determining the child's social and emotional development. Childcare practices are influenced by various factors, including the socio-cultural practices and customs, attitudes and prejudices of the society and the family and education and behaviour of the parents, and their social and economic conditions. All of these factors have direct bearing on the child" social behaviour, cultural values and the attitude towards people from different culture, colour, sex, religion and political ideologies.

Parents tend to encourage certain social behaviours in their children. All mothers interviewed in the SCF rural study thought that cooperation and perseverance should be encouraged in children. 98% of mothers also felt that children need to be taught self-control and responsibility. Most mothers thought that these behaviours are most frequently taught to children above four years of age, although they can begin as early as age two.

Other behaviours encouraged by parents include competition (87%), sharing (65%) and manners (60%). Behaviours that are discouraged by the caregivers are being naughty, misbehaving, crying, throwing tantrums, fighting with other children and being noisy.

It was found that mothers play the most important role in socializing the child (80%). Fathers and grandparents play almost equal roles in behaviour training (38% and 37% respectively). Siblings also take part in behaviour training (20%).

In most cases (87% of observed children), mothers used verbal instructions to teach and develop behaviour. Only 5% of mothers thought that a child could be taught by being harsh. Mothers played an equal role irrespective of the sex of the child. Fathers played a secondary role in disciplining children.

Some differences were observed in the caregiving practices by the sex of the child:

- a girl child is more often disciplined;
- caregivers insist that a girl child should be obedient;
- mothers provide the main guidance in training in work and behaviour for a girl child, while fathers are expected to play this role for boys;
- girls are expected to stay at home and take part in household chores, whereas boys can get involved in outside activities; and
- girls get clothed earlier because of the perception that since a girl's body is similar to that of an adult woman, it is more shameful to have it exposed.

In terms of perceived emotional needs, respondents said that children need understanding adults (93%), adults who can explain what is expected of the child (82%), and communicative adults (73%), so that they can "learn to deal with the world through gaining a sense of security, competence and self-esteem." Finally, mothers reported that children need adults to show affection towards them (78%), so that the child "can be happy and learn to love others and behave well with others."

In the SCF urban child care study, it was found that the expression of physical affection was not lacking in most households, but the importance of talking with the child, of listening, playing and encouraging the child to discover and explore were less understood. Less than a third of working mothers said they had time to play with their children. Over 60% of caregivers and more than 80% of working mothers said they spent "no time" on educating children over the age of two years. Fathers and non-working mothers were only slightly more inclined to be involved in educational activities.

In the BINP social assessment, all women and male respondents said that fathers do not give enough time to childcare. A majority of women respondents said that this is "not good for the child, especially boys, whose mental development suffers from the absence of a male role model."

No information or data was found on any comprehensive initiative to date in Bangladesh to support social and emotional development. While some initiatives have taken place to increase awareness and basic knowledge among caregivers in this area, e.g. the *Facts for Life* communication initiative implemented by the Government as well as NGO channels, there was no evidence of any initiative to date that has gone further than this to bring about the desired behaviour development and/or change.

5.2.1.7 Children five or under participating in organized ECCED programmes

The government of Bangladesh (GOB) does not have a holistic early childhood development policy. The National Plan Action of the GOB initiated in 1995 has set targets with respect to six dimensions that followed the Jomtein Framework for Action to Meet Basic Learning needs where "expansion of early childhood care and development activities" was highlighted. This program of Early Childhood Care, Education and Development (ECCED) under the Education for All was incorporated in the NPA. The ECCED activities aimed at nurturing the children of 4-5 years for their physical and mental development and preparing them for schooling. The program included advocacy on ECCD needs and benefits, educating parents on physical and nutritional requirements of children, equipping formal baby classes (pre-primary) and developing pre-school learning and practices. However, the program did not focus on the development of children below 4 years old. Another feature of this programme is that it is centre based and not family based. This is one of the shortcomings of the programme as it is well known that the family plays a critical role for the development of child in the early years.

Although the ECCED (Early Childhood Care and Education Development) of the GOB does not contain specific targets for enrollment of children of 4- 5 years of age or less in pre-primary education there is a growing trend in urban and middle-class of sending children of 3-6 years to schools that have playgroup/nursery sections. The database for the number of children going to pre-school in Bangladesh is very poor, but a 1995 review[10] of available information gives some indication of the situation in Bangladesh. The review noted that a survey of 377 schools in district towns found that in most (83.5%) a baby class for younger children exists in disguise within class I. In 1990 there were 1515 pre-primary schools with 9203 teachers and 223,296 pupils, and around 3000 Kindergarten schools in urban areas offer nursery education to about the same number of children as do the pre-primary schools. A survey carried out by CAMPE of 157 NGOs revealed 35 of them offered pre-primary education. The average class size was 33. The total enrollment in these NFE pre-primary programs was 38,000. About 55% of the students are female and 45% male.

The quality of services in pre-primary schools and centres varies greatly. In the schools which serve a middle-class clientele there is a tendency to promote academic learning of a type which is not consistent with the developmental needs of the age group. An expansion of this type of provision would not be advantageous for young children.

10 M., Ahmed, Recent Developments in the Education Section of Bangladesh?s Experiences with Economic Refosrm, Centre for Policy Dialogue/University Press Limited 1995.

5.2.2 6-10 years – Balyakal

Most of the Education for All (EFA) indicators are relevant to the 6-10 years age group, and a review of the progress Bangladesh has made in meeting the EFA goals is essential for assessing the current situation of the age group. Some of the key indicators are presented below, followed by other issues of vital importance for the development of children both in and outside of primary school. The tables are based on official data, prepared for the EFA 2000 Assessment Preliminary Report of May 1999. The Government is currently checking and validating the data for the final report. The information should be seen as indicative and is supplemented, where possible, with other sources.

5.2.2.1 Gross Enrolment Ratio

Table 5.3: Level And Trend In Gross Enrolment Ratio (%) in Primary Level by Sex

(Figure in '000')

Year	Primary Age Group Population			Gross Enrollment (Grade I-V)			Gross Enrollment Ratio (%)		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
1991	8710	8310	17020	7072	5797	12869	81.19	69.76	75.61
1992	8879	8471	17350	7048	5969	13017	79.38	70.46	75.02
1993	9016	8629	17645	7526	6541	14067	83.47	75.80	79.72
1994	9152	8760	17912	8048	7133	15181	87.93	81.43	84.75
1995	9343	8912	18255	9094	8190	17284	97.33	91.90	94.68
1996	9502	9062	18564	9219	8361	17580	97.02	92.26	94.70
1997	9655	9208	18863	9365	8667	18032	97.00	94.11	95.58

Source: PMED, EFA 2000 Assessment Preliminary Report, May, 1999

The gross enrolment rate at the primary level for both sexes increased from 76 percent in 1991 to 96 percent in 1997, indicating a 20 percent point increase over the period. The enrolment by sex indicates a narrow gap between the male and female group. There were 0.8 female student per male student in 1991, while it was 0.9 female student per male student in 1997. Impressive progress has been made in achieving gender parity in enrolment. There has been a 32 percent increase in male enrolment between 1991 and 1997 compared to a rise of 50 percent for girls during the same period.

However a further analysis of gender issues reveals that full equality has not been reached in primary schools. Girls are not given equal treatment in the schools or at home. They are often expected to care for younger brothers and sisters as well as to take household responsibilities. This generally results in lower scores[11] for girls on achievement tests and is later reflected in lower pass rates from secondary education and lower numbers of girls as students progress through the education system.

The increase in gross enrolment rates has been the result of a number of initiatives. Although the majority of children attend Government schools, there are a variety of alternatives and many different types of schools.

11 CAMPE, Hopes not Complacence, UPL 1999

Definitions of what constitutes primary education vary, but at least 1.5 million children are enrolled in nonformal education programmes run by NGOs. According to sample surveys, approximately 8% of the primary age group are enrolled in nonformal education centres.[12] NGOs tend to focus particularly on children from poor families. Most do not offer the full primary education but encourage their graduates to enrol in formal schools after about 3 years of instruction. In recent years however a number of NGOs have introduced a full programme of 5 years primary education. Currently there is no national system for recognizing the learning that takes place outside the formal school system, and no attempt has been made to establish standards for equivalency so that children from the nonformal sector can be mainstreamed at the appropriate level in the formal system.

5.2.2.2 Net Enrolment Ratio

Table 5.4: Level And Trend In Net Enrolment Ratio (%) In Primary Level By Sex

(Figure in '000')

Year	Sex	Primary Age Group Population (6-10 Years)	Gross Enrollment	Under Aged and Over Aged Enrollment	Net Enrollment	Net Enrollment Ratio
1991	Total	17020	12869	2575	10294	60.48
	Girls	8310	5797	1160	4637	55.80
1995	Total	18225	17284	3456	13828	75.75
	Girls	8912	8190	1639	6551	73.51
1997	Total	18863	18031	2563	15468	82.00
	Girls	9208	8666	1735	693	75.27

Source: PMED, EFA 2000 Assessment Preliminary Report, May, 1999.

There is a large gap between gross and net enrolment ratio at primary school level education. This indicates that a large number of under and over aged children are enrolled and that a number of children of the age group remain outside of school. Total net enrolment increased from 60 percent in 1991 to 82 percent in 1997, while for females it increased from 55 percent to 75 percent over the same period. There are some variations in net enrolment ratio between males and females. The overall enrolment rates only reveal part of the situation. Enrolment rates vary according to economic status. Only about 40% of the children of the very poor are enrolled in primary school. While enrolment is generally higher in urban than in rural areas, in urban slums it is 20% below the national average. About 10% of children never enroll in school at all. [13]

Besides the official data from Government sources, other surveys show a similar net enrolment rate. A sample household survey conducted in October – November 1998 under the auspices of Campaign for Popular Education (CAMPE) found a net enrolment ratio of 77% nationally with girls' enrolment (78.6%) slightly higher than that of boys (75.5%).[14]

12 Progotir Pathey, 1998

13 World Bank Education Sector Review, June 1999 (draft)

14 CAMPE, Hopes not Complacence, UPL 1999.

5.2.2.3 Retention Rate to Grade 5

Table 5.5: Level and Trend in Retention Rate to Grade 5

Year	Survival Rate (%)
1991	45.9
1992	58.3
1993	64.0
1994	67.3

Source: PMED, EFA 2000 Assessment Preliminary Report, May, 1999

Retention rate indicates the percentage of pupils who enrolled in grade I of primary education in a given school year and who eventually reach grade 5. This rate in Bangladesh is very low which is mainly due to high repetition and dropout rates. Retention rate was only 46 percent in 1991 but increased to 67 percent in 1994, showing a 21 percent point increase over the period. This is encouraging but reflects the need for continued efforts to ensure that each child completes the primary cycle.

5.2.2.4 Coefficient of Efficiency

Table 5.6: Level And Trend In Coefficient Of Efficiency

Year	Years Input Per Graduate	Coefficiency of efficiency in primary cycle (%)
1991	8.9	55.9
1992	7.4	67.3
1993	7.2	69.4
1994	7.1	70.0

Source: PMED, EFA 2000 Assessment Preliminary Report, May, 1999, and BANBEIS

Coefficient of efficiency measures the ideal number of pupil years needed for a pupil cohort to complete the primary cycle as the percentage of the actual number of pupil years. Coefficient of efficiency in Bangladesh is observed to be low. It was estimated at 56 percent in 1991 and 70 percent in 1994. Although the estimated figures show improvement between 1991 and 1994, these are far below the expected figures. The low retention rate and coefficient of efficiency figures indicate the inefficiency of the education system.

The number of years input required to produce a primary school graduate decreased from 8.9 in 1991 to 7.1 in 1994. No official statistics are available after 1994. The CAMPE survey conducted in 1998 found that the majority of pupils complete the primary cycle, but they take on average 6.6 years to complete the 5 year cycle, with girls taking slightly less time than boys to complete primary school on average.[15]

15 CAMPE, Hopes not Complacence, UPL 1999.

5.2.2.5 Pupil – Teacher Ratio

Table 5.7: Level and Trend in Pupil - Teacher Ratio

Year	No of Teacher	No of Pupil	Teacher-pupil ratio	Source/Remarks
1990	206470	12635419	1:61	BANBEIS and DPE
1995	319097	17133186	1:54	
1996	324803	17580416	1:54	
1997	316483	18031673	1.57	

Source: PMED, EFA 2000 Assessment Preliminary Report, May, 1999

The pupil – teacher ratio is one of the indicators in assessing the quality of schooling. This ratio has improved to some extent from one teacher for 61 pupils in 1990 to 54 pupils per teacher in 1996. But it increased again to 57 pupils per teacher during 1997. This is an indication that the Government's ability to supply teachers has not kept pace with the growth of the primary pupil population.

Because of the insufficient number of teachers as well as limited space, most primary schools in Bangladesh operate on a shift (staggered) system. Children in Grades 1 and 2 attend for two and half hours in the morning and students of Grades 3 – 5 attend in the afternoon for four hours. Although this has the effect of reducing the actual pupil – teacher ratio, it also means that primary pupils in Bangladesh have one of the lowest number of official hours in the world, for grades one and two less than 600 hours. This compares to 1,100 hours in Indonesia and 1,235 in China.[16] This has major implications on the amount that can be achieved by children in the limited time they have in school.

Having to cope with large classes and two shifts of teaching each day with little support from the system or the community, teachers tend to be poorly motivated. Besides teaching they have a number of administrative duties. There are few opportunities for professional development and advancement and few incentives to take initiative or to improve performance. The result is often poor teaching methodology and a minimum of time given to actual teaching-learning activities, which may be as low as 40 minutes per day.[17]

16 World Bank, Education Sector Study, June 1999 (draft)

17 AHM Karim, Review of *School Based Primary Education in Bangladesh, UNICEF, 1992*

5.2.2.6 Primary Education Expenditure Per Pupil as Percentage of GDP per Capita

Table 5.8: Level And Trend In Primary Education Expenditure Per Pupil as Percentage of Gross Domestic Product (GDP) per Capita

(Figure in million)

Year	Public current Expenditure in Primary Education	Total Enrollment in Primary Education	Gross Domestic Product (GDP)	Total Population	Public Current Expenditure on Primary Education per Pupil as % of GDP per Capita
1990	-	12.05	737570	-	-
1991	7324.10	12.64	834390	111.45	7.74
1992	10149.80	13.02	906500	113.50	9.76
1993	11579.40	14.07	948070	115.63	10.04
1994	14764.70	15.18	1030360	117.72	11.11
1995	17237.50	17.13	1170260	119.82	10.30
1996	17399.50	17.58	1301600	122.10	9.28
1997	18041.10	18.04	1403050	124.03	8.84
1998	18194.50	18.50	1540930	136.14	8.05

Source: PMED, EFA 2000 Assessment Preliminary Report, May, 1999

There is an increasing trend in primary education expenditure per pupil per GDP capita from the years 1991 to 1994. But a decreasing trend can be observed afterwards. Per pupil expenditure as percentage of per capita GDP was highest (11.11%) during 1994.

5.2.2.7 Primary Education Expenditure as Percentage of Total Public Education Expenditure

Table 5.9: Level And Trend In Primary Education Expenditure as a Percentage of Total Public Education Expenditure

(Taka in million)

Year	Public Current Expenditure on Primary Education	Public Current Expenditure on Education as a Whole	Expenditure on Primary Education as a Percentage of Education as a Sector
1991	7324.10	14944.20	49.01
	10149.80	19088.50	53.17
1993	11579.40	22674.30	51.06
1994	14764.70	27608.40	53.48
1995	17237.50	35262.60	48.88
1996	17399.50	35226.20	49.39
1997	18041.10	38473.20	46.89
1998	18194.50	41787.80	43.58
1999	20168.50	46338.90	43.52

Source: PMED, EFA 2000 Assessment Preliminary Report, May, 1999

The percentage of expenditure in education sector as a share of all sectors is very low in Bangladesh compared to the developed and many developing countries. This percentage was highest (16.44%) during the period 1991/95. But within the education sector the primary education sub-sector receives almost fifty percent share. The percentage share in primary education within education sector was highest (53.48%) during 1993/94.

5.2.2.8 Learning Achievement

No nationally recognized and comprehensive data is available on learning achievement of children attending and graduating from primary schools in Bangladesh. Over the years however a number of Assessment of Basic Competencies (ABC) studies have been undertaken. These assessments have shown a low percentage of children achieving even quite basic learning competencies. The UNICEF study in 1992 found that only 46% of children with 5 years schooling satisfied the criteria of basic education.[18] In the CAMPE survey conducted in 1998 a higher percentage of Grade 5 completers (57%) achieved the basic education criteria,[19] but this is still very low.

5.2.2.9 Attendance Rates

One of the reasons for low achievement levels may be the poor attendance rates. Classrooms are crowded and often uninviting. Many children do not appear motivated to attend such schools. Particularly at certain times of year (e.g. harvest times and rainy season) attendance can be very low. The CAMPE survey recorded an attendance rate of only 59% of the enrolled students on the day of visit to schools.[20] Girls' attendance was slightly higher (60.5%) compared to boys (57.6%). An interesting finding of the study was that on average schools have sufficient seating to accommodate only 66% of the enrolled students.

5.2.2.10 Children outside of school

Approximately 10% of children never enroll in school, and according to official statistics about 38% of children drop out before completing the primary cycle. Added to this is low attendance rates. This means that a large number of children (approximately 20%) are not enrolled in school, and a number of those enrolled do not attend regularly. Particularly vulnerable groups are the very poor, children in urban slums and children in rural communities where schools are not easily accessible. Many of the children are already involved in income-related work and their families may be dependent upon their earnings for survival. NGO run nonformal education centres as well as satellite schools partially address the access problems, but from the statistics it is clear that more needs to be done to ensure the fulfillment of every child's right to primary education.

Besides the number of children not attending school, all children spend the majority of their time outside school. In urban areas, particularly in the urban slums, the physical facilities are very limited for play and recreation. There are very few opportunities for organized out-of-school activities. Traditional cultural values often restrict the movement of girls, and in urban areas it may be unsafe for children to play freely outdoors. As noted for the pre-school age group, many common cultural values reinforce the child's feeling of security, but there is little awareness on the part of caregivers of the importance of stimulation and creative play for overall child development.

18 UNICEF, Assessment of Basic Competencies of Children in Bangladesh, 1992

19 CAMPE, Hopes Not Complacence, UPL 1999

20 Ibid

5.2.2.11 Children with special educational needs

The data on the total population in Bangladesh having special educational needs is nonexistent. In most surveys such children are simply listed as being incapable of taking part in school. The provision for children with special educational needs in comparison with the overall numbers expected in a normal population is very limited. Taking into account 64 integrated programmes for the Visually Impaired run by the Depart of Social Services and the few special schools for the Visually Impaired, less than 600 Visually Impaired school age children are receiving full time formal education, a tiny proportion of what must the overall total.[21] At a workshop organized by the Department of Social Services and UNESCO in May – June 1998, the Director of the Department of Social Services supplied the following information about the education of children with other special needs:

- 1 government school, 45 NGO run schools and 21 units in regular schools for children with learning difficulties;
- 63 schools with 2,564 students run by the Society for the Welfare of the Intellectually Disabled;
- A distance-training package developed by the Bangladesh Protibondhi Foundation from which 3,000 children with learning difficulties have benefited; and
- 7 special schools run by the government, 23 schools run by NGOs and 2 units for Hearing-Impaired children with approximately 1,300 Hearing-Impaired children being educated.

All these figures are tentative but clearly indicate the paucity of provision compared to the tremendous need that must exist in Bangladesh. A few NGOs have started to teach children with special needs in some of their nonformal learning centres. But it is safe to say that only a tiny proportion of children with special needs receive any sort of education.

5.2.3. 11-18 years - Koishor

5.2.3.1 Labour Force Participation

As relatively few adolescents are enrolled in secondary school in Bangladesh, participation rates of early and late adolescents in the labour force is pronounced. A 1991 study placed this then at 20.3 percent of 10 to 14 years and 66.8 per cent at 15 to 19 years of age. The ratio of working boys to girls was found to be 3:2 and boys are more likely than girls to be working outside the home. Twelve percent of the child labour force were aged between 5 and 9 years, the remaining 88% between 10 and 19 years. The participation rate in the age group 10-14 was a striking 34%. In the Labour Force Survey of 1995-96, 28% of girls between 10-14 years old and 48% of adolescent girls aged 15-19 years are economically active. On the whole, 36% of adolescent girls are in the labour force whereas for boys of the same age group it is 52% . Child labour is more prevalent in the rural areas: in the countryside it reached 37%, as compared to 26 % in urban areas.

Subsequently, other studies have revealed indicative data that show that more than 6.3 million youngsters under 14 years, work in Bangladesh. Participation rates in the labour force for this age cohorts are among the highest in Bangladesh.

5.2.3.2 Extent of child labour

The best data currently available are those contained in the 1995-1996 national 'Sample Survey of Child Labour in Bangladesh' (CLS), the first comprehensive national household study in this area, as given below:

21 Indicative information supplied by Helen Keller International, Dhaka

Table 5.10: Proportion of children 5-14 years in child labour force by sex

Female %	Male %	Both sexes %	
Urban	13.8	16.5	15.2
Rural	16.7	23.4	20.2
Bangladesh	16.0	21.9	19.1 (6.6 million)

The type of work children are engaged in primarily depends on where they live. Nationally, 66% of children were found to be working in agriculture and 34% in other sectors. In rural areas, children are engaged in about 90 different occupations, and many are found working alongside their families in agriculture.

Urban children engage in a wide range of occupations, including domestic service, selling various goods and services, waste collectors, workers in small informal factories, workers in the formal sector, and other occupations. In total, 301 occupations engaging young children in urban areas were identified by a BBS rapid assessment survey. Of the 301 occupations, 27 could be classified as being hazardous.

According to CLS, only 36% of working children receive any pay. The unpaid workers, 58% of boys and 71% of girls, are mainly family helpers and apprentices in farms and factories. The salaries are low and variable for those children who receive it in cash, an outcome of their weaker bargaining position. The average income in 1995-1996 was Taka 478 per month, or Taka 16 per day. Domestic servants usually earn less than the average, if they are paid at all. Nearly 70% of child labourers mentioned their parent's financial problems as reason for working.

These children are unable to access learning opportunities whether it is education or skill development. Eighty-nine percent of working children surveyed in the CLS was found to have no education, with only 9% being educated up to class 5. It can be argued that the major social cost of child labour is the loss of opportunity of spending time in school. A vast majority of the children surveyed asserted that, given the opportunity, they would attend school. However, they are unable to pay for school related expenses such as tuition, schoolbooks, and other school supplies.

They also have low levels of knowledge relating to their rights and a lack of any access to protection services: health care, legal aid, social and emotional support The main hazard however is the interruption of schooling, and lack of opportunities for recreation, thereby hampering socialization, mental and physical development. Domestic child workers are often subject to physical punishment or other forms of abuse including sexual abuse by their employers. A recent opinion survey of the employers in Dhaka and Chittagong city, undertaken by UNICEF, showed that a domestic worker is engaged in work for 16 hours per day. There are estimated to be more than 200,000 female child domestic workers in Dhaka city alone. A survey of 10,000 households undertaken in Dhaka city by Shoishob, showed 90% of the girls were between 9-16 years old and half of them were completely illiterate.

5.2.3.3 Children in the formal education system

The role of education and educational institutions is important in child development for this age group. The drop out rate increases sharply at the high school level because of poverty, low value of education, gender disparity in investing resources and early marriage in the case the female children. The quality of the education also falls because the school curricula are inadequate, financial resources are limited, the number of trained teachers is insufficient. School enrolment rates decline noticeably from primary to secondary levels in Bangladesh. The size of the secondary system is relatively small. Since independence in the early 70's the Government has given priority to primary education and has therefore decided not to increase the number of government owned secondary

schools. Consequently, while there are almost 20 million children in the 5 primary classes, there are only seven million students attending the 5 year secondary cycle. Only 38% of the corresponding 11-15 age cohort are enrolled in secondary education. Non-government secondary schools enroll about 95% of all secondary schools students. Secondary education is provided in 317 government schools, in about 11,700 non-government schools, and in 4,121 Madrasahs.[22] Non-government schools are owned and managed by school management committees and are partially subsidised by the government.

In 1998, of the 7 million students attending secondary schools 3.5 million (50%) were girls.[23] As mentioned in the World Bank draft Education Sector Review, higher female enrolment may be a consequence of the female stipend programs. It is possible that middle income females are being subsidised while very poor boys are not attending schools due to high cost to their parents. Socio-economic status is a significant determinant of enrolment: 73% of 'non-poor' girls compared to 52% of 'poor' girls were in school. The 1996 Household Expenditure survey (HES) data show that children who complete secondary school come from households with higher than average incomes. This was found to be true for all levels of secondary education. Higher level of education of the father results in a significant increase in the probability that the child completes school. For each unit increase in father's education, the probability of completing lower secondary by a male student rises by 2.5% for females it rises by 4.4%. Electricity is a good proxy for wealth. For households who have access to electricity, the probability of completion of lower secondary for a male student is 11% higher than the probability for households who do not have access to electricity; and for females, it is 33% higher. Although secondary education for girls is in theory free due to the stipend program, the household data show that the probability of female completion rates depends on the household's level of economic well being.[24]

School enrolment rate falls drastically from primary to secondary level. In 1995, about 78% of pupils completing class 5 made the transition to class 6. According to the BANBEIS statistics in 1994, the dropout figure for class 6-10 was 44% (and 49% for girls). The drop out rate for class 11-12 was 38% (36% for girls). Attendance statistics are not readily available, but it is estimated that students are in school less than 120 days per school year. Average in developing countries is 180 school days in a year.[25]

Table 5.11: Percentage of Drop-Outs in High Schools

Grade	1994			1995			1996		
	Boys	Girls	Average	Boys	Girls	Average	Boys	Girls	Average
VI	6.81	5.0	6.50	7.88	4.24	6.29	6.37	3.80	5.23
VII	6.41	5.87	6.19	6.60	5.18	6.01	7.17	4.83	6.24
VII	7.58	6.89	7.85	6.70	4.91	5.90	7.17	6.49	6.86
IX	8.15	7.35	7.85	8.12	6.81	7.62	8.31	7.64	8.01
X	6.22	7.78	6.37	9.51	8.88	9.28	9.87	9.14	9.58

Source: Study of the Impact of Stipend Program. Ministry of Education: August 1998

The Secondary Education Development Project (SEDP) carried out a survey in 320 selected projects (167 co-

22 BBS, 1997 Statistical Yearbook of Bangladesh

23 World Bank, Education Sector Review, June 1999 (Draft)

24 World Bank, Education Sector Review, June 1999.(draft)

25 Ibid

educational high schools were surveyed) to evaluate the situation of secondary education. The survey results show that the averages drop-out rate in grade VII, IX, X has risen. The survey findings also revealed that the majority of heads of the schools surveyed identified financial constraints as the main factor behind dropping out. Bad communication system, lack of awareness about the value of education in the family was identified as the second and third factor. Marriage and growing fundamentalism were identified as important factors behind adolescent girls dropping out of school. The survey results also showed that many schools lacked physical facilities, i.e. library, laboratory etc. Among the 320 schools surveyed two thirds had separate toilet facilities for boys and girls and 260 schools had tube wells.

5.2.3.4 Children in Nonformal Education systems

Table 5.12: DNFE Programmes with Adolescent Beneficiaries

NFE Project	Age Group	Location	Target Population (million)	Main Activities (concerning adolescents)
1	15-24 years	Rural (32 districts)	2.95	Provision and expansion of NFE
2	11-45 years	Rural (31 districts)	8.179	a)Provision and expansion of NFE b)Development of effective post-literacy programme encompassing communication, empowerment, survival and functional skills (esp. employment-related)
3	8-14 years	Urban (6 divisional cities)	0.351	Imparting NFE to 'hard-to-reach' urban adolescents engaged in hazardous work i.e. ' learning with earning'
4	11-45 years	Rural (62 districts)	22.88	a)Motivating out-of-school adolescents b) Imparting NFE

Source: DNFE. 1999, Non-formal Education in Bangladesh

The Directorate of Nonformal Education (DNFE) currently has four NFE projects, each of which includes adolescents within its target group, although the Government treats beneficiaries between the ages of 11-14 years as adolescents and those aged 15 years and over as adults. The NFE programmes have a built-in requirement that at least half the literacy centres will be for female learners only. In practice, females make up around 60 per cent of all learners. NFE 3 project of DNFE runs basic education program for hard to reach urban working children between 8-14 years of age, in the slums. The course duration is for 2 years. It aims to cover 351,000children in six divisional cities. The NGO partners in this program use the CBA (center based approach). A CAMPE survey shows that 108 out of 410 NGOs offer NFEP program to the adolescents. The average size of a center is 29. About 347,000 adolescents are enrolled of which 65% are female. However, the quality of many of these programs can be questioned. The curriculum materials and delivery need improvement. The monitoring of DNFE programmes needs further strengthening. The training of the teachers also needs improvement in some of the projects. However, there are schools like BRAC's Basic Education for Older Children (BEOC) for 11-14 years age group, which maintain a ratio of 65-70 girls to 30-35 boys and which have an average drop out rate of 15%. The Centre for Mass Education in Science (CMES) also has an innovative programme for adolescent girls. It addresses a total of 3,150 girls aged 11-19 years, through life-oriented non-formal education and income generating activities. Girls are supported to take up activities in non-stereotypical areas involving technology, carpentry, etc.

5.2.3.5 Technical and Vocational Training

Out of the three types of skill training - formal , non-formal and informal - which exist in the country, informal training is the main avenue for skill acquisition in Bangladesh. It includes both enterprise-based training and traditional "apprenticeships" in small shops and garages.

Formal technical and vocational training is provided within the school system at the certificate level (class 8+2 years), diploma level (SSC+3 years), and degree level (HSC+4 years).

The system of technical and vocational education and training is small in Bangladesh, enrolling about 3% or less of the comparable enrolments in secondary and upper secondary general education. The government plans a major expansion in provision of facilities so as to increase coverage from about 3% of enrolments at present to 20% at the secondary level.

The formal and non-formal technical and vocational training is not well linked with the job market, consequently, the skills trainees acquire are not much in demand in the market. Also, these technical and vocational training are mostly geared to in-school male youth in grades 9-10 as part of Secondary School Certificate (Vocational). Underprivileged adolescents outside the school system, mainly females, do not have access to acquire the skills - which will help them raise incomes in the informal sector - through the formal and non-formal technical and vocational education and training system. Just 15% females are enrolled in vocational training institutes out of 57,000 students and 7% females in technical training institutes out of 61,000 students.[26] A handful of NGOs like Underpriviledged Children's Education Programme (UCEP) and the Centre for Mass Education and Science (CMES) have established systems to provide vocational and technical training to underprivileged adolescents through their technical training institutes and para trade centres. These NGOs also help in job placement for the young trainees. However, many of the skills are geared toward self-employment.

5.2.3.6 Recreation

Recreation facilities are few for adolescents, especially girls. Social norms and taboos, fear and security consideration narrow the young females' access to outdoor recreation facilities. Moreover, at home she may be burdened with domestic chores. Many of the young female children are married off and are expected to carry out responsibilities at their new home. Rapid urbanization has led to the shrinking of physical facilities available to the adolescent in the urban areas. As for the working children many work long hours and their need for recreation may remain unrecognized (especially for those who work as domestic help). A 1996 study, on hazardous child labour found that 62% of the sample of child workers in urban areas worked 8 or more hours each day, and 38% for more than 10 hours. They often worked overtime on holidays. The government and its related ministries have failed to provide proper recreational programs or important life skill development programs that would help the healthy and productive development of adolescents. Moreover, the community, family and service providers are not aware about the needs of adolescent children for recreation, for expressing their views and participating in matters that affect their lives. The adolescents are expected to act as adults by the family and the community on some matters, like work, responsibilities toward parents/family - their capacity to undertake such adult responsibilities is over estimated. While on other matters - like, what they want to study in future, what work they prefer to do, if they want to get married, how they wish to plan their future, etc. - where children of this age group are all full of ideas and eager to share their views - their potentials are under-estimated and they are treated as young children. Neither the family/community nor the schools address the confusions and concerns which arise in these young minds. Institutions do not have provision for family life education and sex education, and families do not have the time or awareness to listen to their adolescents and provide them emotional support.

26 BANBEIS 1997, UGC 1996

Table 5.13: Participation of Boys and Girls in Extracurricular Activities Held at the Thana Level (High Schools)

Activities	Between 1993 and 1994			Between 1994 and 1997		
Increased	Decreased	No change	Increased	Decreased	No change	
Debating	51 (33.55)	9 (5.92)	92 (60.53)	66 (43.42)	9 (5.92)	77 (50.66)
Cultural functions	68 (44.74)	10 (6.58)	74 (48.42)	82 (53.95)	14 (9.21)	56 (36.84)
Sports and games	79 (51.97)	17 (11.18)	56 (36.84)	107 (70.39)	12 (7.89)	33 31.71)
Religious functions	50 (32.89)	8 (5.26)	94 (61.84)	62 (40.79)	1 (0.66)	89 (58.55)
Annual drama	13 (8.55)	9 (5.92)	130 (85.55)	23 (15.13)	7 (4.61)	122 (80.26)
Science fair	14 (9.21)	12 (7.89)	126 (80.89)	19 (12.50)	7 (4.61)	126 (82.89)

SEDP surveyed 167 high schools. The survey findings reveal the poor state of co-curricular activities in general and non-science orientation as a whole. In the case of girls high school the participation increased in cultural function and religious activities.

5.3 MANIFESTATIONS OF MAJOR PROBLEMS AND GROUPS AFFECTED

5.3.1 Prenatal to 5 years – Shoishab

Based on available research, survey reports, and other sources, the major problems manifested among this age group can be categorized as follows:

- Insufficient care and support for the development of the young child, contributing to reduction in the physical, mental/cognitive and spiritual development of the child, both actual and potential. Some of the indicators related to this are:
  - Values and attitudes overloading mothers with work and preventing mothers from getting sufficient rest and nutrition during pregnancy and providing sufficient care to the young child;
  - High levels of stunting (sub-optimal growth) among children in Bangladesh;
  - Decreasing amounts of time spent on child care by caregivers as the child grows older; and
  - Low levels of awareness, knowledge, and value accorded to child development
  - Needs and rights by most all duty-bearers.

- A major persistent problem is that there is insufficient allocation of resources and priority accorded to child development and care, which decreases the realization of the full potential of children. Some indicators of this include:
  - Lack of clear policy and strategy guidelines, set by policy makers and carried out by service providers;
  - Insufficient facilities, technical expertise and support for promoting and ensuring appropriate early childhood care and development at the community and family levels;
  - Insufficient support and alternative care for ensuring the optimal development of children of working mothers, children in need of special protection measures, and other vulnerable groups—for example there are virtually no crèches or day care centres at workplaces, and very few mechanisms of support, institutional or otherwise, that ensure adequate care for children with disabilities, or those who have been abandoned or separated.
- Insufficient equity in care provided to girls and boys, as shown in trends and study cited above, whereby girls are disciplined more often, constrained socially and in recreational activities.
- Insufficient access to facilities and initiatives providing support, technical resources and knowledge promoting early childhood care and development.

Case Study

Supporting Caregiver's Strength

The ECD unit in Nasirnagar run by SCF (USA) has managed to impart with important child development information and practices through care giving sessions with the local women's saving group members. The learning sessions use various active participatory methods and experimental methods. The focus is on child rights and overall development which includes health, nutrition, cognitive development (importance of play, talking, making toys from junk), negative impact of physical punishment, and gender equity. The feedback from the participants has been very positive.

Shova Rani said that she had learnt good ways to manage her children and she has become more conscious in expressing her love and affection. She is also aware about the negative impacts of physical punishment and does not beat her children anymore. Rahela a mother of three makes toys for her children from junk. She said that playing is good for "increasing intelligence of the children." She also noted that her children were busy with the toys and were less pushy.

Many asked for special care giving sessions for the male members of their family and for pictorial guidebooks to record what they have learnt. Kanon said that she shared what she learned with her husband who has become more caring towards the children and makes toys for them. She feels that the ECD needs to reach out to the other mother in the neighbourhood. She thinks the mothers would be eager to learn. Kanon said that one mother told her "Children are the most precious resource we have –what else is more important than learn how to rear them?"

Case Study

Motajee Government Primary School is not typical of rural schools in Bangladesh, but it is an example of what is possible when communities become involved to work with teachers to ensure the best for their children. The school is located in Mymensingh District and is considered one of the best schools in the area for its extraordinary performance towards quality education for the children in the area. The involvement of the teachers, community and students in the school is the key behind its success. Even though the pupil-teacher ratio of 45:1 may be considered high by international standards, for Bangladesh it is relatively low.

The tidiness and cleanliness of the school with catch the attention of nay visitor upon first sight. Even though the partitions between the classrooms are just bamboo, the school yard, classrooms and toilets are clean and tidy. There are two small flower gardens in two corners of the school area. The two large classrooms are divided with partitions to make four classrooms and the walls are brightly painted, something which the children appreciate. From one look at the school, the students' and teachers' care for and pride in their school can be seen.

The teachers use various creative methods and active learning is encouraged. Project writing, out door school activities are undertaken to make learning a joyful experience and nurture creativity.

Community involvement is high in this school. The members of the School Management Committee are actively involved in organizing and mobilizing resources for picnics, study tours, cultural programs and other events. Teachers and the community organize annual debate competitions, cultural programmes on national holidays and on birth/death anniversaries of renowned persons so that the students can spontaneously participate and explore their talents.

5.3.2 6-10 years - Balyakal

During the decade of the '90s the number of children enrolling in primary school greatly increased as the Government put a very strong emphasis on expansion of the system. However during this time little emphasis was given to what was actually taking place in the schools. The quality of learning was not a major consideration. In child development terms, only part of the goal was being fulfilled. Children from families who had not previously sent their children to school now have the opportunity to attend, and many of them take advantage of it. However, in many cases the school experience is not conducive to the child's full development.

The major problems in primary education include:

- Almost one fifth of children of primary school age (nearly 4 million children) do not attend school.
- Attendance rates are low, averaging less than 60 percent.
- Approximately one third of those who enter primary education do not complete the five grades.
- Pupil–teacher ratio is high and the number of hours spent in school in meaningful teaching–learning activities is low.
- Due to the unfavourable conditions in schools, inadequate support and few incentives for professional development, teacher morale and motivation are low, and teachers tend to rely primarily on traditional didactic teaching methods which on their own do not promote effective learning.
- Inefficiency is high–huge resources are wasted–with most students taking more than six years to complete the primary cycle.
- Only about half those who complete five years of primary school achieve a minimum basic education criteria.

These problems all revolve around issues of access, equity and quality. Although the percentage of the age group has decreased during the past decade, there are still a number of children who never enroll in school, either because of distance of the school, because of their family's economic condition which makes the opportunity costs too high

or because of factors within the school which make it an unattractive option. Many children drop out each year for these same reasons. The poor are the most adversely affected. While generally enrolment is higher in urban than rural areas, in urban slums the enrolment rate is nearly 20% lower than the national average. These are issues of access and equity. The enrolment of girls is now almost equal to that of boys, but there are still many practices within the school which favour boys, and minimum facilities for girls (e.g. toilets) are still absent in many schools. Gender stereotypes and gender biased classroom communication are drawbacks faced by the female students. Low attendance, high drop-out rates and low achievement levels are all indicators of poor quality of the teaching and learning experiences in the classrooms. In Bangladesh teaching tends to be didactic with rote memorization one of the most common methods. Only a minority of teachers use approaches and methods which stimulate creative and critical thinking, which stretch the child developmentally and which are likely to contribute to the achievement of the child's full potential. Communities often see the school as the responsibility of outside agencies, but recent efforts both by Government and NGOs have shown that when communities become involved in schools the result is greater accountability and improved learning environments. The quality of the education becomes everyone's responsibility. For this to be achieved in Bangladesh, efforts are needed at the top to decentralize and at the field level to actively involve families and communities in the management of their schools.

5.3.3 11-18 years - Koishor

Overcrowded classrooms have a detrimental effect on the quality of teaching and learning achievements. Classrooms are small - for 40 students - but in many cases 60 students are somehow accommodated. In 1970, the teacher student ratio was 1:26. In 1997, it was 1:38, and class-student ratio rose from 18 to 56 in the same period.[27] Increases in enrolment have not had commensurate increases in the number of teachers or investment in infrastructure.

Many secondary school teachers are not motivated to teach well. There are few incentives to take initiative and few opportunities for professional development. The support and supervision system is weak. The teaching-learning process tends to be traditional and didactic, focusing on the memorization of information rather than on the development of analytical skills.

The level of knowledge relating to life skills, health and sexuality is very low among the adolescents. The knowledge on the need of children beyond formal and non-formal schooling is lacking. School, media and family/household, which should have been the main source of such information, are not aware of the needs and priority of the adolescent group. In addition, cultural norms do not value children/adolescents' views and opinions.

A growing metropolis like Dhaka is a magnet to the rural poor who flock to its promise only to settle in the burgeoning slums and take their chances in the low skills, low wage subsistence economy. Limited family income compels the children to take up hazardous jobs.

Within the context of these slums, many of which have yet to develop into communities, children and adolescents must negotiate the daily perils of life at the margins of a metropolis. In addition to exploitation at the hands of employers, many themselves marginal, the children and adolescent girls in particular have to circumscribe their lives, their movements lest they come to the attention of the anti-social elements whose spurious offers of marriage - no to be lightly spurned - bring terror to many girls and their helpless families. Many of these children are also victims of abandonment of their mothers by their fathers, small but growing problem of substance abuse, violence both social and personal. The irony is that while there is a demand for children's - under 14 years - labour the situation with respect to those 18 years and above is reversed and under and unemployment for this group is pronounced.

27 World Bank, Education Sector Review, June, 1999 (draft)

Case Study

Bahadur, aged 12 years, lives at Maskata Dhighi of Katakakhali under the district of Rajshahi. He is a tempo helper, working 10-12 hours daily and earning Tk. 20-25 everyday. He has been on this job for 2 years and gives all his earnings to his mother.

Bahadur, wakes up at 6:00 a.m. everyday. After washing himself he goes for his duty. After some trips he comes back home to have lunch and again goes back to his duty. He completes his duty at 9:00 p.m. He goes to sleep after having dinner. He watches television occasionally. He doesn't like his job. He said, ".... I feel dizzy and pain in the legs standing on the footboard of the auto and also fear. That 's why I shall switch over to some other available job as soon as possible."

He left government primary school after completing grade two. He said, "both the male and female teachers used to sleep sitting on the chair in the class. They didn't praise me on my good performance. Besides, I couldn't afford necessary study materials like notebook and pencil. That's why I left school." His father, who is a rickshawpuller, said, "I couldn't afford study expenses due to hardship. We are from lower strata of life. We couldn't render any of his desires into reality." His mother said, "we let our son go to school but couldn't afford any home tutor. As a result he couldn't prepare his home task properly. Teachers used to harass him for failing in his home works. Ultimately, he left the school." After leaving school Bahadur searched for jobs at various places like biscuit shops, clothing stores, etc., but he didn't get any job anywhere. "... At last I found a job at auto" (tempo). If he again gets admitted into any school, he wishes to complete secondary school certificate or even higher secondary. He thinks if he is educated he can get better job, visit unknown places, read signboards of various institutions and shops, magazines, newspapers and run business. He would like to play at school, after or before the class.

Regarding his education, Bahadur's father said, " I have no objection if he can do even HSC or Bachelor's degree without any expense. But I cannot afford his education."

Case Study

Mariam is 11 years old. She lives with her mother and siblings in Jatrabari, Dhaka ever since they came from Patuakhali, 3 years ago. She sells rice cakes (pitha) while her sister and mother work in a garment factory. She wakes up before dawn washes herself and goes to learn arabic. Coming back home she takes breakfast and cooks food. At 11:00 a.m. she goes to a non-formal school for two hours. The school is run by an NGO under the DNFE-UNICEF run Basic Education for Hard to Reach Urban Children (HTR) project. After lunch she starts selling rice cakes up to 8:00 p.m. or until her mother comes and takes over the charge. Mariam has a lot of interest for education. She got admitted in class one in a primary school in her village but had to leave soon due to work to meet the needs of the family. Coming to Dhaka, she got the chance of continuing with her education at BEHTRUC learning centre. Before joining school Mariam had the desire of writing and reading anything, doing something valuable in future after her education. She said, "I learnt writing my name and multiplication tables in the school and now I can use the multiplication tables in settling the accounts of my shop. I want to continue my education up to grade five, to learn English and to read the time on the watch." She wants to carry on both the education and the job. She said, "I cannot afford food if I don't work. And I will remain illiterate and unhappy if I don't get educated." Mariam does not get the chance of playing due to lack of time. She does the household works for the whole time and spends the rest of the day selling rice cakes and attending the HTR school. She works everyday even on the school holidays.

5.4 ANALYSIS OF CAUSATIVE FACTORS

Based on the review of key elements, assessment of trends and analysis of major manifestations of problems and the groups affected, key areas of concern and unrealized rights for each of the three age groups were selected as shown in the diagram below. Taking these statements as topics for further analysis, participatory workshops were held with technical advisers from within and outside the Government and UNICEF. Obstacles encountered in fulfilling the rights of children were identified, and an analysis was carried out of their causes and the levels at which they occur--immediate, underlying, or structural.

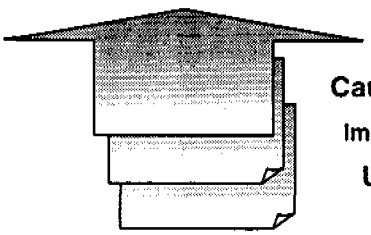
Overview of Accountability and Causality Analysis

Desired outcome: **Fulfillment of the full potential of the child by exercising rights and assuming responsibilities**

Optimal / development to the full potential in:-
Cognitive, mental and emotional development
Control over body, motor skills and coordination
Ability to interact successfully in social relationships
Ability to interact successfully with the physical environment

AREAS OF CONCERN / UNREALIZED RIGHTS

Prenatal– 5 years	6-10 years	11-18 years
Inadequate care of the young child	Inadequate access, equity and participation in quality education	Inadequate recognition of the needs, capacity and potential of the age group
	Lack of out-of-school opportunities for development of full potential	



Causes:
Immediate
Underlying

Following is a summary of obligations borne by key groups of duty bearers responsible for fulfilling the rights of children. These obligations were identified through review and analysis of the situation of children at various stages of childhood.

Table 5.14: Obligations of Duty Bearers towards Children of All Age Groups (Prenatal - 18)

Family	Community	Service Providers	Policy Makers
Common: ◆ Physical needs ◆ Love & affection ◆ mental/emotional/support ◆ stimulation ◆ equal care for boys and girls **For one or more groups:** ◆ Safe, secure environment ◆ Learning about child care & development ◆ Sending children to school ◆ Time for recreation ◆ Appropriate work & responsibilities ◆ Listening to children ◆ Involving children in decision making ◆ Protection from hazardous & exploitative work	**Common:** ◆ Healthy, safe, secure environment ◆ Recreation facilities ◆ Mobilization of resources ◆ Support to mothers/parents/ families/service providers **For one or more groups:** ◆ Child friendly community ◆ Promote traditional games/ toys ◆ Listening to children ◆ Participation in school affairs ◆ Involve children in decision making ◆ Information sharing ◆ Support for vulnerable groups	**Common:** ◆ Awareness/knowledge of child development & skills ◆ Community involvement ◆ Quality services (from young child care through adolescent programmes) **For one or more groups:** ◆ Child centred/child friendly services ◆ Mass media involvement for awareness & good practice ◆ Life skills ◆ Out-of-school activities ◆ Children's participation/ involvement ◆ Services to meet specific needs	**Common:** ◆ Relevant age group specific policies enactment and/or enforcement (e.g. on ECCD, child labour, compulsory education) ◆ Allocation of resources ◆ Communication - mass media ◆ Policies for safe environment ◆ Imparting a vision of child development ◆ Intersectoral linkages

For each age group the technical advisers identified a number of obstacles that constrains the duty bearers in fulfilling their obligations. These were analyzed and categorized as immediate, underlying and basic/structural based on the groups' perceptions of the complexity of the problem and the amount of time which would be required to alleviate it. The analysis was carried out for each of the three age groups. The following table is a summary of cross-cutting/common obstacles which spanned the age groups:

Table 5.15: Obstacles and Casuality Analysis For Children of All Age Groups (Prenatal - 18)

Family	Community	Service Providers	Policy Makers
IMMEDIATE			
◆ Lack of awareness/ knowledge/ information ◆ Lack of resources	◆ Lack of awareness/ knowledge/ information/ interest ◆ Inability to mobilize resources	◆ Lack of awareness/ information/ knowledge ◆ Lack of skills/ appropriate training ◆ Low motivation ◆ Lack of accountability ◆ Lack of resources	◆ Lack of awareness/ information/ interest ◆ Lack of motivation
UNDERLYING			
◆ Child development not valued or seen as relevant ◆ Parents' (mother's) time limitations	◆ Lack of participatory approach/attitude ◆ Child not seen as individual ◆ Lack of physical facilities (for urban: space)	◆ Lack of motivation ◆ No accountability ◆ Faulty view of child development ◆ Poor skills	◆ Lack of commitment to child development ◆ Lack of resources
STRUCTURAL			
◆ Poverty ◆ Illiteracy/lack of education ◆ traditional & social taboos	◆ Lack of resources ◆ Traditional & social taboos	◆ Inadequate resources ◆ Traditional & social taboos	◆ Lack of resources ◆ Traditional attitudes

The family is seen as the key unit for the fulfillment of the rights of the child, particularly in the early years. The community, service providers and policy makers also have obligations to ensure the full development of each child. By examining the various obstacles which constrain the duty bearers, interventions can be planned which will assist them to fulfill their responsibilities and thus ensure the that each child's right to development becomes a reality.

5.5 LESSONS LEARNED

A great variety of educational initiatives and projects have been undertaken in Bangladesh by Government, NGOs and civil society. Specific interventions in the first few years of life with a focus on child development needs and rights are quite recent and mainly limited in scope. The primary school age group has been the focus of much attention and many interventions, both formal and nonformal. There have been few initiatives for older age groups, but Government is increasingly recognizing the need for work with this group, and a number of programmes have been undertaken by NGOs.

The technical advisers from their knowledge and experience suggested a number of key principles to identify what does and does not seem to work in Bangladesh. From this analysis as well as a review of recent interventions, some of the key principles of "lessons learned" are summarized below. It should be noted that much of the experience to date is based on experimental and pilot projects, and many of the findings need to be validated on a larger scale. The following list of principles is indicative rather than conclusive:

- It is possible to increase awareness and knowledge of child care and development among caregivers.
- ECCD programmes can link successfully child care centres and primary schools.
- Innovative communication approaches increase interest and awareness in communities.
- National communication campaigns are effective but need support by longer, more intensive initiatives for behaviour change.
- Integrated approaches (e.g. linking child care education with credit groups) are most effective.
- Education must be relevant and of a high quality to attract and retain students and to enable the achievement of their full potential.
- Participatory, active teaching and learning methods can be implemented at all levels for all age groups in formal, nonformal and informal settings.
- For families, communities and service providers to exercise responsibility and accountability, decentralization of the education system is essential.
- Targeted programmes can make a difference (e.g. the secondary girls' stipend projects).
- For older adolescents education and literacy programmes need to be supplemented with life skills and vocational training.
- Culturally sensitive and age appropriate approaches to family life and sexuality can be developed.
- In urban areas, there is rapid social change which challenges many long held assumptions and requires innovative approaches.
- Children's participation, particularly involvement of youth in decision making, is inherent to a child's rights perspective and should be included in every stage of programme design.

5.6 STRATEGIC DIRECTIONS

Based on the rights of children, their needs and past experiences of educational development initiatives, the technical advisers identified some principles for choosing strategic directions in future programme planning. Based on this analysis as well as a review of various development initiatives, the following represents a summary of the strategic directions needed to fulfill the development rights of children in the future.

5.6.1 Common Vision and Understanding

- In order for everyone to meet their obligations to promote the fulfillment of development rights of children in Bangladesh, and for programmes to be planned effectively in a coordinated manner, there needs to be a "culture of rights" and a common vision and understanding of child development from a rights perspective. In strategic terms, this will help lead to:-
  - Common goals and objectives in the area of child development, and a common, framework whereby everyone has a role and an obligation to promote the fulfillment of children's development rights, from the prenatal to early adulthood periods;
  - Common indicators for monitoring progress and effectiveness of initiatives, approaches and support provided to child development; and

  - Broader partnerships among Government, development partners, families and children, leading to greater synergy and coordination.
- There is already a traditional, sociocultural prioritization of child care, especially for children at very early stages of childhood. It is thus likely and possible to develop programme strategies that build on these existing values.

5.6.2 Behaviour Development and Communication

- This is a key strategic area. This can have a direct impact on improving caring practices and the quality of care provided to children and their development. Multi-level, multi-media communication programmes can enhance or increase the following:-
  - Increase awareness and understanding of child development among caregivers at all levels, including parents, relatives, community-level service providers, communicators, the media, local governments and policymakers;
  - Motivate all concerned to provide the best care possible in the best interests of children, their rights and development;
  - Using children's development as a critical social indicator, monitor progress made as well as draw attention to areas that need support and urgent action.
- Research has also shown that this is an area where there are both significant gaps in knowledge about child development, among direct care providers as well as communicators and media, and thus an area where interventions are likely to have substantial impact;
- There are many positive communication and social mobilization initiatives that have already been developed in Bangladesh, and it is possible to build on them, both operationally as well as in content, by adding child development components where appropriate to ongoing initiatives.

5.6.3 Access, Equity and Quality

- For ensuring access to education by all children, learning opportunities must be available, attractive and affordable.
- There is the need for continued work on equity issues to enable full access and participation of all children in meaningful educational activities.
- For the development of the full potential of the child, both in- and out-of school interventions are required.
- The quality of services should be a major focus for both existing services as well as new initiatives, for reasons including:-
  - To enhance the motivation of teachers and ensure a more supportive, holistic learning environment;
  - To raise learning achievements;
  - To increase retention rates;
  - To maximize the development and learning potential of children; and
  - To ensure maximum effectiveness and efficiency of the system.
- Some areas of inequity have been identified, which, from a rights perspective, should be priorities for action, and, if addressed, are likely to have significant impact. These include:-
  - Disparities in time and care given to boys as opposed to girls;
  - Lack of support and good quality alternative care options for working mothers, especially in urban areas;
  - Need for strengthening the quality and reach of Early Childhood Care, Education and Development programmes, and to establish appropriate interventions to promote social and emotional development;

- Need to address the development and participation rights of children with disabilities;
- Need to provide learning opportunities for working children;
- Need to strengthen skills, capacity, motivation and understanding of child care providers, teachers and other service providers; and
- Need to provide support and address the particular development needs of adolescents, including in life skills, secondary education and vocational training.

5.6.4 Participation

- Working with broad coalitions, young people need to be actively involved to become aware of and to access their rights to development and growth. This strategic principle is also likely to increase appropriateness and sustainability of interventions, as young people will have a direct say in developing or tailoring interventions, and will take on greater responsibility in making them work.
- As the development of children at all ages depends so much on the care and interaction with those in direct contact with children, it is essential to involve care providers and all service providers, such as teachers, in all phases of initiatives seeking to promote the full development of children.

5.6.5 Research

- For areas such as early child care and development and programmes for adolescents, continuing research and experimentation are essential.

The common vision should be a "culture of rights," and the guiding principles are equity, access and quality in all child development programmes. In this way child development needs can be met and the rights of children fulfilled as Bangladesh enters the new millenium.

CHAPTER FIVE

CHAPTER SIX

Protection

6.1 KEY ELEMENTS OF PROTECTION

Rights to Protection' covers a large number of issues, pertaining to at least twenty-two separate Articles in the UN Convention on the Rights of the Child. While there are different ways in which these issues could be classified, the adopted clustering is based primarily on the commonality of actors both in the government and NGO sector who work in these areas in Bangladesh:

Protection from Violence, Abuse, Exploitation	Deprivation of family environment	Awareness regarding Child Rights	Right to Identity and Equity
Violence and sexual abuse (Art 16, 19, 34, 36)	Children deprived of liberty and juvenile justice (Art 3, 20, 37, 39, 40)	Awareness regarding child rights (Art 12, 13, 17, 42)	Identity and birth registration (Art 7 and 8)
Trafficking (Art 11, 35)	Street children (no specific reference in CRC)		Refugee children (Art 2, 22)
Child Labour (Art 32)	Children in Orphanages (Art 3, 5, 9, 18, 20)		Children belonging to indigenous groups (Art 2, 30)

Very little quantifiable information exists on each of these areas. Therefore to illustrate the situation of children requiring special protection, we have drawn on credible case studies and other published materials.

Available indicators and random surveys indicate an increase in violence, sexual abuse and exploitation, trafficking and rape (although this may, in part, be due to better reporting). Although both boys and girls are affected, girls are at greater risk of becoming victims of domestic violence, violence from the hands of law enforcement officials, violence in the society at large (including acid attacks), and trafficking. Society rarely views sexually abused and exploited girls as innocent victims, but rather more often as being somehow complicit in the act. They are therefore stigmatized.

Information collected from NGOs and newspaper reports indicate that the problem of cross border trafficking of children (mainly girls, but boys as well) is growing. Poverty is the most common reason for trafficking, but children taken across the border for employment, often end up in hazardous and exploitative occupations (for example prostitution), earning extremely low wages.

Many children in Bangladesh are forced to work under harsh and often dangerous conditions out of economic necessity. The situation of urban working children (especially domestic child workers) is generally worse than for children working in rural areas. The position of child garment workers improved following the signing of an unprecedented 'Memorandum of Understanding' between the Bangladesh Garment Manufacturer's and Exporters Association (BGMEA), ILO and UNICEF on 4 July 1995. Identified children were provided with educational opportunities and stipends to compensate for their families' loss of income.

Children deprived of a family environment, specifically, children who come into conflict with the law, street children and orphans are a subject of concern. Laws concerning juvenile justice are, by and large, humane and adequate. The

problem lies in the fact that key personnel responsible for the implementation of these laws are generally not sensitive to the needs of the children or the provisions of law which provide special protection to them. The needs of the children living in orphanages are not adequately met due to a lack of trained personnel, awareness about their rights, financial constraints etc.

Like working children, street children are engaged in numerous low-range remunerative activities and are not attending regular schools, if at all. Unlike working children, however, street children are often left out of mainstream development activities and outside the reach of most government services and are at extreme risk of abuse and exploitation.

In general, there is limited awareness and knowledge of child rights and the CRC among authorities, civil society and the general public. However, there is evidence that the level of understanding of child rights is increasing, as is evidenced by greater media coverage on both individual and collective concerns for children.

Under the right to identity and the principle of equity, low incidence of birth registration, and the situation of refugees, minorities and disabled children are a matter of concern. The law stipulating the registration of all births is not implemented, thereby making it often difficult to protect children. Initiatives are currently underway to increase the percentage of registered births and establish a well-functioning and reliable civil register.

Local resentment of refugees manifests itself most adversely on refugee girls and women. Though recognized refugees are provided with basic services in the camps set up for them by the Government and UNHCR, however unrecognized refugees, primarily Rohingya refugees from Burma, are considered illegal migrants. Therefore, when their rights are violated, they cannot avail themselves of legal protection, thereby putting them at extreme risk of human rights violations and being pushed back. The Biharis are unrecognised peoples and Jummas returnees are Internally Displaced Peoples, whose rights are also tenuous.

Indigenous peoples have a distinct identity and culture, which they believe, has not been adequately recognised. Children belonging to indigenous experience higher than average incidences of poverty, illiteracy, drop-out rates and disease. Access to education, freedom of movement and expression for Hill children was disrupted for many years because of political and civil unrest in the region. The signing of the Peace Accord on 2 December 1997, to bring about an end to the armed conflict in the Chittagong Hill Tracts has brought optimism to the region, however; the greater challenge lies in its implementation.

Disabled children are regarded as a burden and frequently experience isolation from the family and society. Both the Government and NGOs provide services and educational facilities for disabled children. However, they are inadequate in both quantity and quality for the numbers affected.

In Bangladesh, adolescents between the ages of 10 and 19 years constitute about 23% of the total population.[1] They are among the most vulnerable, and as yet, largely overlooked segments of the population. By the age of 18 years, over 60% of girls are married and many of them have already borne a child. Many children, especially adolescents, are sexually active, but have a low awareness of HIV/AIDS and sexually transmitted diseases. They are also engaged in other potentially risky behaviour (in particular, using drugs and other illegal substances). Newspaper reports note an alarming increase in drug abuse among students and youth.

As summarised above, the rights of many Bangladeshi children are insecure. Nevertheless, the problems raised (and expanded upon in greater detail in the following section) are already being addressed by a number of committed and dynamic individuals working in both NGOs and Government service.

1 Ministry of Health and Family Welfare, Government of Bangladesh, "Adolescent's Health and Development: Issues and Strategies," Country Report South Asia Conference on Adolescents (New Delhi 21-23 June 1998) p.9.

6.2 PROTECTION OF CHILDREN FROM VIOLENCE, SEXUAL ABUSE, EXPLOITATION AND CHILD LABOUR

6.2.1 Manifestation

In June 1997, the Committee on the Rights of the Child, in its Concluding Observations on the Bangladesh State Party Report, made the following statement:

> *"The Committee is concerned at the lack of appropriate measures to combat and prevent ill treatment and abuse, including sexual abuse, both within the family and outside the family and at the lack of awareness and information on this matter. The persistence of corporal punishment and its acceptance by the society and instances of violence by the enforcement officials against abandoned or "vagrant" children is a matter of serious concern."*

Violence, sexual abuse and exploitation are serious problems in Bangladesh and are manifest in different ways. As recognized by the Committee, these violations of human rights occur both within and outside the household. Within the household, corporal punishment is applied frequently, especially against domestic child workers. Children are also at risk of ill-treatment and sexual abuse (defined as rape and incest and associated offences). Outside the household, Bangladeshi children are the victims of commercial sexual exploitation (defined as trafficking, pornography and prostitution), sexual abuse (which includes rape), political agitation/hartals and ill-treatment committed by law enforcement officials. Acid violence occurs both in the public and private sphere and will be dealt with separately.

Age and Groups affected

It is difficult to get accurate statistics on violence, sexual abuse and exploitation in Bangladesh, as many of these crimes go unreported. However, the following data shows that:

- The mean age of first sexual abuse is 11.6 years[2]
- Rape occurs mainly between the age of 6 and 11 years[3]
- 23.5% of an interviewed group of 71 child domestic workers said they had been sexually abused[4]
- Many acid survivors are girls below the age of 18[5]
- There are reported cases of child victims of hartal violence being aged 8 and 13 years old[6]
- Children as young as 8 years have been raped while in police custody[7]
- Adolescents, especially between 16 and 18 years old, are especially at risk when they come into contact with the law.

---

2 Breaking the Silence, Report on Domestic Sexual Abuse, 1997.

3 Sexually Exploited and Abused Children: A Qualitative Assessment of their Health and Services available to them in Bangladesh prepared by Ain O Salish Kendra and United Nations Economic and Social Commission for South Asia the Pacific-February 1999-Draft

4 Therese Blanchet, Lost Innocence, Stolen Childhood, (Dhaka: University Press Limited, 1996).

5 UNICEF, Protection Section, 1999.

6 Daily Star, (Dhaka) 13 April 1999

7 Odhikar, Coalition of Human Rights and Newspaper Reports

All children, regardless of their age and socio-economic background, are at risk of being sexually abused and victims of corporal punishment. Girls from poor backgrounds are especially vulnerable. Many domestic child workers experience physical and sexual abuse. Studies show that both rural and urban children are equally abused and ill-treated. Furthermore, violence that is manifest during hartals or perpetrated by law enforcement officials, often affects poor children, in particular street children, working children, and young female garment workers.

Gender

Girls are valued less than boys and, as a consequence, they experience discrimination at every stage in their life. The sexual abuse, exploitation and violence they experience is a manifestation of society's low regard for girls. The situation is further aggravated by the fact that society as a whole tolerates, even accepts violence on the belief that the female victim is in some way responsible or has behaved inappropriately , and is therefore at least partially to be blamed for the crime. At its most extreme, acid violence is the prime example: the majority of survivors are girls attacked for rejecting sexual and marriage proposals. Furthermore, the practice of dowry is often the cause for violence against girls and young women, which ranges from the threat of divorce or abandonment to physical acts of beating and even murder.

6.2.2 Violence within the household

Violence against domestic child workers

Research shows that a large proportion of children engaged in household work mostly in middle class homes and are subject to ill-treatment and abuse, however, accurate figures are difficult to obtain. According to a 1985 survey, 44% of households in Dhaka employed full time servants, while 27% had a part time worker. Children are thought to comprise 80% of domestic wiorkers found in lower to upper middle class households.[8] One survey estimated the number of child domestics to be between 200,000 and a million[9]. A 1998 study on prevailing opinions and attitudes toward child domestic workers revealed that 25% of housewives physically beat them as punishment for poor performance or ill behavior. In almost 70% of household surveyed, children were scolded for the same reason.[10]

Other forms of violence in the private sphere

Corporal punishment, beating, or ill-treatment within the household is a sensitive issue and is to varying degrees widely accepted; beating is often seen as a part of educating children. As most of these types of abuses happen within the private sphere, data is difficult to collect.

Sexual abuse within the household

A case history report produced by "Breaking the Silence" provides some observations about sexual abuse within the family and household. This includes all children, including child domestic workers and incest victims. Child domestic workers, confined within an abusive household, have few, if any, opportunities for reporting their situation. No less than 23.5% of an interviewed group of 71 child domestic workers had been sexually abused, and 10% said they had been raped by their employers.[11]

8 Research and Computing Services Private LTD, Prevailing Opinion and Attitude towards Child Domestics; RCS Dhaka.

9 Daily Lives of Working Children, UNICEF Bangladesh 1997, also The State of Human Rights-Bangladesh 1997 by CCHRB.

10 Prevailing opinion and attitude towards Child Domestics, Research and Computing Services Private Limited-RCS, December 1998.

11 Therese Blanchet, Ibid.

Nearly all hospitals report an intake of sexually abused children. The Child Development Center at the Dhaka Shishu Hospital reports that 5-7% of patients are sexually abused. However, most cases of sexual abuse go unreported.

Table 6.1 The incidence of sexual abuse [12]

Criteria	# children approached	# children with which topic was discusse	# children admitting to be victim of abuse
Urban Male	12	10	8
Urban Female	30	22	16
Rural Male	48	20	17
Rural Female	30	22	9
Total	120	74	50

The age group most violated is 6 to 11 years. In 1998 alone 187 female children of this group were raped while 164 cases involved victims falling in the 12-15 years old age bracket[13]. Perpetrators of rape are often relatives or neighbours of the victim. Therefore, most molesters are those who have access to the abused without arousing fear or suspicion.

Table 6.2 Profile of the abusers [14]

Abuser / Abused	Father, Uncle & other close relatives	Persons close (House Tutor, Neighbor,Other)	Other known members of society	Strangers	Total
Rural Girls	8	4	2	2	16
Urban Girls	2	10	3	2	17
Rural Boys	3	6	-	-	9
Urban Boys	3	3	2	-	8
Total	16	23	7	4	50

Lack of Security, Protection and Prevention

There is a striking lack of security and protection for children provided at the household and community level. Interviews with sexually abused children confirm the perception that the household prefers to avoid justice than accept consequences of disclosure and subsequent stigma. Interviews with the 35 survivors of sexual exploitation (prostitutes) demonstrates families' unwillingness to take action on behalf of their children. Life skills education at schools, which results in more assertive, well-informed children, needs strengthening. Nor is the media reporting on

12 'Non-commercial Sexual Abuse of Children in Bangladesh', Breaking the Silence, 1997

13 Sexually Exploited and Abused Children, Ibid.

14 'Non-commercial Sexual Abuse of Children in Bangladesh', Ibid.

sexual abuse and exploitation conducive for broader acceptance and action. Family members, neighbours and the community do not react to sexual abuse, and incest victims have nowhere to go for complaints or support. Abused children often fall prey to traffickers and pimps.[15] Power relations and the need to preserve family and social honour at all costs and leads to abused children remaining silent.

Implications for the survivors

The Economic and Social Commission for Asia and the Pacific (ESCAP), and Ain O Salish Kendra (ASK) recently commissioned an informal survey of 15 sexually abused children and 35 child commercial sex-workers. It was found that sexually abused children showed symptoms of disturbed behaviour. Most of the young sex-workers had no shelter, no savings, were undernourished and faced health problems. They showed the same emotionally disturbed behavior as the sexually abused children. Adolescent girls faced ostracization and exclusion after being abused (often after being lured into a relationship under false promises).

A strong link exists between sexual abuse and subsequent exploitation. For example, a child domestic worker who is seduced or raped is regarded not as a victim, but rather as a compliant partner in the act. This puts the child – not the perpetrator – at the receiving end of accusations, which often ends with the victim being thrown out of the household. Rejected and considered unfit for marriage, the child is likely to end up entering prostitution or being trafficked for sexual exploitation.

6.2.3 Violence, sexual abuse and exploitation outside the household

Violence, sexual abuse and exploitation in the public sphere covers a broad spectrum of human rights violations ranging from corporal punishment, physical injuries sustained during political agitation, rape, trafficking (dealt with elsewhere in this paper), pornography and child prostitution. Specific examples are provided below.

Corporal punishment, and sexual abuse in jails

The Committee on the Rights of the Child in its concluding observation to the Initial Report of Bangladesh (June 1997) remarked,

> *[t]he Persistence of corporal punishment and its acceptance by the society and instances of violence by law enforcement officials against abandoned and vagrant children is a matter of serious concern.*

Both the Convention on the Rights of the Child (Article 37) and the Constitution of Bangladesh (Article 35-5) prohibit torture or other cruel, inhuman or degrading treatment and punishment. Despite these binding provisions, corporal punishment is widely practiced in Bangladesh. For example, it has been reported in newspapers that in some schools and residential *madrasa* (religious teaching centers), children face degrading punishment and humiliating treatment from their teachers and school authorities.

15 Sexually Exploited and Abused Children, Ibid.

15 year old Alamgir Hossain, an alleged culprit died in police custody on August 6, 1998. (...) On July 3rd, Alamgir was caught near a cinema hall at Savar Bazar with a bottle of phensidyl. (...) Alamgir was brought in court on July 4 and the next day he was sent to central jail. According to jail sources, on 27th July, he fell down from the stairs inside the jail (...). The boy was rushed to the jail hospital, but his condition deteriorated drastically (...). It was stated in the certificate sent to the hospital that Alamgir had some severe wounds on his body and that he was also having breathing difficulty. Alamgir died on 6 August. Doctors believe he was beaten up cruelly at the jail. The wounds became infected which later resulted in severe breathing difficulty causing his death. So far Savar thana denies torturing Alamgir.

Source: Star Weekend Magazine, [Dhaka] (August 14, 1998).

Young boys and girls taken into "safe" or "protective" custody by the police are among those most vulnerable to rape and physical abuse. Cases of rape of girls in police custody have increased in recent years and many of these crimes take place in broad daylight. In one incident, on 10 March 1998, a minor girl aged eight was raped in the police control room at the Chief Metropolitan Magistrate Court Building.[16]

14 year-old Yasmin Akhter was raped and killed by three police officers as she was returning home in Dinajpur in August 1995. The policemen reportedly picked her up in their van on the pretext of giving her a lift to home. They then raped her. She died as a result of her injuries. The police attempted to cover up the crime by claiming that Yasmin was a prostitute who had died jumping out of the van while it was moving.

Source: Star Weekend Magazine [Dhaka] (19 June 1998).

Violence during political agitation

Hartals or general strikes are frequently used to support political demands. However, they often turn violent and innocent passers-by, including children, become victims. In addition, street children are often detained on vague suspicions by law enforcement officials before hartals. They are frequently treated like older criminals and are occasionally beaten. Incidents of this kind have been reported in recent years. In 1998, at least three children died and 13 were injured in clashes between rival parties, police firing and exploding bombs thrown by snipers, during hartals.[17]

An eight-year-old girl Runa received serious injuries from bomb blast during a dawn to dusk hartal on October 18, 1998. Her wrists blew up when the two bombs she was holding unknowingly during the hartal, exploded. A boy chased by the police during the hartal gave her the bombs to hold for some time near the Azimpur Colony in the city. Four fingers of the left hand and one finger of the right hand of Runa were amputed. Her left eye was also injured.

Source: The Daily Star [Dhaka] (October 20, 1998).

16 Odhikar, a coalition for human rights, also The Daily Star, [Dhaka] April 11 1999.

17 Odhikar, a coalition for human rights

6.2.4 Violence due to acid and other corrosive substances.

Number and reasons for the acid attacks on children

Acid throwing, the most extreme form of violence against children, is committed both within and outside the family. The majority of survivors are girls or young women (many below the age of 18) who rejected sexual advances and marriage proposals. Recently, however, many children, including boys, have also been attacked while they were sleeping with their family members. Reasons for the attacks are many and include also family or land disputes, vengeance and dowry demands.

Monira[18] was only 12 when attacked. After refusing a neighbour's marriage proposal, Monira's father was beaten. He then agreed to the marriage on condition that they only lived as husband and wife after Monira reached the age of 18. Later, when the neighbour stole his rickshaw, the father decided to bring Monira back to the family home. In revenge, the neighbour, threw acid and severely disfigured her. The attacker is now awaiting trial.

Farida was married by her parents at the age of 14. She did not know that her husband was already married. The first wife was poisoned and died. The husband gambled and Farida went to Kuwait to work, often sending money back to him. When she returned home after 10 months, her husband was homeless and Farida went to stay with her mother. Her husband forced her to return to him and, a few days later, threw acid at her.

It is difficult, given the isolated nature of rural communities in Bangladesh, to obtain accurate statistics on the number of attacks. However, evidence indicates an increase in the number of incidents. In 1996 there were 47 *reported* cases of acid violence while in 1997, the number rose to 130. In 1998 there were over 200 reported cases, although the number of *actual* cases is considerably higher, especially in rural areas.

The impact of acid attacks on children

Following the incident, survivors are often faced with social isolation, if not outright rejection, that further damages their self-esteem and confidence. Most of them have to give up their education and/or previous work because of the time needed for their recovery and the often debilitating disfigurement that occurs.

6.2.5 Legal Protection against violence

Bangladesh has a number of legal safeguards to protect children from violence:

- The Penal Code of 1860 (Providing punishment for a wide range of crimes against Children)
- The Police Act of 1861
- The Suppression of Immoral Traffic Act of 1933 (Punishing those detaining minors for Prostitution)
- The Child Marriage Restraint Act of 1929

18 Help Acid Survivors Project, UNICEF-CIDA, 1999.

- The Children Act of 1974 (Regulates the law relating to the custody, protection and treatment of children and punishment of youthful offenders)
- The Dowry Prohibition Act of 1980
- Repression against Women and Children (Special Provisions) Act of 1995 (work on a new bill to amend this Act is underway)

Legislation pertaining to trafficking and prostitution prioritizes suppression of prostitution and trafficking of women, while children are given less priority. This has specific implications for boys, as the legal definition of a prostitute excludes the male prostitute, who are according to some estimates,[19] involved in prostitution in a ratio of 2:3 as compared to girls.

Successive governments in Bangladesh have enacted specialized legislation to curb oppression of women and children. However, these laws have been largely ineffective because of the special requirements concerning evidence (special tribunal, open trials) and very tough sentences. This has restrained judges and prosecutors to bring cases forward and has intimidated witnesses. As a result, the number of cases brought to trial under these acts are minimal. A different approach, with more flexible procedures, is required to enable a more effective intervention from the judiciary in violence cases.[19a]

There are no specific laws defining 'child sexual abuse.' The absence of such specific laws in both the personal law system and the criminal laws of Bangladesh makes redress of offences relating to child sexual abuse problematic. The need for reform of the laws to address this problem is an urgent requirement.

The effectiveness of law enforcement agencies is low due to a culture of complacency. Corruption and collusion of law enforcement officials with criminals are commonly acknowledged as factors which hinder the realization of rights of children. At a more general level, special provisions of the 1974 Children Act for juvenile justice must be followed through. According to a recent ASK report, a recent positive development is the establishment of a police unit in Dhaka, staffed by women officers who specialize in crimes of abuse and violence against women and children.

6.3 PROTECTION FROM ABDUCTION, SALE AND TRAFFICKING OF CHILDREN

6.3.1 Manifestation

Bangladesh, along with Nepal is one of the two countries of origin from where children and women are mainly trafficked to India, which serves as both a destination and transit point for transfer to other countries.

It has been found that 'trafficking,' or the trade in women and children occurs for the following purposes: prostitution, domestic work, marriage, other forms of labour, begging, adoption and camel jockeying. In the Bangladesh context, the term 'trafficking' is used to connote the cross-border movement of women and children, while the terms 'abduction' or 'sale' are used for movement within the country.

19 INCIDIN, 1997; *Misplaced Childhoods*, Red Barnet, Sept. 1997

19a Suggestions from members of the technical group on protection. UNICEF 1999

The problem of trafficking is much more complex and multi-layered phenomenon than often recognized by governments, NGOs and donor agencies. In the words of Radhika Coomaraswamy, the UN Special Rapporteur on Violence Against Women in her report to the UN Commission on Human Rights,

> *trafficking occurs for diverse purposes but the movement of women and girls within countries and across frontiers is usually a result of their unequal bargaining power and vulnerability to exploitation.*

Reported cases

There are no reliable data on the actual numbers of children and women trafficked out of Bangladesh, on account of the clandestine nature of the phenomenon. However data gathered from several sources (both Government and NGO) is summarized below:

Information provided	Source
"...200,000 women and children have been trafficked to the Middle East in the last 20 years....200-400 young women and children are smuggled out every month, most of them from Bangladesh to Pakistan...4500 women and children from Bangladesh are being trafficked to Pakistan each year and at least 200,000 women have been trafficked to Pakistan over the last 10 years. It is estimated by the Indian Social Welfare Board that there are 500,000 prostitutes out of which 2.7% are from Bangladesh..."	Ministry of Women and Children Affairs, Government of Bangladesh. *Combined 3rd and 4th Periodic Report on CEDAW, 1997* Do.
◆ 13,220 children trafficked out of Bangladesh in past 5 years ◆ 300,000 Bangladeshi children work in the brothels of India ◆ 4700 children rescued from traffickers in the past 5 years ◆ 1000 incidents of child trafficking documented in Bangladeshi local press during 1990-92 ◆ 69 children rescued at the border during a 3 month "study" in 1995 ◆ 3500 girls and women trafficked out of Cox's Bazar over the past 10 years	Bangladesh National Women Lawyers Association *Survey in the Area of Child and Women Trafficking, 1998*

Methods used by traffickers

A recent study (see table below) identified that the majority of trafficked children fell victim after being given false promises of work:[20] traffickers often approach poor families with offers of employment or marriage for girls. Even though some of the parents might be aware of the risks involved, they are driven by sheer economic necessity to accept the offers.

20 Compilation of media reports in Prof. Ishrat Shamim and Farah Kabir, Child Trafficking: The Underlying Dynamics, Centre for Women and Children Studies, Dhaka, 1997.

Table 6.3 Methods used by Traffickers

Methods used	Boy Child			Girl Child			
	Below 10 years	11-16 Years	Age Unknown	Below 10 Years	11-16 Years	Age Unknown	Total
Allurement of work	441	198	97	209	320	104	1369
Posing as relative/fake guardianship	37	6	0	5	12	0	60
By force	31	32	19	20	27	19	148
Fake friendship	20	2	1	18	2	0	43
Fake marriage	0	0	0	0	4	2	6
Kidnap	47	10	0	11	10	8	86
Senseless by using drug	16	18	4	11	7	3	59
Total	592	266	121	274	382	136	1771

Source: Compilation of media reports in Prof. Ishrat Shamim and Farah Kabir, *Child Trafficking: The Underlying Dynamics,* (Dhaka: Centre for Women and Children Studies, 1997).

Location

The problem of trafficking occurs across the country, with a slight concentration of reported cases coming from districts situated closer to the international borders and from the more backward and poorer areas of Bangladesh. Information exists on the commonly used routes over which trafficking takes place. In general, the cross-border smuggling of goods and people has a significant function in the economy of the border area on both sides of the Bangladesh and Indian border.

Characteristics of the victims

Children, primarily girls, are taken across the border for employment, often in hazardous and exploitative occupations (such as prostitution), and earning very low wages. Boys are also being trafficked to the Middle East for use as camel jockeys in races. Based on sporadic information it appears the average age of trafficked girls is below 18 years. Boys who have been rescued have often been much younger, ranging from 5 to 8 years. There seems to be very little evidence to show that any specific ethnic group is more vulnerable to trafficking.

6.3.2 Legislation

A number of laws exist which relate to trafficking:

- *The Penal Code of 1860* contains provisions for kidnapping.
- *The Anti-terrorism Ordinance 1992* provides for punishment of all types of terrorism including abducting children and women
- *Suppression of Immoral Trafficking Act, 1993* provides punishment for forcing a girl into prostitution

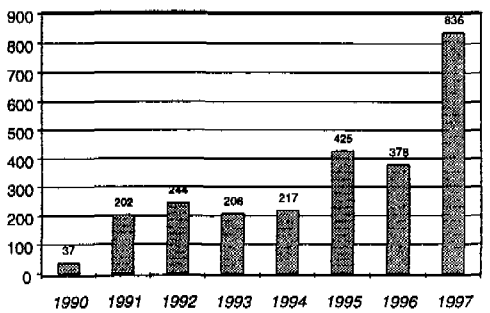
- *Woman and Child Repression (Special Provisions)Act, 1995* provides for capital punishment
- *The Cruelty to Women (Deterrent Punishment) Ordinance 1983*
- *The Children Act, 1974*
- *The Children (Pledging of Labour) Act 1933*

However, these provisions of law have not had any tangible impact on curbing the increasing trend of trafficking.

6.3.3 Trends

The absence of reliable quantitative data makes it impossible to indicate trends with accuracy. Newspaper report and other available information indicate that the problem of trafficking is growing. The demand for child prostitutes remains high, in part because of the belief in myths like having sex with young girls may prevent or cure AIDS. There are no reports of paedophilic sex tourism in Bangladesh so far, but this is an area which requires vigilance, given the trends observed in Sri Lanka and other places in South East Asia.

Figure 6.1 Number of Trafficked Children by year



Source: Child Trafficking, ibid

Additional data on the complexity of trafficking is being gathered through an "action research" project in 3 border locations in Bangladesh. This data may shed more light on the complexities of the problem and suggest some useful directions for interventions.

6.4 PROTECTION FROM EXPLOITATIVE CHILD LABOUR

6.4.1 Manifestation

The right of children to be protected from economic exploitation and harmful work is recognized in article 32 of the Convention on the Rights of the Child. 'Child labour' is recognised as that which interferes with children's education or is harmful to their health or physical, mental, social, moral or spiritual development. Ratifying states are obliged to take certain actions to control child labour and take steps to eventually eliminate it. Bangladesh also ratified ILO convention No 59 (1937) which sets minimum ages for children working in different industries. The minimum age is; 12 years for working in factories which use power and employ more than 10 people; 13 years for doing certain types of work on the railways and docks, and; 15 years for working in mines, quarries or other dangerous or in healthy industrial undertakings. However, Bangladesh has not yet ratified ILO convention No. 138 which specifies a minimum age of 15 years for child's work, unless compulsory schooling ends later. At the regional level, the resolution of the 1996 Third SAARC Ministerial Conference on Children (Rawalpindi Resolution) has set the year 2000 as the target date for eliminating child labour (including bonded labour) in hazardous occupations, and 2010 for the elimination of child labour as a whole.

The Committee on the Rights of the Child had the following to say about child labour in Bangladesh (Concluding Observations 1997),

> *As a means of tackling the integrated issue of education and child labour, including in the informal sector, the Committee recommends that effective information campaigns be carried out to prevent and eliminate child labour, and that active cooperation presently effective between the State Party, international organizations such as ILO and UNICEF and NGOs be further pursued and expanded. Regulations to prevent child labour should be enforced, complaints investigated and severe penalties imposed for violations. Efforts to provide access to education and leisure for child workers and children working and/or living in the street should be strengthened.*

6.4.2 Extent of child labour

The best data currently available are those contained in the 1995-1996 national 'Sample Survey of Child Labour,' the first comprehensive national household study in this area:

Table 6.4 Proportion of children 5-14 years in child labour force by sex

	Female %	Male %	Both sexes %
Urban	13.8	16.5	15.2
Rural	16.7	23.4	20.2
Bangladesh	16.0	21.9	19.1 (6.6 million)

Source: *National Sample Survey of Child Labour in Bangladesh, 1995-1996* – BBS

Students doing economic activities in their spare time were not, however, included in the survey. The ratio of working boys to girls was found to be 3:2 and boys are more likely than girls to be working outside the home. Twelve percent of the child labour force were aged between 5 and 9 years, the remaining 88% between 10 and 14 years. The participation rate in the age group 10-14 was a striking 34%. Child labor is more prevalent in the rural areas: in the countryside it reached 37%, as compared to 26 % in urban areas.[21] In the invisible areas of child labour (i.e. family farm, domestic service) data and statistics are not readily available.

An extrapolation of figures from several independent surveys conducted places the national proportion of children working from 10% - 44% depending on the definition of 'working children' and the type of sampling. These figures include working children as young as 6 years of age.

Reasons and social cost of working

Nearly 70% of child labourers mentioned their parent's financial problems as reason for working. Not all children are driven by poverty alone; they may be working because the main alternative education is neither available nor relevant for their needs. Eighty-nine percent of working children were found to have no education, with only 9% being educated up to class 5. It can be argued that the major social cost of child labour is the loss of opportunity of spending time in school. A vast majority of the children surveyed asserted that, given the opportunity, they would attend school. However, they are unable to pay for school related expenses such as tuition, school books, and other

21 BBS National Sample Survey of Child Labour in Bangladesh 1995-1996

school supplies, they are ashamed of their ragged clothing, or their parents (seeing no use of even basic education for their children) keep them out of school. Expanding education for working children will ease their transition into activities which improve, rather than worsen, their condition. Access to need-based quality education for working children can begin the process of eliminating child labour by converting it from an important cause of the problem to an important element in its resolution. However, the educational value of work should not be overlooked.

Type of work

The type of work children are engaged in primarily depends on where they live. Nationally, 66% of children were found to be working in agriculture and 34% in other sectors. In rural areas, children are engaged in about 90 different occupations, and many are found working alongside their families in agriculture. There is an absence of reliable data on the extent and scope of the problem in rural areas. The urban environment offers a much wider array of work opportunities for children. A joint ILO-UNICEF survey on 74 locations with a high incidence of child labour identified a wide range of occupations for working urban children, including domestic service, selling various goods and services, waste collectors, workers in small informal factories, workers in the formal sector, and other occupations. In total, 301 occupations engaging young children in urban areas were identified by a BBS rapid assessment survey. Of the 301 occupations, 27 could be classified as being hazardous. A 1996 comprehensive study conducted by the US Department of Labor added another 12 occupations to that list. The 'Child Labour Force Survey' (CLS) found 94% of children to be working in the informal sector, in shops, workshops, restaurants or garages.

The jobs most commonly done by children are domestic service, vending, chipping bricks, collecting waste, working in small informal factories and working in the formal sector. According to CLS figures, 16% of working girls across the country are engaged as 'maids and related housekeeping service workers.' Estimates of the number of domestic servants alone range from 200,000 to one million.

Working conditions

Working conditions vary between rural and urban areas and from job to job. In rural areas, work is seasonal and hours of work irregular. Urban working children work longer hours. Large numbers of children are engaged in wage employment including in certain industries, for example, bidi manufacturing, either as factory workers or as home-based *those* makers. A survey conducted by Blanchet, Razzaque, and Biswas found that 42% of the total number of bidi workers were children. Making bidi is time-consuming, monotonous, repetitive, and requires nimble hands. The fastest workers are said to be between 12 and 14 years old, but even at the age of 9 or 10, many children produce more than adults.

A 1996 study on hazardous child labour found that 62% of the sample of child workers in urban areas worked 8 or more hours each day, and 38% (domestic child workers)for more than 10 hours. [22] They often worked overtime on holidays.[23] Not all working children are engaged in harmful and hazardous jobs; a significant number of children valued their work, making reference to good working conditions and prospects for advancement. In addition, it gives them a sense of independence and self-confidence.

Occupational physical hazards include risk to infections and diseases. An example is the aluminum and soap factories, where children work at high temperatures with dangerous chemicals that can lead to various skin and

22 "Hazardous Child Labour in Bangladesh," Rahman, Wahidur, 1996, 1:128.

23 Ibid

respiratory diseases. Other hazards include fatigue, accidents due to long work hours, psychological strain and stress arising from poor working environment and ill-treatment by employers. Children have to stand for long hours, handle waste without gloves, work with heavy or sharp instruments, flames or hot objects and with electricity without proper protection. The main hazard however is the interruption of schooling, and lack of opportunities for recreation, thereby hampering socialization, mental and physical development.

Payment for work

A joint ILO-UNICEF survey found that not all working children receive their salaries in cash. According to CLS, only 36% of working children receive any pay. The unpaid workers, 58% of boys and 71% of girls, are mainly family helpers and apprentices in farms and factories. Some receive payments in kind such as food, shelter and lodging. The salaries are low and variable for those children who receive it in cash, an outcome of their weaker bargaining position. The average income in 1995-1996 was Taka 478 per month, or Taka 16 per day. Domestic servants usually earn much less than the average, if they are paid at all. In Dhaka, an average of Taka 150/month for domestic servants was recorded. A recent study of 80 domestic servants found that around three-quarters had no fixed salary. Those who were paid earned an average of Taka 145 per month, in all but a couple of cases, earnings were paid to the children's parents. On the other hand, children working in the plastic sandal industry can earn as much as Tk. 1,500 per month, while those in the jewelry factory might only get Tk. 200. At the low end of children's 'occupations', we find children engaged in prostitution, many also working as bonded labourers for pimps, while independently working girls and boys can earn up to Tk. 1,500 per month. However, the health and occupational hazards for this kind of work are unacceptable by any standard. In general, children who are self-employed have an average monthly income of Taka 797 while those employed by others earn Taka 369.

The 'Harkin Bill' and follow-up

Child labour in Bangladesh gained international attention with the tabling of the Harkin Bill before the U.S. Congress in 1993. This widely publicized bill proposed sanctions on garment imports to the US for countries utilising child labour in the export garment industry. While the Bill was intended to reduce child labour in developing countries, it initially led to the dismissal of large numbers of children from the garment industry. In 1993, there were 80,000 child workers under the age of 14 in the garment industry[24]. By 1995, the number had declined to 10,547.

In 18% of the affected families, working children were their family's sole income earners, giving more than half their earnings to their parents to buy food and other essentials. Dismissal from the garment industries forced young workers to find work in less secure and lucrative environments. Boys were forced into menial occupations such as waste collection, selling tickets on crowded transports, or other forms of work on the streets. Girls were faced with the drudgery of domestic service, brick chipping, selling flowers at crowded intersections or, for some, selling sex. The attempt to remove child labour from the garment industry actually worsened their situation, as working conditions could not be compared with the relatively better conditions in the garment industries. Although work hours in the garment manufacturing industry were long, the work place was comparatively more pleasant to work. Payment was not high, but regular, and possibilities for skills development and advancement existed. Most girls working in the informal sector, aspire to be garment workers.

24 Bangladesh Institute of Development Studies, 1993

MOU

In order to protect the best interest of child export garment workers, local NGOs and international organizations led by UNICEF and ILO intervened in the interest of the remaining laid-off child workers and advocated for a system of appropriate schooling. A Memorandum of Understanding (MOU) was signed on 4 July 1995 between the Bangladesh Garment Manufacturers' and Exporters Association (BGMEA), UNICEF, and ILO. This MOU stipulates that export-oriented garment factories could no longer offer work for children under 14 years, and that appropriate schooling should be developed for them. In October 1996, the BGMEA declared the garment sector free from child labour.

The thrust of current efforts in the field of child labour is towards the abolition, not of child work as a whole, but of the worst kinds of hazardous and exploitative work.

Lack of legal protection

Laws exist but are barely implemented. Informal sector workers, where the bulk of child workers are employed, are outside the scope of labour inspectors and other law enforcement officials. Implementation of labour laws and the 'Children Act, 1974' is hampered by the inability to determine the age of the child. The registration of all children at birth would be essential in protecting the rights of the children and providing them with access to education, health care and other services. A plethora of laws with different age groups also confuses the situation.

6.5 DEPRIVATION OF FAMILY ENVIRONMENT AND PARENTAL GUIDANCE CHILDREN IN CONTACT WITH THE POLICE, COURTS, DETENTION CENTERS AND SOCIAL WELFARE

6.5.1 Manifestation

In general, attitudes and behavior of law enforcement officials towards children leaves much to be desired. This is true in the case of police personnel who are often not accountable for their conduct and who are also sometimes accused of torture, maltreatment and abuse, including sexual abuse (as discussed in the previous section). The magistrates who hear cases do not generally accord much importance to children's issues and quite often children are detained for very minor offences. Magistrates and judges are also often overburdened and there are long delays in the court proceedings, stretching up to several years. Social welfare officers, who have been given the additional task of probation officers, are not trained for this function and the courts rarely use their services.

The Committee on the Rights of the Child, in its Concluding Observations on the State Party Report of Bangladesh, stated the following:

> *With regard the administration of juvenile justice, the Committee recommends that legal reform be pursued in connection with the very young age of criminal responsibility (7 years), the lack of adequate protection*

for children aged 16-18, ground for arrest and detention of children that can include prostitution, vagrancy or uncontrollable behavior, the possibility of imposing heavy sentences on children and the solitary confinement and ill-treatment of children by the police. In this reform the State party should take fully into account the provisions of the Convention, in particular articles 37, 39 and 40, as well as other relevant international standards in this area (...)

Groups affected

Children come into contact with law enforcing agencies for a variety of reasons:

- Being considered a "vagrant" when found on the streets without ostensible means of livelihood or residence, under the provisions of the Vagrancy Act, 1943 or the Code of Criminal Procedure.
- Being declared "uncontrollable" following the complaints of parents/guardians or the police under the Children Act, 1974.
- Children, being used by political parties for agitation programmes, being arrested by law enforcement agencies as precautionary measures under Section 54 of the Code of Criminal Procedure.
- Children who commit offences under the Penal Code or the Children Act.
- Girls who are arrested on suspicion of engaging in prostitution
- Victims of crimes and others deemed to be requiring "safe custody".
- Children considered "under-trial prisoners" when awaiting trial.

Age Groups and Gender

There are no reliable estimates for age groups of children who come into conflict with law. The absence of birth registration (as discussed in the fourth section) in the country is a major obstacle in obtaining accurate information pertaining to age groups. Both boys and girls come into conflict with law. Boys of all age groups fall into the categories described above. However, for girls, it appears that the age group is generally somewhat higher than that of the boys.

6.5.2 Trends

In the absence of reliable quantified data, it is not possible to analyze the trends in the number of children who come into conflict with law. However from media reports, it appears that the number of reported cases has recently increased. The following figures show that:

- The police apprehend an average of 3,709 children (including 11% female) every year;
- 333 children were arrested in 1997, compared to 44 in 1990, and;
- In Dhaka, from August 1990 till December 1997, 105 children were reportedly locked in safe custody, 186 for vagrancy and 373 for being suspects.[25]

25 Nurul Abedin, Treatment and rehabilitation of juvenile offenders in Bangladesh, (UNAFEI Conference, Incidence of juvenile delinquency in Dhaka), p.4. [Data provided by law enforcement authorities].

Table 6.5 Children in conflict with law

Nature of complaint	1990	1991	1992	1993	1994	1995	1996	1997	Total
Arrested in cognizable cases	37	61	91	65	96	169	241	167	927
Arrested under General Diary	07	119	46	48	118	160	254	166	918
Grand Total Arrested	44	180	137	113	214	329	495	333	1845

Source: Report of Bangladesh Retired Police Welfare Association.

6.5.3 Legal Provisions

Low awareness of laws

The Children Act 1974 is an enlightened piece of legislation and contains almost all the provisions relating to protection of children guaranteed under the CRC. However, as previously mentioned, most of the key implementers, are unaware of the provisions of the law or are inadequately sensitized to the needs of children. In the Children Act, the upper limit of age of a child has been fixed at 16 years. Juvenile offenders below the age of 16 must be tried by a juvenile court. Hence, in Bangladesh, children between 16 and 18 are not protected by the laws on children, including those pertaining to the death penalty. A 17 year-old boy was executed in 1986, which exposes the particular vulnerability of these adolescents.[26] Children below seven years are exempted from the criminal liability under Section 82 of the Penal Code, 1860. Between 7 and 12 years, the child is presumed not culpable of an offence unless evidence to the contrary is established to the satisfaction of the judge.

Law enforcement officials

The provisions of the Children Act 1974 are often ignored. Adults and children are detained together in police stations, in the absence of separate lock-ups, while children are sometimes handcuffed. Often, separate charge sheets are not initiated for offences involving children and adults. In the absence of proof of age, police often show that children are above 16 in their records, in order to avoid the necessity of following the provisions of the Children Act. They often have little recourse to legal protection. For instance, families of children who are detained are not informed and the children are not produced before a magistrate within 24 hours[27]. Children stay in jail with their mothers, who may be awaiting trial or convicted of any offence.

One of the standards of efficiency applied to police personnel is the high number of arrests made by them. In this context it is often easiest for the police to arrest children. Though the junior officials come directly in contact with children, it is mostly only the top-level officials who are recipients of training.

Courts

There is only one dedicated Children's Court in Bangladesh, at Tongi. In all other places, regular courts try children exactly like adults. Children's cases are not recorded under specific headings, but are classified together with all

26 Children in South Asia – Securing their rights, Amnesty International, April 1998.

27 Ibid

other cases. This is because of the lack of understanding of magistrates, the higher priority given to the offence than the offender's age, and the fact that the efficiency of the magistrate is judged on the number of cases disposed off and not on the quality of services rendered.

It can be very difficult for the magistrate to establish the age of the child produced in the court. Though there are provisions in the law relating to obtaining medical evidence in the absence of official records of birth, these are often very cumbersome in practice, and therefore not used.

Out of 9 First Class Magistrates interviewed only one declared to have sat at a Juvenile Court. Nevertheless, this Magistrate's comprehension of the working of a Juvenile Court seemed to be limited. As far as he was concerned, the fact that he had tried offenders under 16 was sufficient to consider that he had sat as a Juvenile Court. Special procedures were never mentioned. One lady Magistrate who knew about the provisions of the Children's Act said that she had never sat as a Juvenile Court. Later she gave a few examples of cases she tried involving a child, but did not consider she was acting in the capacity of a Juvenile Magistrate during trial. She also regularly tries juvenile girls brought before her on suspicion of prostitution. She is not conscious of the fact that many of them are under 16.[28] *Out of 9 First Class Magistrates interviewed only one declared to have sat at a Juvenile Court. Nevertheless, this Magistrate's comprehension of the working of a Juvenile Court seemed to be limited. As far as he was concerned, the fact that he had tried offenders under 16 was sufficient to consider that he had sat as a Juvenile Court. Special procedures were never mentioned. One lady Magistrate who knew about the provisions of the Children's Act said that she had never sat as a Juvenile Court. Later she gave a few examples of cases she tried involving a child, but did not consider she was acting in the capacity of a Juvenile Magistrate during trial. She also regularly tries juvenile girls brought before her on suspicion of prostitution. She is not conscious of the fact that many of them are under 16.*[28]

6.5.4 Safe custody and Detention Centers

The lack of alternative facilities and services for the care and rehabilitation is a huge constraint. Moreover, it is even worse for children in safe custody (victims of crimes or important witnesses are placed in "Safe Custody" by the orders of the Court) because there is no alternative to offer protection to them. There are no separate arrangements within jails for children in "safe custody" and therefore the child ends up with other convicts or under-trial prisoners.

Correctional Centers for children

There are two Correctional Centers for boys in Bangladesh; at Tongi and Jessore. However, the latter has not yet become operational. The only operational Correctional Institute, in Tongi, is mainly filled with "uncontrollable" boys sent by their own parents or guardians and the center is suffering from lack of resources and services. Educational services, including vocational training, are insufficient, and children on remand receive no education at all. There is also a shortage of good rehabilitation facilities, making reintegration of children into society very difficult.

28 A Critical Review of Judicial Institutions in Relation to the Rights of the Child, Radda Barnen, Dhaka, July 1995.

There is no special institute for girl offenders or victims. Girls awaiting trial are always detained in prison, as there are no other Government facilities for their detention, in normal jails or vagrant homes. They are rarely taken back by their families. However, the Government has recently announced that a Correctional Center for girls will be established soon.

Reasons for detention

Both boys and girls under 16 are kept in detention while awaiting trial, unless provided with bail. Some of the boys are transferred to the Tongi Correctional Center. Children who are accused of grave offences under the Special Powers Act, however, are neither classified as children nor sent to Tongi during this period.

One reason for safe custody of girls are "elopement cases" where a charge of kidnapping is brought by the parents of the girl and the girl remains in jail while the case is pending. This applies to victims of child trafficking and children rescued from brothels, and rape cases.

Sima Chowdhury, a 17 year old garment worker was picked off the station by police for being seen with her boyfriend. The reason offered for her arrest was simply 'suspicion.' Sima was raped in police custody by policemen themselves and then sent to prison by a court for 'safe custody.' Sima died of mysterious causes on 7 February 1997.

From 1978 till 1997, the number[29] of children sent to prison by their own parents or guardians (petition or guardian cases) was higher than the number of police cases at the Tongi Correctional Institute:

- Remanded cases: 5443 petition/guardian cases and 901 police cases
- Committed children to the Correctional Institute: 3790 guardian cases and 433 police cases.

Children in prisons

In 1997, there were 257 children under-trial below the age of 16 in various prisons of the country. Of these, about 100 children were detained in Dhaka Central Jail. In addition, about 5,500 juvenile convicts were also being exposed to serious corruption by adults and possible violence.[30]

In 1997, the prison population of 45,444 was more than double the registered capacity of 21,831.[31] With exception of specific cases, prisoners, both convicted and under-trials, juveniles and adults, live in dormitories of 100 to 150 each.[32]

29 Statistics from the Tongi Correctional Institute.

30 UNDP, Ensuring Human Security in Bangladesh: A Precondition for Democracy and Development, (New York: UNDP, 1998) p. 100.

31 Ibid.

32 Ibid.

In November 1980 at the age of 12, Nazrul Islam was arrested. He was convicted of robbery and sentenced to seven year's imprisonment. In late 1992 it emerged that he was still in Satkhira Jail, well after his sentence had expired, and that for most of the past 12 years he had been held in shackles. When his story was exposed, the High Court examined the case. It found that Nazrul Islam's entire 12-year detention had been illegal and ordered his release. During his long imprisonment, the leg irons were removed only when he was transferred to hospital for medical treatment. He was even brought to High Court hearing in 1992 in chains. It was not known if he was awarded any compensation.

Source: Children in South Asia – Securing their Rights, Amnesty International, April 1998.

Social Welfare

Social welfare officers have been designated as Probation Officers and have a duty to assist the courts in matters concerning children. However, this function has not been discharged by the Probation Officers for various reasons: there is no clear understanding of their responsibilities, no training or orientation on how to fulfill these functions, and very little cooperation with the Police, Judiciary and Prison Personnel.

6.6 STREET CHILDREN

6.6.1 Manifestation

The definition of a street child is complex. It is important to distinguish between the child who works and lives "on" the street both day and night, and the child "of" the street who may work between 8 and 12 hours per day and who returns to a family/guardian in the evening. Regardless of whether the child is "on" or "of" the street, they are the most vulnerable of the population. Street children, both boys and girls, are displaced from their homes for a variety of social and economic reasons. Such children who have no access to material resources and who belong to the bottom of the social hierarchy, are known as 'street children'.

6.6.2 Status, Identity and Numbers of Street Children

In the absence of reliable data of street children, it is difficult to ascertain the magnitude of the problem. Available information on street children from Government and NGO sources appear contradictory. The Department of Social Services (DSS) determined that there were at least 188,597 street children in five divisions of Bangladesh.[33] However, there are a number of other estimates. Among these are reports published in dailies indicating the number of street children to be 3 million or more.[34]

33 BPMI 'Survey on street and Working Children in Urban Areas'. DSS Bangladesh 1992).

34 The Bangladesh Observer, April 4, 1997.

CHAPTER SIX

"Statistics show that there were nearly 3 million street children in Bangladesh in 1990. Experts believe it will go up to 4.5 million by the turn of the century."[35]

"Child Hope estimates 1.8 million street children in Bangladesh with an escalated projection of 3 million in 2000. It also reports 3 out of 10 urban children live under difficult circumstances."[36]

At the national level, in 1990, it was estimated that there were 1.8 million children on the streets of Bangladesh and, by the year 2000, this figure is expected to rise to three or four Million. (Source : GoB, Mid-Decade Report on SAARC, October 1996).

To assess the current situation of street children, a Participatory Urban Appraisal was carried out in May 1997 with 156 street children in different parts in Dhaka. The study focused on problems, coping mechanisms and recommendations elicited by children themselves. Interviews with these children revealed their requirements to be very simple. They were content with a secure place of living and with a profession which ensures their survival. In terms of future aspirations, most children sought upward mobility in their own line of work. However these expectations are often shattered.

Once a child takes to the street there is a strong possibility that the child, both girls and boys, may end up sexually abused and exploited. This is because survival becomes the sole priority - in the absence of alternatives, street children are forced to do anything which keeps them alive. During political demonstrations, they are exposed to dangers like bombs, and stray bullets. Lack of secure employment can pull them into unethical illegal behaviour like drug trafficking and stealing.

Four street children aged from 7 to 10 years were searching for abandoned cans at a garbage dump. A can taken up by one of them blasted and all of them got seriously injured.
Source: The Independent, (Dhaka) 24 January 1999.

Sagar aged 12 have been staying on the road for the last two years. He came to Dhaka due to his parent's separation. He was harassed or beaten by muscle men. They also extorted money from him. Before hartal or any such political movement, Police arrested and tortured him, labelling him as miscreant.
Source: A Street Children's Research 1997 by C.S.K.S. (Sponsored by the Save the Children Fund UK).

K. is now mentally imbalanced. She is a girl of nine years of age. She used to be a garbage collector. She was found gang raped and bleeding in Ramna Park. She was picked up and cared for by a gang of street prostitutes and when she got better the gang induced her to take clients.
Source: Misplaced Childhood: A short study on the street child prostitutes in Dhaka City by Incidin (Sponsored by Red Barnet, Dhaka).

35 The Independent; March 30, 1997.

36 GoB, Mid-Decade Report on SAARC, October 1996.

Groups Affected

Urban children (especially slum children) and children of migrants are the sections of the child population which constitute the most vulnerable section. These children have a strong possibility of becoming street children as well as being involved in the sex market.

NGOs working on street children point out certain factors: family disintegration (due to early marriage and remarriage of the parent(s), father's inability to earn due to ill health, prolonged sickness of either parents, too many family members, homelessness due to river erosion, and family violence play an important role in triggering children leaving home.[37]

A survey among one hundred children shows the following reasons why children leave their homes:[38]

Table 6.6 Reasons for Leaving Home

Reasons	%
Seeking employment	36
Poverty	32
Orphan	12
Escaping from home	10
With parents	10

Gender

The Street Girl Research study of DUICSP, World Vision 1992, estimated the number of street children in Dhaka at 215,000, out of which, 100,000 were girls. A survey conducted on 298 children from 12 localities of Dhaka found the ratio of girls to boys in prostitution to be 3:2.[39] Predominant social and moral values discriminate against girls and violence against the poor urban females is increasing. This has a particularly negative impact on street girls: from the very beginning of street life, they are considered 'fallen' and are perceived as the common property of adult males. This puts all girls at extreme risk of sexual abuse/ assault.[40]

Location

Street Children are not only found in metropolitan cities, but also in suburban areas. The concentration of these children in the urban setting depends on the occupation they are involved in. Street children engaged as street vendors, transport labors, brick chippers, waste collectors, market cleaners, beggars and prostitution, are mostly located in near market places, airports, bus, launch, railway terminals. More than half of the children live in slums and the rest spend their night on the city streets.[41]

37 CCHRB, State of Human Rights Bangladesh 1997 and CSKS, A Street Children Research (Sponsored by Save the Children Fund U.K).

38 A Study on the Situation of Street Children in Bangladesh and the U.N. Convention on the Rights of the Child 1989, Radda Barnen.

39 Incidin, Misplaced Childhood, A short study on the street child prostitutes in Dhaka City. (Sponsored by Red Barnet, Dhaka).

40 Zarina, R. K., Afreen, H.K. The Situation of Child Prostitutes in Bangladesh CSS, (1990), pg. 44.

41 A Study on the Situation of Street Children in Bangladesh and the U.N. Convention on the Rights of the Child (1989) [arranged by Radda Barnen].

Some information on migratory trends to the city of Dhaka from other districts is available[42]:

Area-wise Trend of Migration to City

District	Percentage
Greater Mymensingh	25%
Dhaka	14%
Barisal	13%
Comilla	12%
Faridpur	12%
Other Districts	24%

Relevant Legal Provisions

Laws impacting on the street children and the situations they encounter include:

- The Children Act, 1974 (Regulates the law, relating to the custody, protection and treatment of children and punishment of youthful offenders)
- The Vagrancy Act, 1943 (which permit the police to detain "vagrants" under which definition street children commonly fall)

6.6.3 Policy and Assistance to Street Children

The United Nations Convention on the Rights of the Child provides the broad rubric under which the National Children's Policy, 1994 has been formulated. However, there is no specific mention of the term "street child" in the Convention and this may be one of the reasons why the problem of street children has not found programmatic focus. The successive Government five year plans have not specifically addressed street children's issues. The Honorable Prime Minister has however stressed the necessity of undertaking activities to improve the lives of street children.

Government services

On going assistance to this sector is concentrated on providing education and shelter homes to provide for the basic needs of under-privileged children. The Compulsory Primary Education and the non formal education programmes of the Government are aimed at addressing most of the crucial development issues of the child. Other issues of child welfare, for example access to temporary shelter, food, basic education, health services and other basic opportunities for working and street children are addressed by the Department of Social Services, under the Ministry of Social Welfare. These programmes are designed for destitute children including vagrants, orphans, disabled and juvenile delinquents. No specific programme is at present addressing street children.

42 Ibid.

The role of NGOs

NGOs have assumed an important role in this sector. In major cities, NGOs are working with street children, providing night shelters, health facilities, counseling, non-formal education or vocational/skills training, though the coverage is limited. NGO projects are more popular with the street and working children than the Government interventions due to the more flexible arrangements and their proximity at venues close to their work places. Nearly 80% of working children, as per a survey by Save the Children Fund U.K. stated that they wanted to be able to combine work with education.[43] The more formal and rigid residential regulations are not acceptable to most children who are used to the freedom on the streets. Most children prefer the combination of freedom and economic opportunities that NGO interventions offer. Increasingly good practices are being consolidated to promote institutional efforts to quality models and explorations for the development of the underprivileged street children.

6.7 SITUATION OF CHILDREN IN ORPHANAGES

6.7.1 Manifestation

The situation of orphans, specifically children living in both government, government-assisted and privately established orphanages, is a matter of serious concern. With only some exceptions, reports from NGOs and newspaper articles reveals that many orphanages do not have an adequate number of qualified staff and lack adequate facilities. Many also have insufficient operating budgets, preventing them from providing for basic needs and services (which thereby leads to higher levels of illness in children). Moreover, studies have found that, in many cases, children in orphanages are deprived of the basic needs of love, care and affection, which, in addition to basic material and physical needs, institutions are obliged to provide to them. Finally, it must be recognised that less than 5% of 'orphans' (under Bangladeshi law, defined as children under the age of 18 years who have lost their father or who have been abandoned) reside in orphanages, the majority either fending for themselves or working as domestic servants.[44]

While the CRC Committee, in its Concluding Observations on the Bangladesh State Party Report, did not specifically mention the situation of children in orphanages, it made the following (and relevant) statements:

> *[The Committee] ...remains concerned at the lack of adequate and systematic training provided to professional groups working with and for children, including...personnel working in child care institutions for children...*[45]

The Committee also noted that, *"[it] is also concerned at the lack of adequate provision in legislation and practice for alternative care for children deprived of an adequate family environment."*[46]

---

43 Alam, Vanessa , "A brief analysis of non-formal education for street children in Bangladesh," The Independent [Dhaka] 11 November 1998

44 Md Shamsul Haque, Orphanages in Bangladesh a study on orphanage situation (Dhaka: Radda Barnen, 1991) p.13 and Thérèse Blanchet, Ibid.

45 CRC Committee, "Concluding Observations to State Party Report of Bangladesh," Future CRC/C/15/Add.74, Par. 13.

46 Ibid., Par. 19.

6.7.2 Legal Definition and Protection

Orphanages and Widows Home Act, 1944

Under the 'Orphanages and Widows Home Act, 1944,' an 'orphan' is defined as "a boy or girl below 18 years of age who has lost his or her father or has been abandoned by his or her parents or guardians." [47] The act also provides for the granting of licenses to private individuals and associations for establishing and operating orphanages.

Orphanages are under the administrative control of the Department of Social Services (DSS). As of June 1998, 73 State-run institutions were in operation.[48] In addition, 'Shishumani Nibash' (or Government Baby's Homes), existed in Dhaka, Rajshahi and Chittagong and plans are to build three additional homes in Barishal, Sylhet and Khulna Districts. [49] The Shishumani Nibash in Dhaka, Rajshahi and Chittagong currently care for approximately 107 infants (0-5 years) and have a total capacity for 225 children. [50,51] All these orphanages are open to children irrespective of their socio-economic and religious background.

As of June 1991, there were 972 NGO children's homes (orphanages) registered with the DSS under the 'Voluntary Social Welfare Agencies Registration Ordinance, 1961.'[52] Of that total, 72 were receiving funding from the GOB for maintenance of 3,849 children.[53] Some government-aided NGO orphanages have been established based on religious faith. As of June 1991, there were 311 Muslim (madrasa)[54], 4 Christian, 9 Hindu and 5 Buddhist orphanages.[55]The majority depend on donations and other sources of funds to operate. A number of orphanages are operated by international NGOs and collaborate with the DSS.

Gender

According to the law, only if a child's father or both parents/guardians dies is he/she considered an orphan. This is based on the assumption that it is the father, not the mother, who provides for the child. As Md Shamsul Haque found in his survey of orphanages, 87.36% of children in state orphanages have only lost their fathers, whereas only 12.64% have lost both parents.[56]

---

47 Md Shamsul Haque, Ibid.

48 "Annual Report for Ministry of Social Welfare," (Dhaka: MSW, June 1998).

49 Ashish-ur-Rahman Shubho, "Innocent, identity-less children growing up in three government children's homes," Daily Janakantha (4/3/99).

50 According to the, "Annual Report for Ministry of Social Welfare," (Dhaka: MSW, June 1998), there are 113 infants, however, in Ashish-ur-Rahman Shubho, "Innocent, identity-less children growing up in three government children's homes," Daily Janakantha (4/3/99) there are 107 children.

51 Md Shamsul Haque, Ibid.

52 Ibid.

53 ibid.

54 Many madrasa schools have orphanages attached. They mainly assist boys, however; where they are female orphans, separate facilities are made for them. They are characterized by having a strict policy torwards children and often lack of facilities for recreation. They are provided with government funds. (Source: Ministry of Social Welfare, 12 July 1999).

55 Md Shamsul Haque, Ibid.

56 Ibid.

Educational and training opportunities for orphans appear gender-biased. In a recent article on SOS Youth Villages, it was stated that *"the main objective ...is to guide boys through higher education and skill training to help them be integrated into society."*[57] Moreover, it was mentioned that *"[o]ver 150 girls have thus far been integrated through marriages [our emphasis] [and] over 120 boys now live on their own income [our emphasis]."*[58] From the article it does not appear that an equal emphasis has been placed on educating girls and making them financially independent. In another example, at the Shishu Palli Plus-Bangladesh, boys are trained in traditionally male spheres, such as auto repair and electrical wiring, whereas girls are taught in weaving or craft making.

In the 1991 survey of orphanages, no breakdown was made according to the children's sex. It is therefore difficult to ascertain if there are higher numbers of girls in orphanages.

6.7.3 Groups and Ages Affected and Location

Children become orphans due to the illness and subsequent death of parents, guardians or fathers, natural calamities, broken families and abandonment by fathers or parents. In the case of infants, many are either found by police or brought to institutions soon after their birth, some 'with their umbilical cords uncut' and most near death.[59] People working with orphans have, however, noted a decline in the number of abandoned children over the past two decades, in part, due to increased awareness and availability of contraceptive methods and practice.[60] Poverty remains the underlying factor which renders families, especially female-headed households, unable to care for their dependents.

In some cases, single mothers are residing in "orphanages" with their children or keep regular contact with them. According to Thérèse Blanchet, 85% of children living in orphanages have mothers.[61] For example, the Shishu Palli Plus-Bangladesh (NGO) orphanage in Sreepur, Gazipur district, supports 500 children aged 2 months to 15 years and 270 mothers.[62] Mothers and 20 staff members look after the children. (Mothers are paid 250 Taka per month).

In 90% of cases (from interviews with children and Deputy Superintendents of a variety of orphanages), children were brought by family members/guardians who could not afford to take care of them.[63] In the remaining 10% of cases, parents could not support their educational expenses.[64]

According to several sources, the age of orphans in either government or private institutions varies from orphanage to orphanage. According to a 1991 study, the age limit for admission into either a Government or Government-assisted private orphanage was between 5 and 9 years.[65] Children may stay in the institution either until they reach the age of 18 years or pass the Secondary School Certificate (10th Grade), whichever is reached earlier.[66] Girls, however, may be allowed to remain in the orphanage until they either are married or placed with their guardians.[67]

57 Muneera Parbeen, "50 years of SOS Children's Village - A successful revolution," Star Magazine [Dhaka] 9 July 1999.

58 ibid.

59 Ashish-ur-Rahman, "Innocent, identity-less children growing up in three government children's homes," Daily Janakantha, 4/3/99.

60 Ashish-ur-Rahman, Ibid.

61 Thérèse Blanchet, Ibid.

62 "An orphanage with a difference," Bangladesh Observer [Dhaka] 11/2/99.

63 Md Shamsul Haque, Ibid.

64 Ibid.

65 Md Shamsul Haque, Ibid.

66 Ibid.

67 Ibid.

In the Bangladesh SOS Children's and Youth Villages (an international NGO), the ages vary from "under four" to university and college level-age adolescents.[68] For children up to the age of four, 13-15 are placed under the care of a woman whom they treat as their mother, the objective being to recreate the family atmosphere that the children have lost. In addition to Dhaka, SOS Children's Villages are located in major centres, in Rajshahi, Khulna, Bogra and Chittagong. At the age of 12 or 13, the adolescents are transferred to a SOS Youth Village where the aim is to teach them to live independently under supervision from employees at the village. There are seven Youth Villages in Bangladesh, and one exclusively for girls, in Khulna.

6.7.4 Numbers of orphans

There are no national statistics on the total number of 'orphans' in Bangladesh; the BBS does not publish any such data in its Statistical Yearbooks. However, as of June 1998, 8,843 orphans were living in Government orphanages.[69]

In a study conducted by Md Shamsul Haque, only 49,730 out of an estimated total 1 million orphans were being taken care of in institutions, the majority in NGO orphanages not receiving Government grants. Of that total, 3.65% were between the ages of 0 and 5 years; 46.48% between 5 and 10 years, and 49.86% between 10 and 18 years.[70] As Therese Blanchet's research revealed, poor children who have lost both parents are more likely to be working as domestic servants (normally under highly exploitative and arduous conditions) than living in orphanages.[71]

6.7.5 Facilities

In 1991, a sweeping overview of the conditions for children in orphanages made the following observations: most of the orphanages (State-run, government-aided, and NGO) do not meet basic food, clothing, education and health needs of the children.[72] In addition, most NGO orphanages have inadequately trained staff.[73]

Compared to the NGO orphanages surveyed in 1991, the State institutions were comparatively better in term of the health and sanitation conditions for the children. The EPI programme covers children in orphanages across the country.[74] However, in government orphanages, the supply of medicine was inadequate and irregular. In addition, children suffered most commonly from olds, fevers, dysentery, diarrhoea and skin diseases.[75] The drinking water in both Government and NGO orphanages was deemed satisfactory due to the existence and construction of tubewells.[76] Access to sanitary latrines is not consistent.[77]

---

68 AZM Haider, "Where orphans find home and 'mother,' Independent [Dhaka] 7/5/99.

69 Discussion with Ministry of Social Welfare, Dhaka, 11 July 1999.

70 Md Shamsul Haque, Ibid.

71 Thérèse Blanchet, Ibid.

72 Ibid.

73 Ibid.

74 Ibid..

75 Ibid.

76 Iibid.. This safety issue should, however be revisited since arsenic has been discovered in a significant number of tubewells, primarily in the Central West and Eastern parts of the country.

77 Md Shamsul Haque, Ibid.

In terms of food, it was found that in many cases the dietary situation of children was inadequate in the Government and NGO orphanages. In Government and Government-sponsored institutions this is due to the 320 Taka/month/child allotment [a 1991 figure] which does not sufficiently account for increasing food prices.[78] NGOs rely on charity and therefore their income is often irregular, which means quality and quantity of food can vary tremendously.

6.7.6 Recent developments and reforms

According to the recommendations of the Muzibul Haque Committee (1991), State Children's Homes were to introduce a more family environment and be made more child-friendly (based on the model of the SOS Children's Villages).[79] This meant, in part, that up to the age of 10 years, boys and girls reside in the same institution and between 10 and 18 years, boys and girls are segregated and move into separate facilities.[80] Also, the institutions were renamed from 'Sarkari Shishu Sadan' [or 'State Children's Homes'] to 'Shishu Paribar.'[81]

As of June 1998, children in 38 out of a total of 73 Government orphanages had been fully converted into Shishu Paribar, the remaining 35 remain to be transformed when funds become available).[82] On 15 June 1999, however, it was reported that the former State home in Jhalakathi had been fully converted into a 'Shishu Paribar', thereby bringing the total number to 74.[83]

In 1997-1998, a total of 2.5 crore Taka was provided by the State to government-assisted orphanages, however, it is unclear how much was provided to each institution and child.[84]

According to a newspaper report of 11 March 1999, the children living in three government-aided orphanages in Shakhipur were suffering from a lack of funds.[85] The 'Capitation Grant'supposed to be provided by the Government at the beginning of the year and used for the children's food, medical treatment and clothing was 8 months behind.[86] The orphanages affected were Shakhipur Thana Sadar, Araipara and Dabail.

In the Government-supported Parbattaya Bouddha Mission in Khagrachhari District, 146 orphans, including 42 girls, receive from the Social Welfare Department 20,000 Taka every month.[87] According to the Director, it only meets the food costs for 50 out of 146 orphans."[88] The mission also receives financial support from international and national NGOs and hopes to expand it programmes for the children, including the construction of a mini-hospital, and training centre.

---

78 Ibid., p.19.

79 Ibid., p.42.

80 Ibid.

81 Ibid..

82 Discussion with Ministry of Social Welfare, Dhaka, 11 July 1999.

83 "Children's home upgraded: 100 orphans rehabilitated," Dainik Sangbad 15/6/99 and Ashish-ur-Rahman, "Innocent, identity-less children growing up in three government children's homes," Daily Janakantha, 4/3/99.

84 "1998 Annual Report of Ministry of Social Welfare," (Dhaka: MSW, June 1998).

85 "Orphans in miserable condition," Dainik Sangbad 11/3/99.

86 Ibid.

87 Shuva Jyoti Chakma, "Buddhist mission needs fund to help orphans," Daily Star [Dhaka] 4/3/99.

88 Shuvra Jyoti Chakma, Ibid.

Baby's Homes (or 'Shishumani Nibash') receive from the Government 660 Taka/month/child (460 Taka for food and the rest for clothing, medicine, books, and other supplies).[89] In addition, money for milk is provided.[90]

In some cases, however, NGO-operated orphanages are world-class models. For example, SOS Children's and Youth villages recreate a family atmosphere for the children, with surrogate 'mothers' and 'fathers.' The 'family unit' consists of 13-15 children. During adolescence, they are transferred to Youth Villages and segregated according to sex at which time they are prepared for adulthood. All educational expenses up to university stage are borne by the NGO. Currently 543 adolescent boys and girls are studying in schools and colleges and 12 are in university.[91]

6.7.7 Admission Procedures

As mentioned above, less than 5% of the identified orphans are cared for in either state or private orphanages. NGO and other sources have found that, "to get a child admitted [to State or Government-aided orphanages], these institutions usually require some patronage (and bribe)."[92] For example, a 1991 study discovered that in 30% of cases, "orphan children get admitted through tadbir (persuasion) and thereby influencing the decision of the [District Admission] Committee by the guardian/well wishers of the orphans who are not otherwise deserving one."[93] The official procedure for admission to a state or Government-aided orphanage (a recipient of Government 'Capitation Grants') is, however, for guardians to apply to the District Admission Committee.[94] In the case of NGO orphanages (not aided by the Government), there are no set procedures for admission.[95]

6.7.8 Protection Issues, Incidences of Abuse and Neglect

A 1991 survey of 1,372 orphanages (including 73 State Children's Homes, 3 government-operated Baby Homes, 324 Government-aided private orphanages, and 972 NGO orphanages) asked the children (49,730 in total) about the quality of the services provided to them. Thirty-five percent were dissatisfied; 30% remained silent and 35% expressed satisfaction with the prevailing conditions.[96]

---

89 Ashish-ur-Rahman, "Innocent, identity-less children growing up in three government children's homes," Daily Janakantha, 4/3/99.

90 Ashish-ur-Rahman, Ibid.

91 AZM Haider, "Where orphans find home and 'mother'" Independent [Dhaka] 7/5/99.

92 Thérèse Blanchet, Ibid.

93 Md Shamsul Haque, Ibid.

94 ibid.

95 Ibid.

96 Ibid.

6.8 AWARENESS AND FREEDOM OF EXPRESSION: AWARENESS REGARDING CHILD RIGHTS

6.8.1 Manifestation

The Committee on the Rights of the Child, when they were reviewing the State Party Report of Bangladesh in 1997, pointed out that there is a very low level of awareness of the fact that children have rights in Bangladesh.

It has been raised that the concept of 'childhood' itself has a cultural context in Bangladesh, which is very different from the concept based on the age of the child. Thérèse Blanchet, a well known social anthropologist working in Bangladesh has suggested that the concept of childhood is more linked to a state of "understanding" than age.

> *There is no Bangla word to describe a life stage going from birth to the age of 18 which is the span covered by 'the child' in the UN Convention... Children's rights are inevitably construed as needs and the word 'shishu' (the bangla word chosen to translate child) evokes a small child... a classical study on life stages in Bangladesh defines **shishukal** (childhood) as a stage of non-reason corresponding to infancy and pre-school childhood and covering an age span of birth up to five years... On the other hand childhood may be cut short because a child who is forced to work at a young age, a child 'who knows too much', a child who fends for herself or himself is not considered a **shishu** anymore... outside official texts and discourses, the word **shishu** is never used for youth beyond puberty...*
>
> Source: Thérèse Blanchet, Lost Innocence, Stolen Childhood (Dhaka: University Press, 1996).

Nevertheless, age forms the basis of the definition of childhood according to Bangladeshi law. While in the Convention on the Rights of the Child, a child is defined as every person under the age of 18, legislation in Bangladesh provides different punishments, protection or benefits according to one's age and gender. Some of these are illustrated below:

Under 7	No criminal responsibility
6 to 10	Must attend school
Under 12	Cannot work in shops, offices, hotels or certain workshops (except as apprentices)
Under 14	Cannot work in factoriesChild vagrants must be held separatelyRights guaranteed under National Children's Policy
Under 15	Cannot work in certain parts of transport sector
Under 16	May not be held in ordinary prisons or receive capital punishmentGirls cannot consent to sexual intercourse
Under 18	Girls cannot marry
18	General age of majority
Under 21	Boys cannot marry

Source: UNICEF, Children of Bangladesh and Their Rights, (Dhaka: UNICEF, 1997).

It has been suggested that the provisions of law relating to the age of the child be harmonised, but it has thus far not been taken up.[97]

While we find that several interventions in the name of the realisation of child rights have been initiated in Bangladesh, it is not clear how much of these initiatives are based on a clear understanding and internalisation of the concept of 'child rights.' For instance,

The convergence of economic interests and child rights

In order to eliminate child labour from the export garment sector, a tripartite agreement involving the Government, the Bangladesh Garment Manufacturers and Exporters Association (BGMEA) and international organisations was signed in 1995. This was the first time that an initiative to protect working children was addressed.

The MOU was agreed to and signed partly as a recognition of the rights of children not to be engaged in exploitative labour, and also out of compulsion. The Harkin Bill, if passed by the US Congress, would have cut the export quota for countries producing garments produced by children. It would appear that, because of the inevitable economic hardship that would have resulted, the MOU was signed.

Perceptions regarding the girl child

"If I say 'Ma, I like this,' she says, 'No, take the other one.' I can't even visit a friend. Even food is unequal. They say, 'why do girls need to eat so much? It's boys who study and work.' But girls work a hundred times harder! A girl has no value. Her word is disregarded...Boys get more importance all around."

Source: Children of Bangladesh and their Rights, (Dhaka: UNICEF, 1997) p.54.

There is a conception that the potential of the girl child to emerge as a member of the productive labour force and contribute to the economic advancement and the social security of the family is limited in comparison to that of a boy child. Also it is often perceived that investments made in a girl's education will not yield any benefits to her family but rather to her husband and in-laws. These perceptions lead to well-documented evidence of lower literacy rates and nutrition levels for girl children in both rural and urban areas.

6.9.1 Child Rights and indigenous traditions[98]

Apart from the problems regarding conceptualization of the concept of childhood, another problem that is occasionally encountered relates to the view that international human rights standards or norms are Eurocentric and not in keeping with indigenous traditions of justice. This is seen as undermining group rights and community interests and failing to reflect concern for cultural diversity and pluralism. International norms stressing individual

97 'National Workshop on Juvenile Justice,' Dhaka, 11-13 November 1997.

98 Summarized from Savitri Goonesekere, Children, Law and Justice – A South Asian Perspective, (SAGE Publications, 1998).

rights are also thought to give a low priority to social and economic development rights. It is furthermore believed that in the context of an environment of economic deprivation and poverty, individual rights are irrelevant.

This view tends to ignore the reality that there is a core value base in the written laws of the region which are derived from indigenous traditions as well as from received colonial legal traditions. It is also important to realize that modern Western European concepts of "due process" and protection of personal liberty were developed from the historical experience of the conflict between the church and the state, or the king and the parliament and the resulting intrusions on personal liberty. These concepts therefore have universal relevance for people in developing countries who are seeking to realize their right to freedom from abuse of power and authority.

The indigenous legal systems of Asia and Africa indicate that these societies were not unfamiliar with concepts of restrictions on abuse of power and dispute settlements by conciliation and compromise. For example, early Islam emphasizes the importance of consensus arrived at by the *Umma* or the Islamic community. Indigenous fora such as the *Panchayat* in India or the *Gamsabhawa* in Sri Lanka are institutions that reflect these concepts. The model that provides for decision making for the *sangha* or the clergy in the Buddhist tradition also reflects a similar concept.

The philosophical traditions of two religions that have had a major impact on these regions – Buddhism and Islam emphasize the importance of the individual. Islam's recognition of the option of puberty is based on the concept of personal autonomy and the right of a person who has reached that age to reject the decisions made by an adult guardian during minority that were prejudicial to individual well-being. There are other aspects of Islam which emphasize the importance of human endeavour and the significance of the individual in the community.

There are also clear instances of the special place that indigenous traditions have given to the needs of children. Islam recognizes the preferential right of custody of the mother of a young child years based on the child's need for nurturing and caring. However both Hindu and Islamic law, as they have often been interpreted also contain legal values that impinge on the status of women and girl children in particular. The evolution of the rights of women and children in the Western tradition also show that these values can change over time. The Roman law concept placed both women and children under the all powerful authority of a male *pater familias*. In both England and the United States, legislation on the prevention of cruelty to animals preceded legislation on cruelty to children and the first cases of child abuse were brought before the courts on the basis that the child victim was an animal. The evolution to the recognition of the rights of women and children have been slow and both the Eastern and Western traditions have impacted on and influenced each other's law, social practices and public policies.

6.9.2 Awareness regarding Child Rights

There is no data available to calibrate the awareness of child rights in the community, family or even among the children themselves. The awareness of child rights among key decision makers on matters concerning children are seen as their obligation to the less fortunate, rather than as the child's fundamental right.

More often than not, parents or authority figures are regarded as 'knowing best' for the child. The concept that it is the child's right to be consulted regarding decisions that will affect the child has not gained a place in social values.

However, there are specific instances where policy has been informed by child rights:

- Ratification of CRC by Government of Bangladesh (GOB)

- Observing the National Child Rights Week from September 29 to October 5 each year at the national level and in all the districts
- Child Rights programmes on Bangladesh Radio (*Betar*) and Bangladesh Television to the extent of 300 minutes and 25 minutes per day devoted for the promotion of child rights
- UNICEF, ILO and BGMEA (Bangladesh Garments Manufacturer Exporters' Association) agreeing to a Memorandum Of Understanding aimed at eliminating child labour in the export garment sector
- Creation of a Ministry of Women and Children's Affairs (MOWCA) in 1994.
- A legal review of laws relating to childhood to recommend measures of synchronisation and reform
- The Children's Policy, 1994 and the National Plan of Action based on the Child Rights Convention
- Observance of the Decade of the Girl Child, 1990 - 2000

However the major challenge is to see the extent to which the understanding of child rights is fully internalized among the policy makers and implementers.

6.9.3 Children in the Community

Over time, child participation has increased in schools. This holds true for both urban and rural children. Activities range from annual school sports events, inter-school *kabadi*, football, volley ball and basketball tournaments, debates, science fairs and *meena bazaar*.

Low-priced children's books in Bengali are available in the market and enjoy fairly good sales. Titles range from poetry, science, fiction, suspense, drama and non-fiction. There are, however, limited libraries which children can access in Dhaka and other urban areas.

School children in the most prestigious English-medium institutions in Dhaka sponsor, through the school, social programmes in aid of children. These activities are usually done from a charity perspective and not done because they are aware of, or wish to bring awareness to, any particular child rights issue.

6.9.4 Children and the Media

In terms of awareness of children's rights, data on the 'Meena' initiative was collected for the 1998 Media Survey, which covered 10,400 households in 61 districts. Nationally, 26% of the TV viewers had seen 'Meena,' and 19% of radio had listened to or heard the programmes. Interestingly, when asked what 'Meena' was about; 69% said 'girls education,' 42% said 'girls rights,' 16% said 'nutritious food,' 15% said 'sanitation,' 14% said 'save the girl child,' and 12% said 'dowry.' This is significant because 'rights' are not specifically mentioned in any of the 'Meena' episodes. This means that some viewers or listeners already understood or intuitively knew that the issues addressed in the episodes: access to education, nutrition, equity, safe environment, freedom from discrimination, and others constitute 'rights.'

Children, as well as children's issues have also found expression in various newspapers and magazines. Among the ten high circulation national English and Bengali newspapers, four have regular children's pages. The others occasionally cover children's issues, but most stories carried are based on child labour and street children (a few have focused on, though sporadically, domestic labour stories).

While journalists both in the print and the electronic media are aware of children's issues, it is true that by and large they do not have a comprehension of child rights.

Child labour and street children are covered from a human interest angle and/or because they make cute photo-opportunities. All papers regularly print pictures of children engaged in either labour or play, however, child rights issues may not always be mentioned in the photo-captions.

6.10 RIGHT TO IDENTITY AND EQUITY : BIRTH REGISTRATION

6.10.1 Manifestation

Bangladesh has no functioning birth registration system. A legal framework for birth registration is provided by the 1886 Birth and Deaths Registration Act. However, lack of awareness as well as logistics and manpower prevent universal registration of births. A UNICEF supported survey on birth registration practice, carried out in six districts (in urban and rural areas) over five divisions, revealed a low awareness of laws governing birth registration. Little over 11% of births were registered. This figure was slightly higher in urban (11.5%) than in rural areas (10.9%). The general awareness of the legal requirement to register births was also low. The need for birth registration does not yet form part of the information reaching the respondents through Governmental and Non-Governmental organisations, although some media attention on this issue has been reported and is increasing.

The importance of birth registration for child rights

The absence of birth registration is a serious obstacle for fulfillment of children's rights. Article 7 of the Convention on the Rights of the Child stipulates that every child has a right to a name and identity. In its concluding observations to the Bangladesh State Party report, the Committee for the Rights of the Child had the following to say about the status of birth registration in Bangladesh:

> *"The Committee is concerned that most births in Bangladesh remain unregistered. Lack of registration has negative consequences on the full enjoyment of fundamental rights and freedoms by children... the Committee recommends that further measures be taken to ensure the registration of all children in cooperation with NGOs and with support of international organizations."*

In the absence of birth registration, verification of age of any person is nearly impossible, which therefore has serious implications for young offenders, child prostitutes, child workers and others who are being denied access to special protection, facilities, or treatment provided to them by law. Educational and health planning is also hampered by the absence of demographic data that birth registration can provide. At a more general level, a birth certificate is a child's 'ticket to citizenship', which gives the child an identity; a proof of existence, and eventually the ability to exercise all other rights including civil and political rights. In this respect birth registration is crucial for the development of a democratic society that protects children from exploitation and promotes the civil rights of its citizens.

Law and implementation

Laws and regulations with regard to birth registration exist, but are largely not adhered to. The 1886 Birth and Death Registration Act provides for, and designs, roles and responsibilities with regard to birth registration. In 1979, a new Ordinance (No.6) amended the previous Act and appointed persons at village, union, thana and district level

to act as registrars[99]. Pourashava and City Corporation Acts and by-laws confirm tasks and procedures with regard to implementation of these laws.

6.10.2 Trends and developments

Some developments in this field are noteworthy. The Chittagong, Rajshahi and Khulna City Corporations embarked on *birth registration campaigns* in 1997 and 1998 reaching nearly universal coverage in a short time, a result of a decentralized approach and good leadership provided by the Mayors of these city corporations. A similar campaign was held earlier in Holidhani Union Parishad. Plans for expansion of the birth registration initiative are currently being drawn. These include activities designed to streamline the system, create awareness and demand through communication and information, and increase the number of campaigns.

Birth registration - Rajshahi city corporation sets the standards

Rajshahi City Corporation succeeded in registering births of all new born children, but also all children below the age of six. This success was achieved over a short period of seven days during the Child Rights Week 1997. Some of the reasons for this success were:

- *Inspiring leadership: given by the Mayor and his dynamic team in the City Corporation*
- *Decentralisation: the responsibilities for registering births was decentralised to the wards. Each ward maintained a sub-register, which complied the information, which was then transferred to the main register of the Corporation.*
- *Volunteers: the Corporation made use of 300 volunteers selected from among 1,700 NID volunteers. These volunteers made house to house visits to find and register young children.*
- *Attractive birth registration cards. Rajshahi City Ccorporation distributed attractive birth registration cards*
- *Sustainability and continuity: this is a crucial point. In Rajshahi, the following process is followed: Within the first seven days of the birth of a child, the EPI and family Welfare field workers register the birth in each ward using a special 'birth registration' format. This format is submitted to the ward Commissioner every week. After the Ward Commissioner certifies the Birth registration format, the information on births is entered in the Ward birth register. The birth registration formats are then sent to the health Section of the City Corporation for entry in the Corporation Birth Register*

6.10.3 Marriage registration

Marriage registration, the formal recording in an official register of the essential details of the marriage, is applied in an estimated 40% of all Muslim marriages, and none of the Hindu marriages. The Muslim Marriages and Divorces (Registration) Act 1974 requires every Muslim marriage to be registered in the *Nikah* register. Fees for registration depend on the amount of *denmohr* (dower). The Hindu Family Law Rules contain no provision for registration of marriages. The 1872 Christian Marriage Act makes registration of every Christian marriage compulsory. All marriages in the small Christian community are registered because registration is an integral part of the marriage ceremony. However, accurate information on Christian marriages is hard to obtain in the Government records.

99 Huda S, The working children in Bangladesh' Children's rights and child labour. (Proceeding of the second South Asian Conference on Working Children), Dhaka 1989.

The main reasons for the low level of marriage registration are the lack of awareness of the existence and benefits of a marriage registration system, as well as a reluctance to strengthen the position of women through registration.

Marriage registration increases protection, foremost to women. In particular, the marriage certificate (*Nika-Nama* or *Kabin*) proves the existence of the marriage, enabling the wife to take legal action against her husband if he marries another women without her permission or to prevent such marriage from taking place. The wife can obtain maintenance for herself, recover the *demohr* (dower) specified in the *Nika-Nahma* or, where no sum is specified, such amount of dower as is judged to be reasonable. On the death of the husband or wife the surviving spouse can, in theory, recover his or her legal share of the deceased spouse's estate.

Promotion of marriage registration is a tool to reduce under age marriages. Child marriages cause girls leaving school early, premature pregnancies and associated health risks. Approximately half of women in Bangladesh are less then 18 when they marry, despite the prohibition by law. The 1929 Child Marriage Restraint Act (which applies to all religions) makes it an offence to marry or play a part in the marriage of a child, defined as a female under 18 years of age or a male under 21 years of age. The Act does not declare these child marriages void but provides penalties for those involved (excluding the child). It is also possible to obtain an injunction from the court prohibiting a planned child marriage. Additional protection is available under the Muslim law for girls given in marriage before they reach the age of 18. The Dissolution of Muslim Marriages Act 1939 gives such girls the rights to obtain a court order dissolving the marriage.

Rahim and Moina's marriage was solemnized orally; it was not registered. Three years later, Rahim married another women and divorced Moina. He refused to pay the denmohr and maintenance for Moina. When Moina threatened to go to court, Rahim simply denied that the marriage existed. Moina was unable to prove the existence of the marriage in court due to a lack of evidence. If the marriage had been registered, Moina's legal position would have been much stronger.

6.11 RIGHTS OF REFUGEE CHILDREN

6.11.1 Manifestation

With only few exceptions, the Government rarely allows refugees to settle permanently, to avail of local services (including legal protection and access to the courts), and to seek employment. Because they are not citizens, refugees are regarded as outsiders. Locals resent the presence of refugees in their communities because of the provision of food, healthcare, education and other assistance to some of them --at no cost-- by humanitarian organisations. Refugees are also viewed as unfair competition in the labour market because they undercut local wages.

In its 'Concluding Observations to the State Party Report of Bangladesh,' the Committee on the Rights of the Child stated the following:

The Committee recommends that the State party ensure adequate protection of refugee children, including in the field of physical safety, health and education. Procedures should also be established to facilitate family reunification. The State party may consider seeking assistance from UNHCR in this regard.[100]

The internationally accepted definition of a refugee is as follows:

"owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."[101]

Not all of the refugees living in Bangladesh have been officially recognised as refugees.

6.11.2 Rohingyas: officially recognised refugees

Rohingya Muslim refugees from Arakan State in Northern Burma, comprise the bulk of the officially recognised refugee population in Bangladesh. As of 31 March 1999, there were a total of 22,378 UNHCR-recognised Rohingya refugees (3,772 families) living in two camps, Kutupalong and Nayapara, in Cox's Bazar District. [102]

Of the total number of refugees still living in the camps, almost half (12, 791) are under the age of 18 years.[103] For both political and economic reasons, the Government of Bangladesh has refused to allow the Rohingya refugees to settle locally, to work, and to avail themselves of local medical treatment and attend local schools.

Provision of Services and Living Conditions

The Government permits UNHCR and its implementing partners to provide assistance to the recognised refugees. In the camps, the Government of Bangladesh provides for administration and security, and the World Food Programme supplies food to the Government which is subsequently distributed to the refugees by the Bangladesh Red Crescent Society. While most health services are supplied by UNHCR's implementing partners, the Ministry of Health also has a role in the camps.[104]

---

100 United Nations Committee on the Rights of the Child, 15th Session, "Draft concluding observations of the Committee on the Rights of the Child: Bangladesh," CRC/C/15/Add.74, 6 June 1997, par. 45.

101 Convention relating to the Status of Refugees, 28 July 1951.

102 "Refugees from Rakhine State of Myanmar in Bangladesh," Situation Report No 99, 1-31 March 1999, UNHCR, Dhaka, Bangladesh.

103 MM Sunnah, Protection Officer, UNHCR, Bangladesh as of 28 February 1999.

104 Discussion with M M Sunnah, Protection Officer, UNHCR, Dhaka (13 May 1999).

Education

Of the 12,791 Rohingya recognised refugee children (up to the age of 17 years), 2,913 are enrolled in school (1920 are boys and 993 are girls).[105] Schools have been provided in the camps only since 1997.[106] Presently, only 17/18 schools are operational in Kutupalong due to a shortage of teachers.[107] There is no fixed policy with regard to education in the camps, it is mainly non-formal, quality and level of education is likely highly variable, and a breakdown by age of school-going children is difficult.[108]

Healthcare

In the two Rohingya refugee camps, UNHCR's implementing partners provide all other care and maintenance to the refugees, including health services, water and sanitation and nutrition programmes.[109] For 1998, the health indicators (which compare very favourably with those of Bangladeshi children) of the recognised refugee children in Kutupalong Camp are as follows:

Expanded Programme of Immunization (EPI):	99-100% coverage
Infant Mortality Rate (IMR):	34.53 per 1000 live births
Under 5 years mortality rate:	1.27 per 1000 live birth
Maternal Mortality Rate (MMR):	0 per 1000 population
Vitamin A high potency capsule distribution:	99.1% coverage (89/3758 children ages 1-6 years received the capsule)
Latrine:	1 for 22 people
Bathroom:	1 for 130 people

Source: Concern Bangladesh, "Sub-Project Monitoring Report (Narrative SPMR Part–2" January – December 1998), Dhaka, Bangladesh, pp 3-5.

6.11.3 Rohingyas: lacking official refugee status

Numbers and Location

In addition to the recognised refugees from Myanmar, according to Dr C R Abrar, Coordinator, Refugee and Migratory Movements Research Unit, Dhaka University,

> *"there are tens of thousands of unrecognised Rohingya refugees who have arrived since 1992 (when UNHCR officially stopped recognising them). Without having UNHCR refugee status, they are completely on their own and receive no assistance or services from humanitarian organisations."*[110]

105 UNHCR, Refugees from Rakhine State of Myanmar in Bangladesh Situation Report No 99, 1-31 March 1999.

106 Ibid and before 1997, the Government of Bangladesh did not allow UNHCR to establish educational facilities for fear that it would encourage the refugees to remain in Bangladesh and not return to Myanmar.

107 UNHCR Situation Report 1-31 March 1999.

108 Discussion with M M Sunnah, Protection Officer, UNHCR, Dhaka, Bangladesh (13 May 1999).

109 Data from UNHCR Dhaka and discussion with Md Siddiqur Rahman, Concern Bangladesh, Dhanmondi, Dhaka (26 April 1999).

110 Discussion with Dr Abrar, Coordinator, Refugee and Migratory Movements Research Unit, Dhaka University, (12 May 1999).

According to a study commissioned by Save the Children-UK, "[a]bout 25,000 Rohingyas...entered Bangladesh during 1997."[111] Although the majority of those Rohingyas interviewed said the main reason they left Myanmar was due to torture by the army, the Government of Bangladesh considers them "illegal immigrants and they have been refused refugee status."[112]

Services and Living Conditions

Of the 1039 unrecognised refugees contacted by UBINIG, 548 were in the age range of 1-15 years.[113] Moreover, of the total number, 24% were children under the age of 5 years.[114] None of the children ages 5 and under were found to be immunized (which explains an incidence of children with polio) and are not permitted to participate in the EPI programme, or enrol in schools.

"Malnutrition is very severe among the children. The common indications of swollen bellies and golden hair are found.." (Source: UBINIG, "Vulnerability and Insecurity," (August 1998) p 21.

Many have settled in local communities in Teknaf and Cox's Bazar or live (unofficially) in the refugee camps. As they have little choice but work illegally, they work for less-than market wages and are at greater risk of exploitation from their employers than the local population. While their husbands and/or fathers work in the local economy, it has been found that in many cases, "the wives and **children [our emphasis]** work as domestic servants without food or pay."[115] In addition, there are many female-headed households, the father engaged in forced labour in Myanmar.[116]

Many women and girls were found to be at risk of sexual exploitation and abuse from the local population. While UNHCR-recognised refugees can, at least, avail themselves of legal services, unrecognised refugees are considered illegal migrants and therefore cannot approach the authorities when their basic human rights are violated. Of 200 sample families interviewed by UBINIG researchers, the women and girls in 70 families had experienced sexual harassment of varying degrees.[117]

"The Rohingyas feel general sense of insecurity, specially women. The widow or the single women face many threats. The expression is that they do not sleep at night, out of fear. The families having young/adolescent girls remain in constant pressure from the local young boys. There have been many incidents of sexual assault on the young girls.

111 UBINIG, "Vulnerability and Insecurity, Study on Situation of Rohingya Women and Children in Cox's Bazar and Teknaf," (Dhaka, August 1998) p 2.

112 ibid, p 1.

113 ibid., p 10.

114 ibid.

115 Discussion with Dr C R Abrar, Coordinator, Refugee and Migratory Movements Research Unit, Dhaka University, 12 May 1999 and UBINIG, "Vulnerability and Insecurity," p 3.

116 Ibid.

117 UBINIG, "Vulnerability and Insecurity, " p 18.

The unrecognised Rohingya refugees are also at special risk of being pushed back into Myanmar by Bangladeshi security forces because they lack the protection that is, in theory, to be accorded to them by having official refugee status.

Protection: Rohingya Refugees and Non-Recognised Refugees

During the interagency meeting held on 14 March 1999, representatives of each of the organisations operating in the camps spoke to a group of 400 refugees and commented on "the alarming increase of incidents of mistreatment and assault on refugee women and **children [our emphasis].**"[118]

6.11.4 Urban refugees from Somalia and Iran

There are also 148 refugee asylum seekers mainly from Somalia and Iran who have, at the request of UNHCR, been granted permission by the Government of Bangladesh to remain in the country until resettlement elsewhere can be arranged.[119] Of that total, 44 are under the age of 18 years.

Unlike the Rohingya refugees, children are permitted to attend local schools and their parents are allowed to work. Heads of household receive a small subsistence allowance from UNHCR that provides money for school fees, books and uniforms for school-going children. Their medical treatment is also reimbursed.[120]

6.11.5 Legal protection

Neither the Constitution nor national law includes provisions for granting refugee or asylum status. Refugees, (with the exception of the small number of refugees from Somalia and Iran) are not permitted to seek employment in Bangladesh. The Government of Bangladesh (GOB) has signed neither the 1951 United Nations Convention Relating to the Status of Refugees nor its 1967 Protocol.

Nevertheless, as outlined in the UN Convention on the Rights of the Child (CRC), which was ratified by the GOB in September 1990, the government must safeguard and protect the rights of all children (which therefore includes those who are refugees). Moreover, the principle of *non-refoulement* (forced expulsion/repatriation) has become part of international customary law thereby binding all states to abide by it, even those which have not ratified the Refugee Convention.

In practice, the Government generally grants temporary asylum to individual asylum seekers whom the United Nations High Commissioner for Refugees (UNHCR) has interviewed and recognised as refugees, on a case-by-case basis.[121] However, as mentioned previously, there are thousands of refugees who have been arriving since 1992, many of whom are under the age of 18 years, who appear to meet the international definition of a refugee but who have yet been denied refugee status.

---

118 "UNHCR situation Report No 99, 1-31 March 1999.

119 Discussion with M M Sunnah, Protection Officer, UNHCR, Dhaka, Bangladesh (13 May 1999).

120 Ibid.

121 "Bangladesh," Country Report on Human Rights Practices for 1998, US Department of State (Washington, DC, 26 February 1999).

Trends

The number of Rohingya refugees living in camps in Bangladesh has dramatically reduced since late 1992 and the Government of Bangladesh appears keen to repatriate all remaining families at the earliest possible date. However, some of the remaining refugees (and certainly the bulk of the unregistered refugees) have expressed an unwillingness to return to Myanmar because the overall human rights situation in the neighbouring country is still precarious. There is no guarantee that the Rohingyas will again be pushed back to Bangladesh should repression in Myanmar of the Muslim Rohingyas resume. Other trends worth noting include the impact of budgetary cutbacks and shifting priorities of humanitarian organisations to the delivery of services to the refugees. For example, UNHCR's Director for Asia and the Pacific, recently said funds were needed in Kosovo, *"[d]onors were no longer interested to support the Rohingyas."*[122]

6.11.6 Unrecognised Peoples and Internally Displaced Peoples (IDPs)

Biharis: unrecognised peoples

A legacy to the break up of East and West Pakistan, there are now about 500,000 Bihari Muslims living in Bangladesh, of which 70% of those living in 66 camps scattered across the country, are between the ages of 15 and 35.[123] By that figure, at least 150,000 are between the ages of 0 and 15. According to UNHCR, they do not formally meet the definition of a refugee, therefore they have not been provided with status nor assistance.

The Government of Bangladesh provides to the Biharis a rice allotment of 3.25 kg/person/month and in some of the camps, the cost of electricity and water is borne by the Government. As compared to the average Bangladeshi, the quality of life is "better than those living in Dhaka slums because they don't have to pay any rent."[124] Nevertheless, camp conditions are cramped and poor. For example, in Mirpur No 11 Camp, "Bihari families live crammed...There is one latrine for 25 families, [and] little water."[125]

Issues of concern to children, especially girls, include high drop out rates (after getting a job in a garment factory) and early marriage.[126] The frustration of camp life, in particular, the political impasse with the Government of Pakistan is apparent in the refugees, however, the sense of insecurity has not yet manifest itself in destructive activities or violence.[127] As outsiders, Biharis experience discrimination.[128]

---

122 Mostafa Kamal Majumder, "Early repatriation of refugees sought," The Independent [Dhaka] 22 April 1999.

123 Kazi Mahmudur Rahman, "Bihari Refugees in Bangladesh, On Way to Integration?" The Daily Star [Dhaka] 6 May 1999.

124 Ibid.

125 Ibid.

126 Ibid.

127 Ibid.

128 Ibid.

Jummas: refugees from Bangladesh in India and now internally displaced peoples

Following the signing of the Chittagong Hill Tracts (CHT) Peace Accord, more than 50,000 *Jumma*[129] refugees originally from Bangladesh were repatriated from Tripura Sate in India.[130] It is difficult to determine the exact number of returnees. However, according to Dr Abrar, there are unresolved issues between the returnees and the local population (in particular, land disputes): children, because of their vulnerability, are at risk of getting caught in the cross-fire of any violence that may ensue.[131]

6.12 MINORITY CHILDREN

6.12.1 Manifestation

In its Concluding Observations to the Initial State Party Report of Bangladesh, the Committee on the Rights of the Child noted that, *"[d]iscriminatory attitudes towards...children belonging to tribal minorities [is] a matter of concern."*[132]

However, the Government of Bangladesh submission made no reference to the situation of children belonging indigenous groups. The same happened in 1992, when the Government of Bangladesh submitted its initial report to the Committee on the Elimination of all Forms of Racial Discrimination (CERD).[133] That report stated that,

> *"... racially and culturally, Bangladesh has been a melting pot for thousands of years, and today has a completely homogenous population. There is no racial discrimination in Bangladesh, since there is but one mixed race and there are no traces of separate racial identity and prejudices.*[134]

There are reasons to believe that this statement is not factual. In general, indigenous people, especially children, experience a higher incidence of poverty and lower social indicators than the rest of the population. It has been reported to the CRC Committee that, in some extreme cases, children of indigenous groups, particularly girls, have been the specific targets of security forces.

---

129 The Jumma Peoples belong to the Tibeto-Burmese linguistic group and differ distinctly from the mainstream Bengali Muslim population of Bangladesh. Jumma is a pejorative term used by the Chittagonian Bangalis for their shifting cultivation practices, or Jum cultivation. The Chakmas, Marma, Tripura, Khiyang, Lushai, Khumi, Chak, Murun, Bowm and Pankoo are collectively known as "Jummas." (Source: "Alternate Report and Commentary on the First report of the Bangladesh Government to the UN Committee on the Rights of the Child," Jumma Peoples Network, New Delhi, India, 6 April 1996.)

130 "Alternate Report and Commentary on the First report of the Bangladesh Government to the UN Committee on the Rights of the Child," Jumma Peoples Network, (New Delhi, India, 6 April 1996).

131 Dr Abrar, Coordinator, Refugee and Migratory Movements Research Unit, Dhaka University, (12 May 1999).

132 Committee on the Rights of the Child, 15th Session, Draft concluding observations of the Committee on the Rights of the Child: Bangladesh 6 June 1997, Future CRC/C/15/Add.74. Par 15.

133 Bangladesh ratified the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) in 1992.

134 South Asia Human Rights Documentation Centre, "Racial Discrimination: The Record of Bangladesh A Report to the UN CERD Committee, 24 February 1999.

6.12.2 Groups, numbers and location

According to 1991 Bangladesh Population census the size of indigenous population is approximately 1.2 million, constituting 1.13% of country's total population.[135] Chittagong division has the highest number of indigenous groups: 687,319, followed by Rajshahi with 314,337 and Dhaka, with 123,258.[136]

There are about 30 indigenous groups in Bangladesh which are distinctly different for the mainstream Bengali population in culture, tradition language, and religion. The main tribal groups consist of Chakmas, Santals, Marmas, and Tripuras and live in the Chittagong Hill Tracts region of South Eastern Bangladesh. Collectively, they are known as "Jummas" because of their shifting, or "Jum" cultivation. The Chittagong Hill Tracts (CHT) which comprise the southeastern region of Bangladesh includes three hill districts called Bandarban, Rangamati and Khagrachari. Garos and Santals are other major indigenous groups and they primarily live in Dhaka and Rajshahi divisions, respectively.

6.12.3 Status of Hill Children

Little information has been collected in the Chittagoing Hill Tracts, where the bulk of the tribals live. Although a Population Census was conducted in 1991, at that time, approximately 70,000 indigenous Jumma peoples, many of whom were children, had fled to Tripura State in India because of extreme civil and political unrest in the CHTs.[137]

Between 1994 and 1998, however, a "Multiple Indicator Cluster Survey," was prepared by BBS, UNICEF and SURCH on the "Situation of Tribal children and Women in Bangladesh." It contains data that was previously unavailable. In addition, reports from NGOs about the situation of indigenous people, children in particular, contribute to the overall assessment.

Socio-economic data

The people in the Hill Tracts are very poor. Compared to national per capita income (US$ 230) the per capita income of the hill people is US$ 102:[138]

- The literacy rate of the female belonging to indigenous groups in general was about half of the male
- Literacy rates for 7+ years and adults belonging to indigenous groups was 25% and 26% respectively in 1991 as against 32% and 35% for the nation as a whole
- School attendance among 5-9 years old Hill children was 22.5% as against 41%of the national average

Interestingly, only 17.9% of adolescent Hill female are married as compared to 26.3% of the national females.

Data on education for Hill children, however, lags behind the national average:[139] Between 1994 and 1998, it again appears that Hill children lag in net enrollment. However, in terms of attendance, both boys and girls are ahead of the national average:

135 Bureau of Statistics, Bangladesh Population Census, 1991.

136 BBS, UNICEF, SURCH, "Situation of Tribal children and Women in Bangladesh: Evidences from Multiple Indicator Cluster Surveys 1994-1998, p.2.

137 Jumma Peoples Network, "Alternate Report and Commentary on the first report of Bangladesh Government to the UN Committee on the Rights of the Child," 6 April 1996 (New Delhi).

138 CHTDB baseline survey, 1993. This situation is also prevalent in many other disadvantaged resions of Bangladesh.

139 BBS Population Census 1991.

Table 6.8 Distribution of tribal population by enrolment and attendance of children by year (%)

Indicators	All tribal during 1994 -1998					National
	1994	1995	1996	1997	1998	1998
Children net enrolled in school						
Boy	74.0	69.1	65.0	73.3	71.3	80.0
Girl	69.4	61.9	66.3	64.9	68.0	82.9
Attendance in school last 3 days						
Boy	62.5	65.5	64.6	703.3	77.7	70.9
Girl	64.1	71.4	54.9	80.2	77.1	74.7

Source: Situation of tribal children and women in Bangladesh: Evidences from MICS Surveys 1994 – 98, A Draft Report, By BBS, SURCH and UNICEF p.4.

School drop-out rates are also reportedly higher than the national average. In part, fewer children are in school because of an inadequate number of schools. In addition, for the past two decades, the education of Hill children has been frequently disrupted due to conflict in the CHTs. Their right to freedom of expression was also curtailed during the unrest.

The signing of the 25-year-old armed conflict in the Chittagong Hill Tracts (CHTs) on 2 December 1997 has brought optimism to the region, indeed the country as a whole. However, the treaty is still only a statement of intent. The real challenge lies in its implementation.

Health and Nutrition

A large majority of population lives outside the reach of existing health and nutrition facilities which causes high incidence and prevalence of communicable diseases. Malaria is the most prominent among the major killers.

Prior to the signing of the Peace Accord, freedom of movement was often curtailed due to the disturbed situation in the area. This had adverse consequences on Hill peoples' livelihoods and food security, thereby putting children at risk of malnutrition and disease.

Data provided below is from 1994-1998.

Table 6.9 Distribution of tribal population by Maternal and Child Health Indicators by year

Description	All tribal during 1994 -1998					National
	1994	1995	1996	1997	1998	1998
Place of last delivery						
Health Centre	1.2	2.7	1.4	2.7	4.5	6.2
Home delivery	98.7	97.3	98.4	97.3	95.5	93.8
Pregnancy delivered by						
Trained person	16.7	11.9	25.6	18.1	25.7	17.9
Untrained person	88.3	88.0	73.4	81.9	74.3	82.1
Tetanus Toxoid	30.1	80.3	34.9	46.8	50.6	80.2
Pregnancy complications	NA	NA	NA	NA	22.3	67.3
When to seek help for ARIFast/ Difficult breathing	94.3	74.9	73.6	88.3	92.8	92.5
Immunization DPT/Polio						
0 dose	47.8	34.1	24.1	24.1	32.7	11.5
1-2 doses	7.4	12.4	30.7	14.9	19.7	21.0
2+ doses	44.9	53.6	45.2	61.1	47.7	67.5
Immunization Polio						
0 dose	47.8	34.1	24.1	24.1	22.8	8.6
1-2 doses	7.4	12.4	30.7	14.9	24.3	25.0
2+ doses	44.9	53.6	45.2	61.1	52.9	66.0
Immunization Measles	38.7	59.5	67.3	53.2	51.2	70.7

Source: Situation of tribal children and women in Bangladesh: Evidences from MICS Surveys 1994 – 98, A Draft Report, By BBS, SURCH and UNICEF.

Water and Sanitation

Due to peculiar hydrological characteristics in this region (stony layer) tube wells are not successful in most of the areas. As a result most of the people have little access to safe drinking water. More than 90% families have no sanitary latrine.

Table 6.10 Distribution of tribal population by Water and Sanitation practices by year

Type	All tribal during 1996 -98			National
	1996	1997	1998	1998
Source of drinking water				
TW/Tap/RW	63.9	68.4	70.6	97.1
Marsh/Pond/other	36.1	33.2	33.6	4.0
Source of household work water				
TW/Tap/RW	34.3	41.3	30.9	38.4
Marsh/Pond/other	50.7	47.5	53.6	28.3
Type of latrine				
Water seal	6.2	9.7	5.9	11.4
Pit	31.9	40.7	35.6	29.0
Hanging	11.2	4.7	11.3	37.6
Other	50.9	45.2	47.9	27.0
Hand washing material after defecation of children				
Only water	66.2	51.8	40.2	6.1
Water Soap/ Ash/Soil	1.3	6.2	21.3	47.8
Not wash	0.1	7.2	8.4	0.9

Source: Situation of tribal children and women in Bangladesh: Evidences from MICS Surveys 1994 – 98, A Draft Report, By BBS, SURCH and UNICEF.

Protection Rights

Due to the armed conflict situation in the CHTs, the Government of Bangladesh has been reluctant to allow independent human rights monitors into the region. It is expected that, with the signing of the Peace Accord, international observers will be permitted to enter the region and gather data from the tribal peoples about their situation and experiences. Despite the lack of statistical information, data from NGOs, researchers, and others, attests to the fact that tribal children have been frequent victims of the armed conflict situation which has prevailed in the CHTs.

Gender

Interestingly (and as mentioned above) girls of the indigenous community, on average, marry later than their national counterparts. However, in terms of literacy rates, girls lag behind boys belonging to indigenous community and the national average. Girls belonging to indigenous community, in particular, are at risk of violence, sexual abuse, and discrimination.

Legal safeguards

Article 27, 28 and 31 of the Constitution of Bangladesh state that all its citizen irrespective of religion, race, caste, colour, sex, and place of birth are equal before the law and are entitled to protection of the law. This commitment is repeated by adhering to the following Conventions and treaties listed in box below:

- *International Convention on the Elimination of All Forms of Racial Discrimination (ratified by the Government of Bangladesh in 1979)*
- *Chittagong Hill Tracts manual*
- *Peace accord signed on 2 December 1997*
- *1993 International Year of the World's Indigenous Peoples*
- *1995 – 2000 International Decades for World's Indigenous Peoples*
- *The Universal Declaration of Human Rights*
- *ILO Convention on Indigenous and Tribal Population, 1957*
- *Convention on the Rights of the Child*

However, it has been reported that these fundamental guarantees are sometimes violated. [140]

6.12.4 Trends

On 2 December 1997, the Parbattay Chattagram Jana Samhati samity – PCJSS and the Government of Bangladesh signed a Peace Accord which aims to resolve the 25 years armed conflict in the Chittagong Hill Tracts. The Chittagong Hill Tracts Regional Council was officially launched on 27 May 1999. The Accord has yet to be implemented in entirety. While UNICEF has been active in the area for several years, UNDP, World Bank, DFID, Danida, ADB and NGOs are among interested organisations expected to assist in the development of CHT. A UNDP needs assessment mission recently worked in the region to assess the needs of the stakeholders of the CHT region. The mission identified immediate, short and long-term needs, which will both directly and indirectly assist children belonging to indigenous groups.[141]

Children living in hard to reach areas

Children living in char lands, haor and baor have little access to education health care facilities due to the fact that these areas are inaccessible. These areas do not have primary education or primary health care centers. The literacy rate in these areas is low. Trained education personnel are not available in these areas. Maternal health care is poor, as trained health personnel are not willing to stay on. Infant mortality rate is high caused by prevalence of water borne diseases There is a paucity of safe drinking water in these areas. Proper sanitation is not available. Life is insecure for these children, as their families have no legal rights over the land and other resources they use to maintain their livelihood.

140 Bangladesh Manobadhikar Samonnoy Parishad, State of Human Rights 1994 Bangladesh, Dhaka 1995 [in South Asia Human Rights Documentation Centre, Racial Discrimination: The Record of Bangladesh a Report to the UN CERD Committee 24 February 1999, p. 21].

141 "Support for the Chittagong Hill Tracts Peace Accord, Findings and recommendations of a UNDP-sponsored Mission" (UNDP, Dhaka) 14 May 1999.

6.13 RIGHTS OF CHILDREN WITH DISABILITIES

6.13.1 Manifestation

In its Concluding Observations to the State Party report of Bangladesh, the Committee on the Rights of the Child noted the following:

> *"Discriminatory attitudes towards...children with disabilities...is...a matter of concern (Par 15). The lack of a national policy to ensure the rights of children with disabilities is noted. Additionally, the Committee is concerned at the absence of psychological programmes addressing the mental health of children and their families (Par 20). Efforts are also required for the prevention and treatment of children with disabilities and to raise awareness about the need to facilitate the active participation of such children in the community, in the light of article 23 of the Convention. The Committee also encourages the State party to pursue efforts required to ensure the implementation of integrated mental health programmes and approaches and that resources and assistance be devoted to these activities (Par 42)."*[142]

The Bangladesh Constitution provides for equality for all, however, it makes no specific mention of the rights of disabled citizens, including disabled children. The Government adopted a National Policy for the disabled persons in 1995. There has been little follow up action and very little public awareness regarding the policy itself.

Disabled children are generally regarded as a burden. Parents and families are reluctant to accept the disability of their members and signals sent to the disabled child often lead him or her with the feeling of being *inferior,* and can feel neglected and isolated. Instead of receiving intense and /or special care, the child is made to feel marginalised. Not only does this undermine the chances of maintaining, improving or preventing a further deterioration in the child's condition, but also it can undermine his/her self-esteem.

Outside the private sphere, segregation and discrimination continues. The negative attitude society in general holds towards disabled children results largely from ignorance about disability, and fear and superstition.

Numbers and Statistical Data

It is unknown how many people in Bangladesh live with disabilities: no comprehensive national survey has been undertaken. WHO estimates that 10% of the world's population is suffering from one or more types of disability, which suggests that Bangladesh has over 12 million disabled people.[143] Based on two surveys in 1982 and 1986, the Government estimates the national prevalence rate of disability to be 0.64% and 0.52%, respectively. The Bangladesh Bureau of Statistics (BBS) statistical yearbook for 1995 showed the national rate to be 1.06%. As shown below, according to the BBS (1996), 1.26% of children age 14 (with a higher incidence among 5-14 year-olds) are disabled:

142 UN Committee on the Rights of the Child, 15th Session, "Draft concluding observations of the Committee on the Rights of the Child: Bangladesh," Future CRC/C/15/Add.74, 6 June 1997.

143 The Daily Star [Dhaka] 7 April 1999, p. 9.

Age Specific National Child Disability Rates Per 1000 Population

Age 0-4 years	*4.3*
Age 5-14 years	*8.3*
Age 15-49 years	*10.2*

(Source: Bangladesh Bureau of Statistics, Survey Findings, 1996 p.17)

However, an 1996 ACTIONAID Bangladesh (1996) survey among 47,000 people found a higher rate of 1.4%.

Disabilities, for example, night blindness and goitre, are preventable and could have been avoided with adequate vitamin A, and iodine. Factors like lack of nursing, high fertility rates and malnutrition increase the chances and degree of disability. Another factor is marriages between blood relations. People from all classes are unaware of causes, condition and treatment of disabilities.

Gender

No research or study indicating gender differences with regard to disabilities was found. NGOs working with disabled children report that girls with disabilities are more likely than their male counterparts to be hidden from society and the public eye. Disabled girls are considered to be a double misfortune that may bring bad luck to the marriage prospects of other females in the family. As compared to disabled boys, disabled girls are less likely to be sent to school and seldom get an opportunity to be married.

6.13.2 Services

It is difficult to get a grasp of all programmes and activities being undertaken by different organizations working with the disabled. Of the 12 million disabled people in Bangladesh, 3 to 3.5 million are school-going age children of whom the Social Welfare Department and a variety of non-governmental organizations are providing special education for an estimated ten thousand.[144]

For Visually Impaired Children;

As part of its "Integrated Education Programme," the Ministry of Education holds 10 seats/places for visually impaired[145] children in government schools in each of the 64 districts in the country.

- 188 pupils regularly attend the 64 integrated programmes run by the Department of Social Services (DSS). The total available number of participants is 640. A further 101 attend the programmes irregularly (less than 3 times a week).
- 50 pupils attend the 5 integrated education programme run from Baptist Sangha School for Blind Girls.
- 100 pupils attend Baptist Sangha School for Blind Girls, in Dhaka (Mirpur). The Baptists have other branches across the country.

144 Bangladesh Observer, 3 December 3 1998, p.12.

145 Source: Helen Keller International Bangladesh, "Integrated Education Programme for Visual Impairment Report Assessment (March 1999) [Preliminary/Draft Report of assessment undertaken in December 1999].

- 150 children attend 5 government "special schools" in 5 division towns (in Dhaka, Chittagong, Khulna and Rajshahi and Barisal).
- 30 children attend the integrated education programmes run by the Salvation Army (Schools exist across the country in main cities).

For the Mentally Retarded, there is the following;

- one government school, 45 schools and 21 units existing in regular schools- all NGO-sponsored and operated.
- the 'Society for the Care and Education on the Mentally Retarded Bangladesh (SCEMRB)' has 63 schools with space for about 2,564 students country-wide.
- the Bangladesh Protibondhi Foundation has developed a distance-training package from which 3,000 students are benefiting.

For the Hearing Impaired, there are;

- seven special schools run by the government.
- 23 schools run by NGOs and 2 integrated units for the hearing impaired. Approximately 1,300 hearing impaired children are being educated.

6.13.3 Trends

In the absence of comprehensive data on disability, there is no indicator to determine trends. However, it may be assumed that increasing poverty coupled with crowding, and lack of safety and preventative measures, the trend is toward an increasing incidence of disabled children.

6.14 RIGHTS OF ADOLESCENTS

6.14.1 Priority concerns for participation, development and protection

In Bangladesh, adolescents between the ages of 10 and 19 years number 27 million, which constitutes about 23% of the total population.[146] About 48% of them are females and 52% are males.[147] This is significant, not only because of their numbers, but also because they are among the most vulnerable, and as yet, largely overlooked segments of the population.

As stated in Article 12 of the Convention on the Rights of the Child (CRC),

> *"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."*

This fundamental right to participation, which is pertinent to adolescents is still inadequately addressed in Bangladesh. As noted by the Committee on the Rights of the Child in its Concluding Observations to the Initial Report of Bangladesh,

146 Ministry of Health and Family Welfare, Government of Bangladesh, "Adolescent's Health and Development: Issues and Strategies," Country Report South Asia Conference on Adolescents (New Delhi 21-23 June 1998) p.9.

147 ibid.

"The Committee wishes to encourage the State party to facilitate children's participation and the respect for their views in decisions affecting them (Par 36)."[148]

Nearly half the population of adolescents in Bangladesh is illiterate. Even among those who go to school, the proportion of boys is much larger than that of girls. Statistics indicate that over 70 percent of males and nearly 60% of females between the ages of 15 and 18 years are employed. By the age of 18 years, over 60% of girls are married and many of them have already borne a child. There is an urgent, and as yet, largely unrealised demand for information on reproductive health, sexually transmitted diseases (STDs) and HIV/AIDS, and drug and substance abuse. In particular, there is little child specific information on these topics. Nevertheless, from the data collected thus far, it would appear that children, especially adolescents are sexually active and are engaged in potentially risky behaviour (in particular, using drugs and other illegal substances). For example, in a study of street boys in Bangladesh and India, it was found that they became sexually active between the ages of 7 and 9 years.[149] Newspaper reports note an alarming increase in drug abuse among students and youth.

In the following survey, two priority areas of concern: the situation of drug and substance abuse and HIV/AIDS among youth in Bangladesh will be assessed.

6.15 DRUGS AND SUBSTANCE ABUSE

6.15.1 Manifestation

Apart from data collected from rapid assessment studies of selected cities, gathered from drug rehabilitation centres, studies on specific population groups, specific drugs and newspaper reports, a national figure for the level of drug and substance abuse (for example, alcohol) amongst youth and adolescents does not exist.

Youth, especially adolescents and young people, are at risk of drug and substance abuse. . Seventy percent of the addicts in the Central Drug Addiction Treatment Centre are between the ages of 16 and 35 years and according to a 1989 study of 4931 students, 68% of male respondents between 15 and 19 years reported they used drugs.[150] This is, in part, because of the many pressures youth experience at this critical time in their lives: peer pressure, and curiosity and experimentation, frustrations, and unemployment. Also alarming is the fact that the popularity of injectable drugs, often taken with shared needles, has implications in terms of the spread of HIV/AIDS amongst the young population.

It is important to point out that most experts, organisations and individuals working in the area of drug abuse would agree that the accurate picture of drug abuse in Bangladesh is significantly higher than the reported cases would otherwise indicate. Moreover, the vast number of stories that appear in newspapers on the problem of drug abuse pertain to urban areas; it is therefore difficult to get an accurate picture of the extent of the problem in rural areas

148 Committee on the Rights of the Child, 15th Session, Draft concluding observations of the Committee on the Rights of the Child: Bangladesh Future CRC/C/15/Add.74, 6 June 1997. Par 36.

149 SCF-UK, HIV/AIDS and Children: A South Asian Perspective (Kathmandu: SCF-UK Office for South And Central Asia Region, March 1998) p. 12.

150 "Drivers responsible for 60 pc road mishaps," Independent [Dhaka] 17 May 1999 and Mokerrom Hossain, A Rapid Assessment Study on Bangladesh Drug Abuse Situation (Dhaka: UN International Drug Control Programme, October 1997) p. 17

Extent and Pattern of Drug Use

Bangladesh is geographically situated close to the Golden Triangle and Golden Crescent (which play a significant role in opium production and heroin conversion) and has many porous borders. These conditions would therefore suggest that the smuggling of illegal drugs has the potential of being a significant problem in the country.

SCF-UK estimates that at least 100,00 drug addicts in Bangladesh are using brown sugar heroin, usually smuggled in from India.[151] Phensidyl, an addictive (and illegal) cough syrup, is also smuggled in large quantities into Bangladesh from India. In addition to smuggling, some drugs are freely available. For example, in Bangladesh, 90% of intravenous drug users use buprenorphine (a synthethic opioid which is available without a prescription).[152]

6.15.2 Groups Affected and Age

From the data presented below, it would appear that drug and substance abuse cuts across all socio-economic levels, however, with several exceptions, there does appear to be a direct correlation between the type of substance/drug used and one's economic status.

"Thirty-seven per cent of all drug takers are students of whom 15 per cent are addicted to heroin and phensidyl syrup, 16 per cent to pathedrine injections, six per cent to hashish and 3 per cent to alcohol."[153]

According to the International Drug Programme, *"drug taking is rife among the educated class. Some 4,40,000 of this class, a third of them students, are taking a wide range of drugs."*[154] ("Students" generally refers to university-going youth, who are between the ages of 16 and 23 years).

According to the Central Drug Addiction Treatment Centre, the characteristics of its clients (673 clients, including one female, between the ages of 16 and 35 years) are as follows: heroin was the most frequently abused drug, the majority were unmarried and between the ages of 20 and 34 years.[155] Moreover, 70% of the addicts in the Centre were between the ages of 16 and 35 years, of whom 34% were unemployed and 23% small traders.[156]

According to a study undertaken in Pabna district, students comprise a significant number of the 50,000 identified drug addicts in the area:

> *Students of schools and colleges, transport workers and unemployed youths have become addicted to heroin, phensidyl and hemp in Pabna town and several outlying areas.*[157]

The study also stated that over the past 15 years, 1000 youth have died due to heroin addiction.[158] Purchasing these types of drugs is not difficult: "in the shops around various educational institutions, heroin, phensidyl and

151 Save the Children (UK), HIV/AIDS and Children: A South Asian Perspective (Kathmandu: SCF-UK, March 1998) p.19.

152 UNDCP Regional Office for South Asia, South Asia Drug Demand Reduction Report (New Delhi: UNDCP ROSAP, 1998) p.205.

153 Ibid.

154 Ibid.

155 Mokerrom Hossain, Ibid.

156 Ibid.

157 Ranesh Maitra, "Over 50,000 drug addicts detected in Pabna," Daily Star [Dhaka] 8 May 1999.

158 Ranesh Maitra, Ibid.

hemp are on open sell."[159] Also, shops near bus stands, bus terminals, ferry-ghats, railway stations and junctions also sell the drugs.[160]

In FN Khan's 1988 study, 115 students surveyed, heroin was fifth most used drug and is readily available in many dens in Dhaka city and 66.6% of abusers used multiple substances.[161] Pethedine was found to be the sixth most frequently used drug. Both heroin and pethedine were taken intravenously, thereby increasing the chances of contracting HIV/AIDS through infected needles.[162]

Reasons

According to the findings of a 1988 study, in which 115 students of Dhaka Medical College were surveyed:

- Youth with wealthier and well-educated parents were associated with greater tendency for drug abuse
- Abusers were more likely to respond that their parents were inattentive, have a pessimistic view of the future and report frustrations in life
- Curiosity is the most common reason for initial use, and occurs at about 20 years of age
- 92.5% of abusers were well aware of the harmful effects, and 90.5% admitted that it adversely affects their lives.[163]

The period of adolescence is a critical time in a young person's life: decisions taken at this stage can have a permanent and irreversible impact on the rest of one's life. Reasons for taking drugs and/or engaging in substance abuse include; peer pressure, and curiosity, frustrations, and unemployment.

6.15.3 Gender/Ethnicity

Drug and substance abusers are overwhelmingly male, however; a large number of women are becoming users, addicts, and even drug traders. As quoted in a recent article,

*"...a large number of men and **women [our emphasis]** have been ferrying the drugs in different localities before the very nose of police."*[164]

While no data exists regarding the correlation between drug and substance use and membership in a specific ethnic group, it would appear that amongst the hill people in the Chittagong Hill Tracts, drug cultivation is taking place. According to a newspaper report, the higher incidence of poverty of ethnic peoples in that part of the country (in addition to its proximity to the border with Myanmar) makes these groups of people more susceptible to the appeal/coercion by drug traders to cultivate opium.[165]

---

159 Ranesh Maitra, Ibid.

160 Ranesh Maitra, Ibid.

161 FN Khan, "A Study on the Problem of Alcohol and Drug Addiction Among the Students of Dhaka Medical College," (1988) in Amy Gale Dunston and Naila Sattar, A Literature Review of Behavioural Factors related to the Spread of STDs and HIV/AIDS in Bangladesh (Dhaka: UNICEF, 1993) p.36.

162 Amy Gale Dunston and Naila Sattar, Ibid.

163 Amy Gale Dunston and Naila Sattar, Ibid.

164 Ranesh Maitra, Ibid.

165 "Army seizes large quantity of drugs from CHT region, Independent [Dhaka] 18 May 1999.

Location

According to a newspaper report, *"[m]ore than half of the drug users buy their drugs in slum areas, mostly located in the cities."*[166] *"A senior police official said about half of the drugs in the capital are being traded through slums. More than 60 per cent of their total seizure of drugs are from slum areas, the official added."*[167] In Pabna district, however, drugs are freely sold in shops around schools and colleges, bus stands, ferry-ghats, railway stations and junctions.[168] According to one journalist, drugs are available inside Pabna's district jail.[169]

Therefore, from the data gathered, it would appear that the availability of drugs is not strictly limited to slum areas, but in fact, drugs are widely available in urban areas, near schools, in slums, in and around bus and train depots and in border areas. Little is known about the extent and nature of trading in rural areas of the country.

6.15.4 Control and Prevention

The only government organisation responsible for "de-addiction services" is the Department of Narcotics Control (DNC).[170] The National Narcotics Control Board (NNCB), the highest policy making body created under the provision of the Narcotics Control Act 1990, is tasked with the responsibility for framing policies for law enforcement.[171] Currently, however, "[a] comprehensive policy guideline...for drug abuse control is non-existent."[172]

Current government capacity to address the problem of drugs –from the preventative side is inadequate. The Director General of the DNC said there are only 1274 sanctioned posts across the country, which is insufficient to combat the drug trade.[173] "Some 350 posts are currently vacant and we have shortage of logistics and equipment but the drug traffickers are well organised and well equipped."[174] "We have only one official for every 10,000 drug users," he said.[175]

Data on drug-related arrests and drug seizures is being collected by the Department of Narcotics and Control. In Dhaka city alone, arrests have increased 81% since 1991 (however, this information is not broken down by age). In 1990, drug-related arrests were under 1600, in 1995, that number topped 2600 arrests.[176]

---

166 "Drivers responsible for 60 pc road mishaps," Ibid.

167 "Drivers responsible for 60 pc road mishaps," Ibid.

168 Ranesh Maitra, Ibid.

169 Ranesh Maitra, Ibid.

170 UNDCP Regional Office for South Asia, South Asia Drug Demand Reduction Report (New Delhi: UNDCP ROSA, 1998) p.258.

171 Dr Syed Kamaluddin Ahmed, "Drug Abuse Control in Bangladesh: Need for a Policy Document," [no date].

172 Dr Syed Kamaluddin Ahmed, Ibid.

173 "Drivers responsible for 60 pc road mishaps," Ibid.

174 "Drivers responsible for 60 pc road mishaps," Ibid.

175 "Drivers responsible for 60 pc road mishaps," Ibid.

176 Mokerrom Hossain, A Rapid Assessment Study on Bangladesh Drug Abuse Situation (Dhaka: UN International Drug Control Programme, October 1997) p.19.

In the 1980s, Bangladesh introduced preventative topics in school textbooks, including those for language, social studies and religion for grades 4 to 10.[177] Published by the National Curriculum and Text Book Board for the use of government schools, the content covered alcohol, tobacco and other drugs.[178] Currently, under the Master Plan for Drug Abuse Control in Bangladesh, the GOB has undertaken a "Sector Plan of Preventive Education and Information."[179]

In addition, the Bangladesh Army, "as part of its public welfare and motivation programme has launched a campaign to familiarise local people about the harmful effect of drugs and its abuses."[180] This appears to have been prompted by the discovery, between March and May 1999, of a large quantity of drugs in the Chittagong Hill Tracts region of Bangladesh. Allegedly, drug traders had taken advantage of the poverty in the hill region to encourage them to cultivate the drugs.

Regionally, members of SAARC, have attempted to develop a drug prevention core curriculum for its members.[181]

In addition to Bangladesh Anti-drug federation of NGOs (established on 25 October, 1990, and recognized by DNC)ADF, on 1 September 1996, the National Coordination Council of Anti-Drug NGOs (NCCADN), with its secretariat at VHSS, in Dhaka, was established.[182] Its' main objectives are to organise forums of drug and substance abuse, and increase the capacity of NGOS in community prevention of drug and substance abuse through training of trainers.[183]

6.15.5 Legislation

The Narcotics Control Act, 1990

penalties for drug abuse and trafficking vary according to the type of drug and quantity found on person (from a minimum 2 years to death sentence or life imprisonment)

Treatment and Rehabilitation

Drug rehabilitation centres exist in Bangladesh. Some of the facilities and services provided include primary treatment, halfway homes for aftercare, drug awareness and outreach programmes in the community. Some of the services are provided at no cost to the patient, and others can be expensive. From the data gathered, it would appear that centres are concentrated in urban areas, in particular, Dhaka.

177 UNDCP Regional Office for South Asia, Ibid.

178 UNDCP Regional Office for South Asia, Ibid.

179 UNDCP Regional Office for South Asia, Ibid.

180 "Army seizes large quantity of drugs from CHT region," Ibid..

181 UNDCP Regional Office for South Asia, South Asia Drug Demand Reduction Report, Ibid.

182 UNDCP Regional Office for South Asia, South Asia Drug Demand Reduction Report (New Delhi: UNDCP ROSA, 1998) p.182.

183 UNDCP Regional Office for South Asia, Ibid.

Child, Women Relief and You (CWRY) a human rights NGO in Gulshan, Dhaka also operates a drug rehabilitation centre and 24-hour drug help line.. Services are free, however space is limited. In 1990, when it started admitting patients to its treatment programme, 6 adolescents were admitted (either by their parents/guardians or on their own volition) and received treatment (aged between 14 and 19 years).[184] In 1995, the number of admitted youth was 61, in 1996, the number was 60, in 1997, only 22 and in 1998, 56 were admitted and received treatment.[185] Amongst very poor youth, ganja and phensidyl are the most commonly abused drugs; amongst middle class youth, many of whom are secondary or university students, alcohol and heroin are more commonly abused.

While facilities do exist for some addicts, in Pabna district, parents and guardians of drug addicts, for lack of alternatives, are urging:

> *Police authorities to arrest their drug addicted wards and detain [them] under the prison-bars. Many other guardians have approached the lawyers to start cases against such wards. They were so much tortured by the addicted wards that they were compelled to take such measures against their sons or daughters.*[186]

6.15.6 Trends

From the studies gathered, however; it appears that drug abuse and addiction is a growing problem in Bangladesh As an example, in 1983, heroin was reportedly first available in Bangladesh and by 1996, the number of reported heroin addicts reached 400,000.[187]

Drug addiction among youth, especially a noted increase in the number of female drug and substance abusers is on the rise. Apart from the detrimental impact drug and substance use and addiction have on one's health and economic opportunities, the direct consequences also include an increase in the spread of HIV/AIDS (through contaminated needles), and an increase in crime rates (increasing need for money to purchase drugs).

6.16 HIV/AIDS

6.16.1 Manifestation

In Bangladesh, very little reliable data exists on the number of HIV/AIDS cases among the general population, let alone among children. In fact, according to the Ministry of Health, 12 persons have tested positive for HIV/AIDS (6 of whom have already died, of which one was a child, and the remaining 6 were suffering from TB and in critical

184Statistics from Child, Women Relief and Youth (CWRY), House #2, Road #49, Gulshan-2, Dhaka.

185 Statistics from Child, Women Relief and Youth (CWRY), Ibid..

186 Ranesh Maitra, "Over 50,000 drug addicts detected in Pabna," Daily Star [Dhaka] 8 May 1999.

187 University Campus, a monthly publication, No 5, December 1997.

condition).[188] From an AIDS Day newsletter published in 1998, the Ministry of Health and Family Welfare reported 105 people had tested positive for HIV/AIDS.[189] This official figure, however, under-estimates the real scope of the problem in Bangladesh. According to the World Health Organisation (WHO) and UNAIDS, at the end of 1997, the number of HIV-infected individuals was 21,000.[190] Of that, it was suspected that 31% are between the ages of 16 and 30 years.[191] However, the number of cases of sexually transmitted diseases (STDs) "which offer a safe hinterland for HIV infection" was 2.3 million by the early 1990s.[192]

Most disconcerting, very few youth in Bangladesh (especially rural youth) have access to reliable and accessible information about HIV and STDS and given access to the means of prevention. The knowledge level of adolescents about HIV/AIDS and STDs is very poor: 64% cannot identify the symptoms of HIV/AIDS and 48% of men cannot identify the symptoms of an STD.[193] A random survey of 216 urban adolescent girls found that 38.4% had no idea about HIV/AIDS.[194]

In another case, a questionnaire administered to 50 students in each of the three private and government universities in Dhaka (to which a total of 136 responded) showed that all but one of the respondents had heard of AIDS.[195] However, 13% did not know that using condoms during sexual intercourse and clean needles for injections would help reduce transmission.[196]

As summed up in "Behavioral Research and HIV/AIDS in Bangladesh. A Critical Analysis,"

> *"Adolescents or young people are the most neglected section of society with regards to access to information and services regarding sexual health; the situation is ironic given that events like menarche, coital experiences, marriage and access to health behaviour services (like PHC and FP/MCH) occur during the adolescent period."*[197]

It is difficult for many policy makers, service providers and parents to acknowledge that children, especially adolescents, are sexually active and at risk of infection and transmission. Moreover, sexual matters are regarded as taboo, especially with children.[198] This is despite the fact that students account for 50% of STDs and 80% get them from commercial sex workers.[199]

---

188 Ministry of Health and Family Welfare, 1 December 1998 [newsletter] and discussion with VHSS, 12 May 1999.

189 AIDS Day Newsletter, 1998.

190 UN Head of Agencies, "AIDS Presentation," [handout] 15 November 1998.

191 "21,000 were HIV positive by 1997 in Bangladesh," Financial Express, 2 December 1998.

192 Dr M Tawhidul Anwar and Dr Nazma Kabir, A Draft Report Situation Analysis of HIV/AIDS BCC in Bangladesh August 1998, p.1.

193 Anwar and Kabir, Ibid.

194 data from Khan Foundation, Dhaka, Bangladesh, May 1999.

195 Bloem, MA, Barua, E, Gomes JV and Karim D, "Behavioral Research and HIV/AIDS in Bangladesh. A Critical Analysis," 4th International Conference on AIDS in Asia and the Pacific, 25-29 October 1997, Manila Philippines, p.14.

196 Bloem, Barua, Gomese and Karim, "Behavioral Research and HIV/AIDS in Bangladesh. A Critical Analysis," 4th International Conference on AIDS in Asia and the Pacific, 25-29 October 1997, Manila Philippines, p.14.

197 Bloem, Barua, Gomese and Karim, "Behavioral Research and HIV/AIDS in Bangladesh. A Critical Analysis," 4th International Conference on AIDS in Asia and the Pacific, 25-29 October 1997, Manila Philippines, p.13.

198 SCF-UK, HIV/AIDS and Children: A South Asian Perspective (Kathmandu: SCF-UK Office for South and Central Asia Region, March 1998), p.3.

199 Parveen Ruma, "Sepulchral silence," Weekly Dhaka Courier, 25 December 1998.

From the data collected it is evident that youth in Bangladesh are engaged in risky sexual behaviour and without enough access/power to information that might lead them to alter their activities.

6.16.2 Reported Cases

The HIV/AIDS epidemic has not yet emerged as a serious problem in Bangladesh, however; this is likely because many cases are undocumented or focus mainly on specific at-risk population groups.

For example, UNAIDS, with the approval of the Government of Bangladesh, has contracted the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) in 1998 to establish a National Sentinel Serological and Behavioural Surveillance for HIV and syphilis in the country. However, the groups being studied include brothel-based sex workers, floating sex workers, STD patients, truckers, injecting drug users and "Men having Sex with Men.".[200]

Nevertheless, UNAIDS and WHO data on Bangladesh is as follows for the end of 1997:

Adults (15-49 years)	21,000
Women (15-49 years)	3,100
Children (0-15 years)	270

Source: UNAIDS and WHO Bangladesh, 1998.

- *The estimated number of AIDS cases in adults and children that have occurred since the beginning of the epidemic (late 1980s): 4900.*
- *The estimated number of deaths due to AIDS (including children): 4,200 and during 1997, 1,300 adults and children died of AIDS.*
- *The estimated number of orphans (children under 15 years who have lost their mother or both parents to AIDS): 810.*
- *The estimated number of children who have lost their mother or both parents to AIDS and who were alive and under age 15 years at the end of 1997: 720.*

(Source: UNAIDS, WHO 1998)

According to *HIV/AIDS and Children: A South Asian Perspective* (March 1998), in Bangladesh the;

- *first reported case of HIV/AIDS occurred in 1989.*
- *cumulative number of reported HIV cases: 85 (as of 30 December 1997)*
- *% of total population infected: 0%*
- *reported number of children (up to the age of 19 years): 3*
- *future projection by year 2000: 300,000*

(Source: Save the Children UK, HIV/AIDS and Children: A South Asian Perspective (Kathmandu: SCF-UK, March 1998), p 9.

200 UN Head o f Agencies (meeting notes) Dhaka, 15 November 1998.

As previously mentioned, in Bangladesh, incomplete and under-reporting of HIV/AIDS cases is a problem. For every case of HIV reported, WHO estimates that the number of infected persons could be between 100 and 5,000 depending on the accuracy of the original reporting. Therefore, the estimated number of HIV infected children in Bangladesh (based on WHO's 'HIV estimates formula' is as follows:

6.16.3 Groups Affected and Location

According to a study on sexual behaviour undertaken by the Bangladesh Chapter of Population Council, the rate of premarital sex among unmarried adolescents is high. Moreover, a national survey of STDs indicated that almost 50% of cases were of students under 25 years of age.[201]

> "Of 216 urban adolescent girls interviewed in Dhaka in early 1999, 20.8% surveyed had engaged in pre-marital sex; 62.4% of those sexually active girls were using contraception; and 39.4% of all the adolescents interviewed did not know what contraception was.[202] Fully 85.6% claimed a need for sex education and reproductive health services, however, 90.7% were not receiving any services from either NGOs or Government." [203]

A key factor enabling the transmission of HIV/AIDS is mobility: "Extremely mobile groups such as travellers, fishermen, truckers and migrant workers tend to have high HIV prevalence. These groups are reported to be exploiting children."[204]

A research project on street children in Bangladesh indicated that street boys become sexually active between the age of 7 and 9 years.[205]

According to a UNAIDS newsletter, 42% of HIV positive individuals are migrant workers and housewives, commercial sex workers and infants born to HIV-positive mothers together account for 22% of HIV/AIDS cases.[206]

Professional blood donors (PBDs) are another high –risk group in Bangladesh. According to a 1996 study, ¾ of PMDS had multiple sex partners, most of whom were commercial sex workers.[207] Over 1/5 of PBDs had been selling blood "knowing that their blood was positive for syphilis and hepatitis B respectively." Given their high risk behaviours, and unsafe sex practices, the study concluded that there is a high chance that PBDs will acquire and transmit STDs and HIV/AIDs. While the age group of the PBDs were not specified, children will inevitably be adversely affected by this situation.

---

201 The Independent (Dhaka), 8 January 1999.

202 Data from the Khan Foundation, Dhaka, Bangladesh, May 1999.

203 Ibid.

204 SCF-UK, HIV/AIDS and Children: A South Asian Perspective (Kathmandu: SCF-UK Office for South and Central Asia Region, March 1998), p.16.

205 SCF-UK, HIV/AIDS and Children: Ibid.

206 UNAIDS newsletter, Bangladesh no. 1 1995.

207 Study by Hossain Sharif Md Ismail et al "Are We Intentionally Spreading STDs and HIV/AIDS? A Lesson Learnt from Professional Blood Donors," 1996 Dr M Tawhidul Anwar and Dr Nazma Kabir, A draft Situation Analysis of HIV/AIDS BCC in Bangladesh (August 1998) p.76.

In addition to contraction through heterosexual sex, a study undertaken in 1985 and 1997 indicated that male homosexual practices were prevalent among youth in Bangladesh and increasing. The findings of the 1997 study indicated that there is a high-risk behaviour among this group. Of a sample study of 530 homosexual males, the rate of condom use was very low: 66.23% had never used a condom and 27.54% had used one "sometime."[208]

Response

In October 1995, a National AIDS Committee (NAC) was established (and reconstituted in 1988). The NAC acts as an advisory body to the Ministry of Health and Family Welfare on all aspects of HIV/AIDS. In the Health and Population Sector Programme for 1998-2003, a component on "reproductive health care with prevention and control of STDs, HIV/AIDS and adolescent care" was included.[209]

In May 1997, the Government of Bangladesh approved the National Policy on HIV/AIDS and STD related issues. The government, NGOs, community representatives and development partners in Bangladesh developed a "Strategic Plan for the National AIDS Programme of Bangladesh for 1997-2000."[210] In addition to government efforts, the United Nations established its own "Joint United Nations Programme on HIV/AIDS (UNAIDS) in Bangladesh" for 1998.[211]

Since 1989, there has been an annual nationwide observance of World AIDS Day by both the Government of Bangladesh and NGOs.

6.16.4 Gender

Physically, girls and women are more likely than men to be infected with HIV through heterosexual sex because the lining of the vagina is very receptive to the virus.[212]

Apart from female's physical vulnerability, she is also vulnerable to HIV/AIDS due to her relative social and economic weakness in Bangladesh society. Her inferior status limits her ability to exercise control over her life. She is often married at an early age (by 18 years, over 60% of girls in Bangladesh are married), and becomes completely dependent on her husband for her survival. This power relationship, which puts the women at a disadvantage, has adverse consequences on her ability to determine the terms on which she and her husband have sex, whether a condom is used, or whether her partner is faithful.[213]

Many prostitutes, even if they are aware of the importance of using a condom, are unable to convince their client to do so. For example, in a recent study of 466 sex workers in Bangladesh, 95% had contracted genital herpes, mostly from their clients, while 60% had syphilis (HIV/AIDS was not detected).[214] Those with STDs are physically

208 SCF-UK, Ibid.

209 Dr M Tawhidul Anwar and Dr Nazma Kabir, A Draft Report Situation Analysis of HIV/AIDS BCC in Bangladesh August 1998, p.2.

210 Dr Shah Md Mahfazur Rahman, "World AIDS Campaign with Young People," Bangladesh Observer 18 December 1998.

211 UNAIDS Bangladesh, "UN Response to AIDS/STD in Bangladesh 1998 Workplan UN Theme Group on HIV/AIDS," (Dhaka: UNAIDS Bangladesh, March 1998) P.2.

212 UN Head of Agencies, AIDS Presentation, Dhaka, 15 November 1998.

213 SCF-UK, Ibid.

214 Shakeel A I Mahmood, "Young People and HIV/AIDS in Bangladesh," Daily Star 8 January 1999.

more susceptible to contracting the HIV/AIDS virus. It is believed that there are more than 100,000 commercial sex workers in Bangladesh, almost half of whom are commercially exploited **children [our emphasis].**[215]

Street girls, especially those who live and work on the streets, are also particularly vulnerable to sexual abuse, rape and exploitation.

6.16.5 Interventions

In terms of testing for HIV/AIDS, Bangladesh currently has 7 facilities where the tests may be undertaken. All of them are situated in urban areas: Dhaka (4), Sylhet, Khulna, Chittagong.[216] No facilities are known to exit in rural areas.
No data was collected on the forms of treatment available and provided for patients with HIV/AIDS.

In Bangladesh, many NGOs have recognised the need for HIV/AIDS and STDs prevention through a variety of educational and intervention programmes. Many such organisations have targeted their activities at specific high-risk groups, for example, commercial sex workers, intravenous drug users, truckers, and garment workers. Children, especially adolescents, participate in each of these economic activities.

With respect to garment factory workers, of whom the majority are young women, several NGOs have organised integrated health programmes, provide STD services and distribute condoms, and educate workers on HIV/AIDS and other health services. Working specifically with Adolescent Girls, several NGOs carry out awareness raising programmes with STD or health care services.

Several national and international NGOs are working with street children to assess their vulnerability to HIV/AIDS and STDs. They also provide for drop-in centres and health care services and basic information on HIB/AIDS and preventative knowledge.

6.16.6 Trends

A survey undertaken by the AIDS Prevention and Control Programme shows that while Bangladesh has a low HIV prevalence as compared to other South Asian countries, it possesses the risk factors which could result in an "explosive...epidemic."[217]

As explained by Joint Secretary Khandoker Mizanur Rahman, "the large and varied turnover of customers of the commercial sex industry, rising number of injectable drug users, and increasing volume of migrant workers are the risk factors for spread of HIV/AIDS in Bangladesh."[218] The high rate of STDs (which increases one's vulnerability and susceptibility to contracting and spreading HIV/AIDS) is another indicator of Bangladesh's vulnerability to an AIDS epidemic.

---

215 SCF-UK, Ibid.

216 R A Raju, Nari O AIDS [booklet] 1997.

217 Shamsul Amin Shamim, "The spectre of AIDS," The Independent [Dhaka] 21 December 1998.

218 Shamsul Amin Shamim, Ibid.

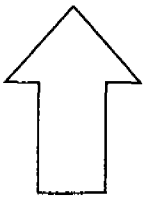
The general public remains largely unaware of the problem and preventative actions. Social stigma and ignorance about the disease, methods of contraction and prevention are still low. Moreover, HIV/AIDS, sex and sexuality remain taboo subjects, and many parents, teachers, service providers and NGO staff are reluctant to discuss such sensitive issues, especially with young people whom they assume are not engaging in risky behaviour.

6.17 ANALYSIS OF CAUSATIVE FACTORS

Having considered the key elements of Protection, manifestation of violation of protection rights of children, trends of such violation, key areas of concern and unrealized rights are presented in the diagram below.

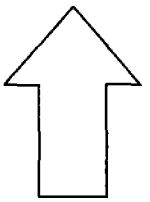
Overview of areas of concern, causality analysis for desired outcome

Desired Outcome:	Protection of the child from abuse, deprivation, exploitation in various contextual situation and provision of identity for a life of dignity and choice.



Optimal enjoyment of protection rights by children

- Protection from violence, sexual abuse, exploitation, trafficking, and child labor
- Protection from deprivation of family environment.
- Identity as a person and awareness of rights.
- Equity of all children, especially those needing special attentions (e.g. disabled children, street children etc) and human treatment when in conflict with the law.



Key Areas Concern

- Violence against children in the household, workplace, justice system.
- Sexual abuse of children in the house, workplace.
- Exploitation of child labor in the household and the workplace.
- Trafficking in children.
- Children in deprived situation (i.e. street children, children of stigmatized condition, minroity children, refugee children. etc).
- Birth and marriage registration.

Following is a summary of obligation of the duty bearers to fulfill the children in the context of protection. Technical team members identified these after consideration of occurrence of non-protection in the context of causative factors.

Family	Community	Service Providers	Policy Makers
◆ Birth Registration ◆ Provide protection from maltreatment and security in and outside home. ◆ Non-discrimination between the sexes. ◆ Be alert about abuse and inform children about their rights and possible exploitative and abusive situations. ◆ Be informed and vigilant. ◆ Create an environment of care, opportunity, participation. ◆ Inform children about their rights and obligations.	◆ Monitor birth and marriage registration. ◆ Emphasize non-discrimination in community work and programs on the basis of gender, race, ethnicity, religion, disability,parentage. ◆ Vigilance and awareness regarding *trafficking, abuse,* harassment, drug use, corporal punishment, and violence. ◆ Provide assistance to children in conflict with law for prevention of mal-treatment in police custody, courts and detention centers. ◆ Create special or inclusive program for street children, *stigmatized* children, children in hard to reach areas.-create equal opportunity for girls and boys for survival and development.-Educate the community about child rights, inclusive of the needs and rights of the girl child.	◆ Effective and non-discriminatory implementation of existing law (e.g. Penal Code of 1860, police Act of 1861, The Child Marriage Restraint Act 1929, The Children Act 1974,The dowry Prohibition act 1980, The Cruelty to Women Act 1983 (deterrent punishment). etc. ◆ The child rights should become a part of the psyche of the service providers and the law enforcing authority. ◆ Civil society could act as watchdogs of service provider activity. ◆ Special training for awareness creation amongst service providers.	◆ Plug the lacunae in law which makes room for child rights violation. ◆ Make non-discriminatory implementation of child protection rights an implementable premise of the law. ◆ Make youth participation in formulation of policy affecting children a required pre-requisite. ◆ Coordination amongst various agencies that implement protection rights be made effective. ◆ Monitoring of child labor employment for use and education opportunity be made mandatory.

The technical advisory team identified a number of obstacles that constrain the duty bearers in fulfilling their obligations. thee have been classified as immediate, underlying, and structural as is presented in the table below.

Family	Community	Service Providers	Policy Makers
IMMEDIATE			
◆ Poverty ◆ Social and cultural taboo, particularly about sex education ◆ Tradition of considering children as objects.	◆ Lack of social commitment to eradicate abuse, exploitation, discrimination, and recognition of child rights. ◆ Lack of community mobilization for eradicating economic and insecurity of disadvantaged families.	◆ Low priority to child protection rights. ◆ Discrimination in providing protection rights related services. ◆ Lack of resources to ensure the achievement of full protection rights of children .	◆ Absence of a well defined plan of action supported by enforceable legal framework for protection rights. ◆ Major governmental policies by pass child protection rights, particularly in non-formal sectors.
UNDERLYING			
◆ Lack of parental awareness about children's protection rights, except intuition and traditional care ◆ Absence of parental guidance concerning children's social, cultural, physical, needs and inter-personal one to one interaction on such matters.	◆ Social stratification creating inequitable access to opportunity and choice for ensuring child rights. ◆ NGO's program do not include all aspects of child rights and absence of an integrated program in this respect.	◆ Service providers are not sensitized about child protection rights. ◆ Easy to exploit and abuse children in insecure situation (e.g . child domestic workers or children working in the formal sector)	◆ Children at risk or disadvantaged have no direct or indirect access to policy makers. ◆ Children are treated as objects and not subjects having rights as adults.
STRUCTURAL			
◆ Low parental awareness about child rights. ◆ Low *familial enrichment* of child centered consciousness. ◆ Absence of parent child interaction on matters of child protection issues.	◆ Donor driven and top down community programs do not give priority to children's protection issues. ◆ Dominance of 'mastan' culture in community matters often create an environment of community silence in matters of child rights violation.	◆ Insufficient GO-NGO civil society coordination with respect to child rights, particularly child protection rights. ◆ Long bureaucratic process for changing the service providing procedure with respect to child protection rights.	◆ Inadequate institutional capacity to address child protection rights. ◆ Inefficient implementation of child protection right enforcing programs. ◆ Lack of inter-sectoral coordination for addressing the protection rights.

6.18 LESSONS LEARNED

Some initiative has been taken and some legal provisions do exist to provide certain protection rights to children. Specific initiatives are formulated as action plan. The technical team members from their knowledge and experience identified a number of key approaches to ensure protection rights to all children.

- It is important to promote positive child centered activities in the community and restrict/ resist criminal and anti-social elements.
- It is necessary to strengthen community support system for families in distress or in disadvantaged situation. For this regenerating community value system is helpful.
- Families in the community when provided with adequate income and when they learn to acquire self esteem, such families are more mindful of the protection rights of the children.
- Even though decision making power remains with the elders, the families that interact with children in matters that affected them seem to protect child rights better than others.
- Motivation for protecting child rights seem to be natural with women service providers and thus, women need to be consulted/ involved in matters related to child protection rights.
- Child workers are normally victims of push factors arising out of poverty and destitution. It is difficult to abolish child labor but legal provision and social awareness for humane treatment of them in terms of working conditions, pay and child rights would go a long way to ameliorate the current situation. Cross border trafficking has to be addressed by creating income generating opportunities and development choices for the disadvantaged.
- Children who are orphans, or socially distanced due to parental stigma, and minority, refugee children and children living in hard to reach areas need special targetted programs.
- Birth and marriage registration is low but requiring such certificate for other purposes and creating social awareness could enhance such registration rate.
- Protection from sexual abuse including rape and acid violence has become an increasing necessity for the girl child. Sex education could be an important step to conscientize the family and community about it.

6.19 STRATEGIC DIRECTIONS

The technical team members after consideration of key elements, manifestation of child protection concluded that *the following steps would be appropriate under current situation.*

Family/Care Giver

- Reach families with appropriate messages regarding their obligations of providing care; respecting rights of children; being well-informed and alert to dangers and keeping children informed about their own rights.
- Use the most effective channel of communication to reach these messages to families.
- "Piggy back" on interventions which are already reaching most households, for example, the immunization network and Grameen Bank, or interventions which are being planned in the near future (the baby weighing programme of the National Nutrition Programme expected to reach every household within 3 days of the baby being born).
- Integrate all interventions, to avoid repeated demands on family time.

Community

- Restore positive community values and traditions of support to families.
- Regenerate community institutions which are now defunct or in control of anti-social elements.
- Build awareness on child rights and children's issues in the community
- Forge closer links between service delivery systems, in particular the law enforcement machinery and the local community.
- Involve community leaders, including religious leaders, in interventions for children.
- Strengthen the role of women in community institutions.

Service Providers

- Adapt measures which will motivate service providers and create a commitment to and understanding of child rights.
- Build capacity among service providers in order to perform their tasks optimally.
- Link service providers with local communities and build accountability to local communities.
- Encourage participatory approaches involving children and adolescents.
- Integrate with other initiatives furthering good governance.

Policy Makers

- Strengthen understanding of policy makers regarding children's issues and rights.
- Improve coordination between Ministries dealing with children's issues.
- Promote broad based consultation on policy issues regarding children, involving members of civil society, academic institutions and experts, NGOs and young people themselves.
- Make optimal use of the CRC reporting system.

CHAPTER SIX

CHAPTER SEVEN

Cross-cutting Issues

7.1 URBAN DIMENSION

Bangladesh have experienced an extremely rapid growth in urban population in the recent decades, especially since the Liberation of the country in 1971. Much of the urban growth is due to migration of the rural poor to the urban areas. In addition, the native urban poor have also been growing through natural increases. Change in the definition of urban areas has also made a contribution to the growth. Already in 1991, there were about 23 million urban people in the country (this being 20 percent of the total population) of which over 60 percent were poor. At present (1999), the total urban population is about 30 million (or 25 percent of total population). Various projections estimate the urban population in 2020 to be anywhere from 60 to 80 million, or almost thrice of its current numbers.

The incidence of urban poverty however, has gone down to some extent. According to the Bangladesh Bureau of Statistics about 49 percent of the urban population were found to be poor in 1998. According to some recent research studies, the incidence of urban poverty is shown to be somewhat lower (around 40 percent). But even at this lower incidence, the absolute number of the urban poor remains considerable, about 12 million. Most of these poor people live in slums and squatter settlements. Slums in the cities of Bangladesh are characterized by high degree of congestion and crowding.

In terms of the socio-economic conditions, it is often stated that the urban areas are better off than the rural areas. However, this ignores the reality that the situation in the slums and urban fringes are far worse than in the rural areas. Compared to the general situation in urban and rural areas the mortality and morbidity patterns are very high in urban slums. Two estimates of infant mortality are much higher than that of the national level (152/180 per thousand). The situation of older children (1-4 years) appears to be even worse (114 per thousand). The trend of MMR also estimated much higher. It has been reported in many studies that the prevalence of diseases in slum area is higher than that of national arrange.

Rising urbanization and the consequent severe pressure on existing urban infrastructure and services including health care, basic education, water supply, sanitation, solid waste collection and drainage services have reduced the quality and the level of availability of urban services. There is no uniform structure of service provider in the urban areas. In most cases it is significantly inadequate. Lack of coordination on the other hand seriously hindering usual flow of services. Because of these factors coverage level of most of the social development and child survival and development indicators are significantly lower in metro slums. 6.4 percent slum children are severally malnourished compared to 3.8 percent in other urban. Against 81.1 percent measles courage and 38.1 percent ORT use rate in urban, only 56.5 percent measles coverage and 24.5 percent ORT use rate achieved in urban slums. Only 22.7 percent slum dwellers use sanitary latrines. Primary School enrollment rate in slums is 20 percent lower than that of the national arrange.

Urban development and service provision is, by its very nature, a localized activity and is best planned and managed at the local level. Yet, the Bangladesh approach has been one of highly centralized control. While decentralization has been a major government debate issue, adequate actions have yet been taken regarding its implementation. There is also no clear government strategy currently to enhance the weak administrative and institution capacities of municipalities and city corporations. The challenges of urban management will differ with the size and complexity

of each city. The biggest problems faced by large cities, such as Dhaka, are geographical limitations and functional fragmentation. In contrast, smaller municipal bodies typically suffer from extremely poor capacities and lack of technical support.

Street and Working Children

In March 1996, the number of street dwellers in Dhaka was enumerated to be about 11,500, found in 105 locations of the city. Of these, 66 percent were male and 34 percent female. Street dwellers have a large variety of sources of income. These are in all cases temporary and rudimentary informal type of activities. The largest proportion of street dwellers are beggars (27 percent) followed by day labourers (26 percent). Some of them, especially women, work as part-time domestic maids or servants (12 percent). Others are street waste collections (7 percent), hawkers (3 percent) and do various other jobs (22 percent), such as, breaking bricks, working as coolie, etc. A large number of street and working children do not enjoy their basic rights. They need support for basic education, recreation facilities for their development, protection from violence and hazardous work, food, shelter, etc.

7.2 CHILD PARTICIPATION[1]

Within the context of the CRC as well as a growing body of experience worldwide, the critical importance of children participating actively in their own development as well as contributing to societal development takes on major significance.

Beyond the tokenism that is many times confused with child participation, it is becoming clear that participation is a critical concept in the development of children as social actors who have a lot to contribute to development.

Within the broader context of creating more open and transparent structures and processes, the acculturation of children in democratic norms, values and processes is a very important for the development of these social values.

The major elements of respecting diversity, seeking consensus, peaceful conflict resolution, gender and environmental sensitivity, accepting oneself and others and learning to take responsibility, are central pillars of a participatory based approach to development.

The CRC explicitly lists the right of children to participation in 8 articles broadly falling under the rubric of freedom of expression (Art. 12 and 13); freedom of thought, conscience and religion (Art.14); freedom of assembly (Art.15); Access to Information (Art.17); special support to disabled Children (Art. 23); Education for Personal Fulfillment and Responsible Citizenship (Art. 29) and the right to play and participate in cultural and artistic life (Art. 31).

In Bangladesh the challenge is to develop participation modes that are consistent with some of the traditional social norms. Within the larger context of the social changes -- the erosion of the extended family, the increasing role of women in society -- now taking place in Bangladesh all offer opportunties to develop unique ways of ensuring meaningful child participation as an end in itself and an important building block of a democratic society.

1 The issue of participation is covered quite extensively in the Common Country Assessment. The emphasis here is on children.

7.3 COMMUNICATION, BEHAVIOUR DEVELOPMENT, AND KNOWLEDGE

Many persistent gaps and untapped opportunities have been identified in knowledge, awareness and practices in Bangladesh promoting the fulfillment of children's rights, their development, and the care they require and have a right to at different stages of childhood. These gaps were found among all key providers of care including parents, communicators, various service providers and the media. There were also direct correlations between gaps in knowledge and practice with undesirable outcomes for children and women—for example, lack of sanitation facilities and hygiene practices, combined with low levels of correct practice of oral rehydration therapy, contribute to diarrhoeal diseases remaining one of the top child killers in Bangladesh, with 110,000 deaths per year of children under five years of age[1*].

The findings of this situation assessment and analysis highlight how critically important communication and advocacy are in all rights and human development-related programmes. Policy-makers need to have an understanding of rights in order to formulate appropriate policies, goals and indicators for programmes. Communicators and service providers need to give correct information to families and providers of care to children and women, monitor practices, as well as provide support and motivation in order to ensure that correct behaviour is developed. Parents and care providers need to have essential knowledge and skills in order to support children's development to their full potential and promote the fulfillment of their rights. All of the above are not only needs and opportunities for improvement that have been identified; they also constitute fundamental rights of each group, as well as responsibilities towards children and women.

There are already numerous success stories and innovative models in the areas of social mobilization, communication, and demand creation for social services in Bangladesh. Patterns of social mobilization have been introduced and intersectoral networks have been activated to implement a wide range of communication activities. There is a growing knowledge base of social marketing techniques and information technology is evolving exponentially. All these serve as the foundation, references, and resources for future action.

Programmes using communication, behaviour development and knowledge creation/sharing as core strategies must also factor in the following:-

- Need to ensure and promote an enabling environment for behaviour development and change to take place. Strategies will also have to address various socio-cultural factors that form, influence, and limit or enable certain practices and behaviours;
- Need for a sustained, comprehensive strategy to monitor and support changes in knowledge, attitudes and behaviour. Knowledge and awareness raising is only one of the first steps; behaviour development and change require support, monitoring, and reinforcement over a long period of time.
- Participation. All key stakeholders have the right to be involved in the process of developing communication strategies that address their needs and rights, and their participation and inputs also help to ensure that strategies are appropriate and fully owned by those who will implement them.
- Need for enhanced coordination among communication programmes being implemented in Bangladesh. While some overlapping and duplication can be beneficial, as this promotes synergy and helps to reinforce core messages, it is critically important that messages are standardized, and that priorities are identified and agreed upon collectively, so that efforts can be well targeted and resources used effectively.

1* BBS- UNICEF (1999)

7.4 GENDER DIMENSION

The Government has made several efforts to promote women's development,. The Fifth Year Plan (1997-2002) recognizes the unequal status of women in the country adopting as objective to ' close the gender gap, giving priority to women's education, training and employment and special support for girls' education'. An entire chapter of the Plan is devoted to women (and children) development issues and 24 ambitious goals and objectives are set for the Plan period. However, of the twelve 'focus areas' of the Fifth Plan, only two, poverty alleviation/rural development and containing population growth, specifically mention the role of women. More resources have been made available for women's development. The share of social welfare, women and youth development increased from 0.68 % in the fourth Plan to 1.6 per cent of the total in the Fifth Plan. Half of this is generated by project aid.

Some, although slow, progress can be reported in the reduction of the gap between the sexes. For instance, the mean age of marriage has slightly increased, female literacy increased, more females are participating in the labour force (In 1996 18.1 % of the labour force was female; in 1989 only 10.6%), and women's control over reproduction increased. The 'microcredit revolution' has given access to microcredit for more than nine million rural women, each of which now has generated savings of Takq 500 –3,000 per capita, a remarkable achievement for the assetless poor rural women. The role of the women as a conduit for valuable resources, has helped to improve her status, and increased the well-being of the whole family. It also enhanced women's confidence and mobility. However, the challenge still remains to reach the poorest of the poor, including wage labourers, certain ethnic and occupational groups at the bottom end of the social hierarchy.

In the education sector, the Government has made major efforts to increase female literacy rates through policy measures and direct affirmative actions including scholarship. Gains were made with increasing literacy among women, but not yet with closing the gap between male and female literacy rates. Currently. 42.2% of the female, and 59.4% of the male population is literate. The situation is better in urban areas where gender literacy disparities are also smaller. But the largest achievement in reducing disparities is the primary school enrollment, where the male to female ration is now 52:48, with the completion rate for girls slightly higher that the completion rate for boys. At secondary level, boys again have the advantage. Obstacles here are that girls secondary education is less valued, restrictions for movement of adolescent girls, early marriage, lack of facilities etc. At the tertiary level the percentage of female students drops to 20%, of which the majority is in the non-science subjects. As a result, women's access to highly skilled and well-paid jobs is very limited.

However, in the health and nurition sectors, the gender gap is still wide. Women's morbidity and mortality continues to be much higher as compared to men (Morbidity among young women is 14% higher morbidity as compared to men) and incidences of diseases (goitre and leprosy) are also more prevalent among women. Women's nutritional status is also much lower, with more than half of women in the reproductive age suffering from malnutrition, up to 18% below the minimum daily calorie requirement. These problems persist despite a significant rise in per capita spending on public health (from Taka 63 to Taka 132 per capita). An example is the chronic lack of maternity and child welfare centres – as mentioned in chapter 4 women's lack of emergency obstetric care is the single most important cause for the high maternal mortality. Less than half of pregnant women seek antenatal care and 86% of child birth are attended by untrained persons. Iron and folic acid deficiencies remain rampant among pregnant women.

Women in Bangladesh are making some advances in a few limited areas of governance, including in participation in Parliament, Government organizations, local government bodies and Government service. Women have reserved seats in the new three tier Government structure (Gram, Union and Zila Parishads) and in the urban local bodies. These measures, completed by NGO awareness raising programmes, have led to a growing role of women in the political arena. Voter education programmes have prompted women to exercise their voting rights, at times in

defiance of locally proclaimed 'fatwas'. The participation of women in the public labour force is with 9% too low, despite a set quota of 20% for female public sector employees. Most women working for Government are in Class II categories and in Departments or Directorates rather than Ministries. Some improvement can be reported; there are presently two women secretaries and two superintendents of police.

Court judgments have in recent years increasingly shown appreciation and sensitivity to gender issues, which includes rulings on maintenance of divorced women by previous husbands and abolition of polygamy (against provision of the Muslim Family Law). The Muslim personal law recognize equal rights of men and women, but in some situations women enjoy fewer privileges, mainly in the areas of marriages, divorce, guardianship and custody over children and inheritance rights. Female headed households are over-represented among the poor.

The CEDAW was ratified in 1984 with reservations in four areas related to discrimination, marriage dissolution and guardianship (where the family laws prevail). However, the combined third and fourth report on CEDAW implementation states that women were subject to discrimination both in cultural practice and in personal law. The CEDAW report also signals a rising trend of violence against women, custodial rape and violence against women (including *fatwas*).

Bangladesh boasts a vocal and active women's rights movement, which includes legal aid NGOs, alternative care centres and others.

Meanwhile, there appears to be an increase in crimes against women and young girls, ranging from rape, dowry killings, acid attacks, domestic violence and *'fatwas'* to trafficking and suicide (induced by rights violations). In the first nine months of 1998 alone, 20,000 incidents were reported, the majority being raoe cases (after which the victim was often killed). It is not uncommon for local communities to settle rape incidents by enforcing a marriage between the victim and culprit, irrespective of the consequences. Domestic violence is a major threat to women's security. Nearly 50% of murder cases with women victims arose out of marital violence, often over unmet dowry demands, tension over polygamous marriages, conflict over child custody etc. Acid attacks and trafficking of women for forced prostitution, dealt with in Chapter 6, are another growing form of violence

Several legislative measures for the protection of women have been taken with the aim to prohibit dowry, cruelty to women and repression of women. These laws often prescribe very tough sentences for culprits. Enforcement of these laws has been a issue of concern although a number of cases recently do seem to end in a successful conviction of the culprit. The State has also acted to establish a Central Cell for the Prevention of Oppression against Women and Children, Women's Investigation Cells in four police stations and a Prevention Cell in Police Headquarters. The Department of Women's Affairs runs Women's support centres in Dhaka and five divisional headquarters

CHAPTER EIGHT

CHAPTER EIGHT

Challenges and Strategic Actions

The discussion in the earlier chapters indicate the following set of strategic action:

- **Taking a Non-Compartmentalized Approach:** The CRC is a part of human rights and women's rights. These cannot be compartmentalized for realization of full potential. Thus, the strategy for activating CRC should be viewed as a part of HRC and CEDAW and implemented as such so that synergic impact of mutually reinforcing provisions could be achieved.

- **Strengthening CRC Related Programmes:** Allocation of resources in sectors to take into account the impact on the situation of children.

- **GO-NGO intervention for Community Ownership of CRC:** Social mobilization and community involvement should be actualized through GO-NGO intervention so that the community could own CRC related activity.

- **Communication and Behaviour Development /Change:** These need to be core components of any strategy trageting the fulfillment of rights, as it is essential for programmatic effectiveness and sustainability that every one at all levels, including direct providers of care to children, social service providers, communicators and policymakers have a common understanding of rights, up-to-date knowledge and skills, and be motivated to provide optimal care and prioritize the fulfillment of children's rights.

- **Raising Awareness at the Family Level:** Family need to prosess not only the basic knowledge of child rights and skills, but also value the child and address gender discrimination and other disparities at the family level. This need to be accompanied by education and skills development in child caring practices for adolescents and new parents. Through communication and advocacy, children also need occupy a place in the family that is the prime focus or determinant of family decisions through a better understanding of the intergenerational dynamics.

- **Transferring Resources to the Poor:** eradication of poverty helps to ensure better opportunities for children currently deprived of care, survival protection and development opportunities. Poverty alleviation and real resource transfer to the poor through such program as micro-finance package like that of Grameen bank is more likely to ensure sustainable child development than some discrete occasional intervention.

- **Empowering Women at the Family Level:** Empowerment of women in family decision-making , community organization and local government is more likely to bring the child and the family as the focus of integrated CRC program than otherwise. Such empowerment should be across income and social class. The psychosis that discriminates against the girl child needs to be overcome through positive intervention.

- **Creating Opportunities for Interaction between the Community and Policy Makers:** Community participation in local level programs and opportunity for interaction with policy and law makers help interactive reinforcement in favor of social initiative and legal framework outside obstructing bureaucratic practices. This would facilitate inter-sectoral linkage that are child sensitive and promotes gender equity.

- **Continuing Follow Up Practices:** Child health care is not mainly a matter of one time intervention like EPI or curative care but continuous follow up practices related to hygiene, nutrition, health education, life skill etc. The society, community and local government institutions need to act towards a change in mindset and poverty caused attitudes.

- **Developing Client Friendly Environment in Health Care and Health Workers Role as Motivators:** Access to health care facilities on a regular basis in a client friendly environment and provided by a trained health personnel is important. Health personnel should also motivate mothers and other caregivers to learn about home based care, hygiene and work place hygiene. Such access should be equitable at affordable cost.

- **Building Institutional Network to Focus on Child Health and Catering to Specific Health Needs:** Institutional network for child health and child education need be widened not only to create better access but also to cater to specific needs of children requiring special attention (e.g. disabled, slum dwellers, orphans, refugee children and children belonging to indigenous groups).

- **Disseminating Information on Domestic Hygiene and Health in a Relevant Manner**: Being informed and putting knowledge in practice with respect to health care, domestic hygiene in their situational context is important because relevance make it sustainable and social mobilization for healthy environment and stoppage of environmental degradation become easy.

- **Focusing on Creating a Healthy Environment and Ensuring Community Involvement:** Provision of safe water and sanitation as well as management of solid waste should become a concern where families participate as units and such service providers need to be made accountable and individually and collectively to the community. Arsenic contamination needs to be taken up through community education, particularly for the poor so that harmful effect of such contamination could be avoided. Social mobilization and community control over are vital for successful management of such basic services.

- **Making Education a Pleasurable Experience**: Education should be made a pleasurable experience of growing up for the child through provision of better school environment, caring teachers, interesting curricula, opportunities for innovation, creativity and recreation.

- **Changing School Management System, Using Innovative Teaching Methods and Making School Curricula Relevant**: Access, equity, relevance and quality are important in promoting participation and retention in schools as are the content of curricula and teaching aids/ methods. School management requires more involvement of the community, participation of the parents. Children need proper guidance and direction for the use of time in school and out of school need direction for development of psychosocial skills. Bureaucratization of education administration and distancing of the community from appropriate involvement was a mistake that require swift corrective intervention. Inadequate recognition of age specific need, capacity and potential by providers and policy makers is an immediacy for improvement of quality and relevance which has social, economic and gender dimension particularly for adolescents. Decentralization and involvement of the community are essential to restore accountability of school to the communities which they are meant to serve.

- **Training Basic Service Providers and Creating Opportunities for Them:** Bringing about the above mentioned changes in the health and education sectors require committed and trained personnel with adequate skill who are paid a competitive salary and enjoy opportunities for career development.

- **Enacting and Implementing Laws and Focusing on Children in the Justice System:** Legal provisions should be made to prevent trafficking of children, violence against children, abuse and maltreatment of children. Existing laws need to be applied promptly and justly. The juvenile delinquents need to be treated appropriately. Children in detention and safe custody should not be locked up with adults. Correction centers need totally different management.

- **Preventing Violence Against Women and Children:** Prevention of violence against women and children within and outside the family requires awareness creation in the community, creation of respect and empathy, cultivation of values that promote gender equity and strict enforcement of laws. This requires a transformation of patriarchal family system and society.

- **Strengthening Family Values and Community Institutions:** The protection of the child should be need specific making families respect child rights after understanding the logic and structural constraints. All parents generally would like to provide best of protection within their capacity. However, erosion of community values and institutions in an increased polarized society makes deprivation a psychosocial basis to undo protective practices and promote violence, discrimination and apathy. Eradication of this malaise requires recuperation of family values and enrichment of community institutions for protecting women and children.

- **Coordinating Intervention by the Duty Bearers and Implementing Interactive Programs**: Coordinated intervention by the government, community institutions (including family as a basic unit) and development agencies that function in the area of child rights, need to have integrative and interactive program. These programs should be inclusive of periodic reviews of certain defined indicators for monitoring and evaluation of trends in promoting CRC and for identification of intervention policy, place and strategy.

- **Empowering adolescent girls**: Strengthening efforts to provide continued access to education, provide vocational and counseling support and advocate for delay in the age of marriage.

- **Strengthen local government institutions:** L Enable elected local government agencies in the urban and rural areas to prioritize concerns for women and children through advocacy and training.

- **Enhance understanding of child rights**: Work with media and the civil society to broaden and deepen understanding of child rights.

- **Build Government, NGO and civil society capacity for monitoring child rights**: Facilitate regular *monitoring of the situation of children at the national and sub-national levels and strengthen the reporting* mechanisms under the Child Rights Convention.