

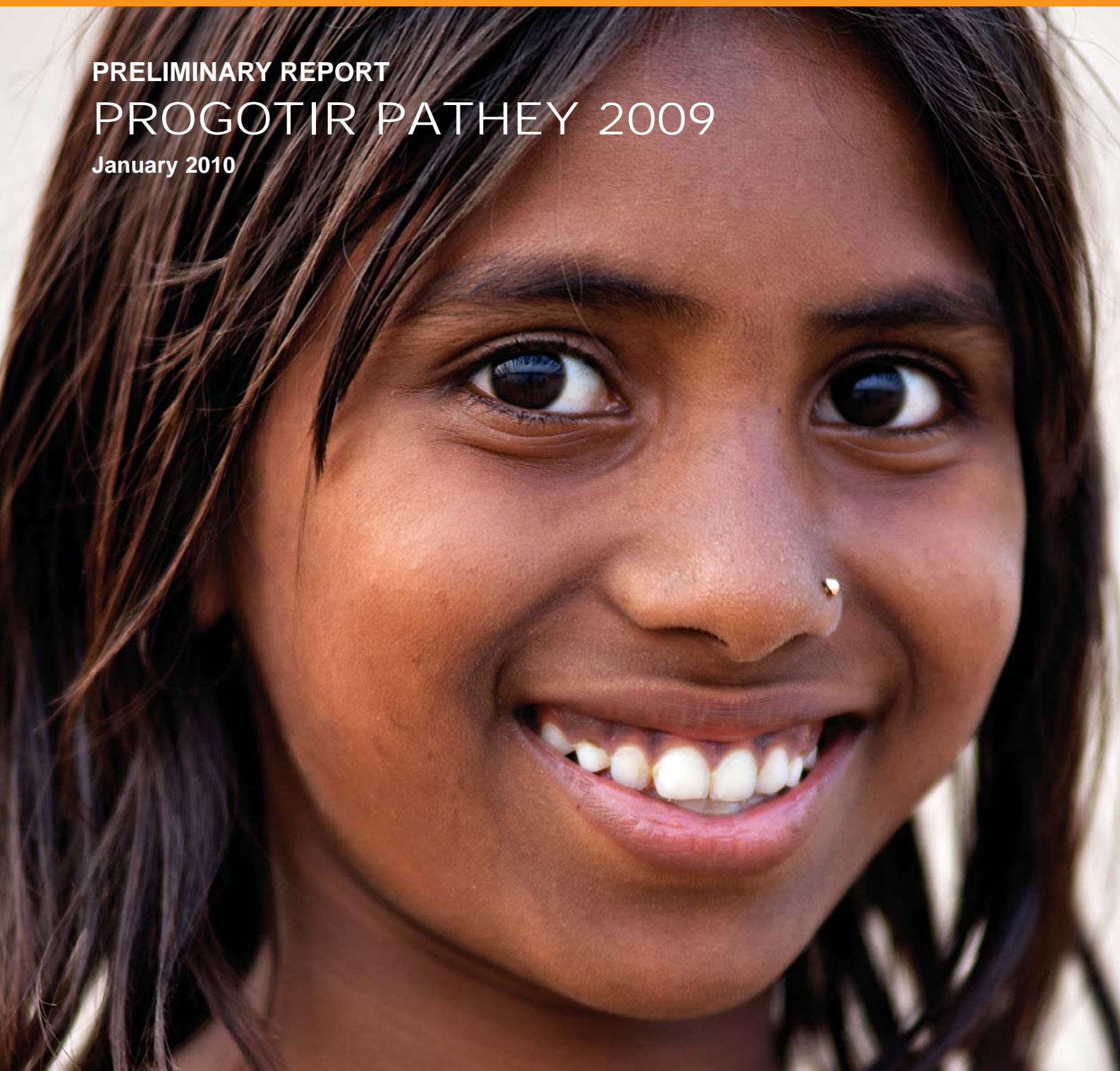
MONITORING THE SITUATION OF CHILDREN AND WOMEN

# Key Findings of the Bangladesh Multiple Indicator Cluster Survey 2009

PRELIMINARY REPORT

## PROGOTIR PATHEY 2009

January 2010



unicef



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# PREFACE

The Bangladesh Bureau of Statistics in collaboration with UNICEF has been conducting the Multiple Indicator Cluster Survey (MICS) since 1993 with the objective of monitoring the situation of children, particularly the MDG indicators related to children and women.

The 10th round of MICS was conducted in May 2009 with the objective of providing up-to-date disaggregated information of children and women at the national and sub-national levels. This round of MICS differed from earlier ones given that a short questionnaire was used to collect data from a much larger sample size comprising 15,000 primary sampling units and 300,000 households.

The MICS 2009 included information on household characteristics, education, water and sanitation, knowledge of HIV/AIDS, child mortality, attendant at delivery, birth registration, and early learning. The key findings focussing on MDG indicators are presented in this report.

I take this opportunity to thank the concerned BBS officials, particularly Mr. Md. Shamsul Alam, Project Director, Monitoring the Situation of Children and Women (2nd Phase) Project, Mr Md. Alamgir Hossain, Deputy Director, Mr. Abdul Rashid Howlader, Programmer and Mrs. Delwara Begum, Statistical Officer for co-ordinating the survey and preparing this report. The data processing of the survey was done by Mr. S.M. Anwar Hossain, Statistical Assistant of the project.

The constant support and guidance from Mr. Carel de Rooy, Representative of UNICEF in Bangladesh was an inspiration for the MICS team. The contribution of Mrs. Siping Wang, Chief Planning Monitoring and Evaluation Section, Mrs. Deqa Ibrahim Musa, Monitoring and Evaluation Specialist and Mr. Mashiur Rahman, Programme Assistant of UNICEF is greatly acknowledged. Mrs. Hongxia Zhang, Data Processing Consultant and Demographer of UNICEF provided technical support for data analysis and deserves special appreciation.

I would like to thank the members of the technical committee for their valuable contribution in preparing the questionnaire, for finalisation of the sample design and preparation of this report.

I hope the report will be useful to policy-makers, elected leaders, researchers and administrators in monitoring progress towards achievement of MDG targets that are related to women and children.

December, 2009



(Md. Shahjahan Ali Mollah)  
Director General, BBS

# SUMMARY TABLE OF FINDINGS

MICS and Millennium Development Goal and  
Child Protection Indicators, Bangladesh, 2009

| Topic   | Indicator  | Value in 2009 |               |               | Value in 2006 |               |               | Change between 2006 and 2009 |               |               |
|---|--|---------------|---------------|---------------|---------------|---------------|---------------|------------------------------|---------------|---------------|
|   |  | Total         | Male          | Female        | Total         | Male          | Female        | Total                        | Male          | Female        |
| <b>Goal 2:</b><br>Achieve universal primary education         | Net attendance rate in primary education*  | 81.3          | 80.2          | 82.5          | 81.3          | 78.9          | 83.7          | 0                            | 1.3           | -1.2          |
|   | Proportion of pupils starting grade one who reach last grade of primary                    | 79.8          | 70.7          | 81.0          | 63.6          | 62.5          | 64.7          | 16.2                         | 8.2           | 16.3          |
| <b>Goal 3:</b><br>Gender equality and empower women           | Ratio of girls to boys in primary education  | 1.03          | n.a.          | n.a.          | 1.06          | n.a.          | n.a.          | -0.03                        | n.a.          | n.a.          |
|   | Ratio of girls to boys in secondary education  | 1.17          | n.a.          | n.a.          | 1.14          | n.a.          | n.a.          | 0.03                         | n.a.          | n.a.          |
| <b>Goal 4:</b><br>Reduce child mortality                      | Under-five mortality rate  | 67            | 74            | 59            | n.a.          | n.a.          | n.a.          | n.a.                         | n.a.          | n.a.          |
|   | Infant mortality rate  | 45            | 56            | 40            | n.a.          | n.a.          | n.a.          | n.a.                         | n.a.          | n.a.          |
| <b>Goal 5:</b><br>Improve maternal health                     | Proportion of births attended by skilled health personnel                                  | 24.4          | n.a.          | n.a.          | 20.1          | n.a.          | n.a.          | 4.3                          | n.a.          | n.a.          |
| <b>Goal 6:</b><br>Combat HIV/AIDS, malaria and other diseases | Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS | n.a.          | n.a.          | 14.6          | n.a.          | n.a.          | 15.8          | n.a.                         | n.a.          | -1.2          |
| <b>Goal 7:</b><br>Ensure environmental sustainability         | Proportion of population using an improved drinking water source                           | 97.8          | 99.5<br>Urban | 97.4<br>Rural | 97.6          | 99.2<br>Urban | 97.1<br>Rural | 0.2                          | 0.3<br>Urban  | 0.3<br>Rural  |
|   | Proportion of population using an improved sanitation facility                             | 80.4          | 86.4<br>Urban | 78.9<br>Rural | 39.2          | 57.8<br>Urban | 31.9<br>Rural | 41.2**                       | 28.6<br>Urban | 47.0<br>Rural |
| <b>Child Protection</b>                                       | Proportion of children under five years who have birth registration                        | 53.6          | 53.4          | 53.7          | 9.8           | 10.1          | 9.6           | 43.8                         | 43.3          | 44.1          |

\* The "net attendance rate in primary education" is the proxy indicator for the "net enrolment ratio in primary education".

\*\* "Improved Sanitation" was measured differently to become in line with the UNICEF/ WHO Joint Monitoring Programme definitions, making comparison between 2006 and 2009 MICS data difficult

# BACKGROUND AND OBJECTIVES

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## INTRODUCTION

Properly planned and conducted household surveys are the most reliable mechanism to assess progress regarding achievement of Millennium Development Goals (MDGs) in countries where the routine development outcome or impact information is not readily available.

The analysis of the 2000, 2003 and 2006 MICSs data indicated that considerable disparities exist among the performance of districts in terms of achieving MDGs. A further preliminary assessment undertaken by UNICEF that attempted to better understand the causes of such disparities suggested that poverty and geographic isolation are amongst the likely factors.

The 2009 MICS was conducted by the Bangladesh Bureau of Statistics. It was designed to collect data related to MDGs except for MDG 1: “Eradicate extreme poverty and hunger”, as other household surveys had already been planned to update data for this MDG. This survey was, however, for the first time in the history of Bangladesh designed to collect representative data at *upazila* (sub-district) level. A total of 24 indicators were assessed.

The preliminary report of the 2009 MICS presents selected results on MDG monitoring indicators as well as a composite index based on nine key indicators. The results in this report are preliminary and are subject to change, although major changes are not expected. The full report is scheduled for publication in March 2010.

The results of the 2009 MICS provide valuable and detailed information for the Government of Bangladesh as well as its development partners to better prioritize, target, plan and budget for social sector interventions, in the context of the 5-year development plan currently being prepared.

Sixty four districts and 481 *upazilas* are ranked by the above mentioned MDG composite index\*. Ranking of geographic areas from the best performing (smallest number) to the worst performing (highest number) provides a solid baseline for the Government at all levels to account for achieving MDGs with equity in Bangladesh by 2015.

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\* Please note that Tables are included in an accompanying CD-ROM, due to the size of the document.

Given that the same survey will be repeated in 2012 and 2015 overall progress will be assessed, but more importantly, individual *upazilas* and/or districts will be able to see how much relative progress they have made in comparison to other *upazilas* and districts as their ranking will change over time. Ranking of *upazilas* and districts will be possible for each individual indicator as well. The frequent and detailed availability of data will enable the assessment of the effect of prioritizing and targeting investments in those districts and upazilas that are lagging in terms of MDGs achievement. Multiple opportunities will hence derive from this context, including the acknowledgement of those *upazilas* and districts that advanced most in ranking, be it on the basis of individual indicators or of the composite index.

## SURVEY OBJECTIVES

The 2009 Bangladesh Multiple Indicator Cluster Survey has four objectives:

- ▶ To provide up-to-date and disaggregated information for assessing the situation of children and women in Bangladesh;
- ▶ To provide data needed for monitoring progress towards achievement of the Millennium Development Goals as a basis for future action;
- ▶ To set a baseline for the Government at national, district and *upazila* levels to better assess future progress made in achieving MDGs with equity by 2015 in Bangladesh;
- ▶ To provide detailed thematic and geographic social sector information that will facilitate prioritization and better targeting of future investments made in the context of the 5-year development plan currently being prepared by the Government.

# III. SAMPLE AND SURVEY METHODOLOGY

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## SAMPLE DESIGN

The sample for the Bangladesh Multiple Indicator Cluster Survey (MICS) was designed to provide estimates on a few indicators on the situation of children and women for urban and rural areas, at the national, district and *upazila* levels. *Upazilas* were identified as the main sampling domains and the sample was selected in two stages. Within each *upazila*, at least 26 census enumeration areas (EA) were selected with probability proportional to size. A segment with 20 households was randomly drawn in each selected EA. The sample was stratified by *upazila* and is not self-weighting. For reporting national and district level results, sample weights were used.

## QUESTIONNAIRES

Three questionnaires were used in the survey. In addition to a household questionnaire which was used to collect information on all household members, questionnaires were administered in each household to women aged 15-49. Mothers or caretakers of children aged under five were identified in each household, and these persons were interviewed on these children. The questionnaires included the following modules:

- ▶ **Household Questionnaire**
  - Household listing
  - Education
  - Water and sanitation, including water sample collection for arsenic testing
- ▶ **Questionnaire for Individual Women**
  - Child mortality
  - Attendance at delivery
  - HIV and AIDS
- ▶ **Questionnaire for Children Under Five**
  - Birth registration
  - Early learning

The questionnaires are based on the MICS3 model questionnaire. From the MICS3 model English version, the questionnaires were translated into Bangla and were pre-tested in March 2009. Based on the results of the pre-test, modifications were made to the wording and translation of the questionnaires.

## FIELDWORK AND PROCESSING

A total of 7,683 interviewers and 1,154 supervisors were trained in April 2009. Fieldwork was undertaken from 28th April to 31st May 2009.

Data were entered on 64 microcomputers using the CPro software. In order to ensure quality control, all questionnaires were double entered and internal consistency checks were performed. Procedures and standard programs developed under the global MICS3 project and adapted to the Bangladesh questionnaire were used throughout. Data processing was concluded in October 2009. Data were analysed using the SPSS software program and the model syntax and tabulation plans developed for this purpose.

## SAMPLE COVERAGE

Of the 300,000 households selected for the sample, 299,988 were found to be occupied. Of these, 299,842 were successfully interviewed for a household response rate of 99.9 per cent. In the interviewed households, 336,286 women (age 15-49) were identified. Of these, 333,195 were successfully interviewed, yielding a response rate of 99.1 per cent. In addition, 140,860 children under age five were listed in the household questionnaire. Questionnaires were completed for 139,580 children corresponding to a response rate of 99.1 per cent. An overall response rate of 99.0 percent was obtained for both the women and for children aged under five (Table 1, in the attached CD). According to the survey design, water samples were to be collected from 15,000 households for arsenic testing. A total of 13,301 water samples were tested which corresponds to an arsenic test rate of 88.6 per cent.



# RESULTS

## MDG COMPOSITE INDEX

The MDG composite index is used to rank the districts and *upazilas* in terms of their status in achieving MDGs. The index comprises nine indicators

1. Net attendance rate of primary education
2. Proportion of pupils starting grade one who reach grade five
3. Ratio of girls to boys in primary education
4. Ratio of girls to boys in secondary education
5. Under-five mortality rate (U5MR)
6. Proportion of births attended by skilled health personnel
7. Proportion of women aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
8. Proportion of population using an improved drinking water source
9. Proportion of population using an improved sanitation facility

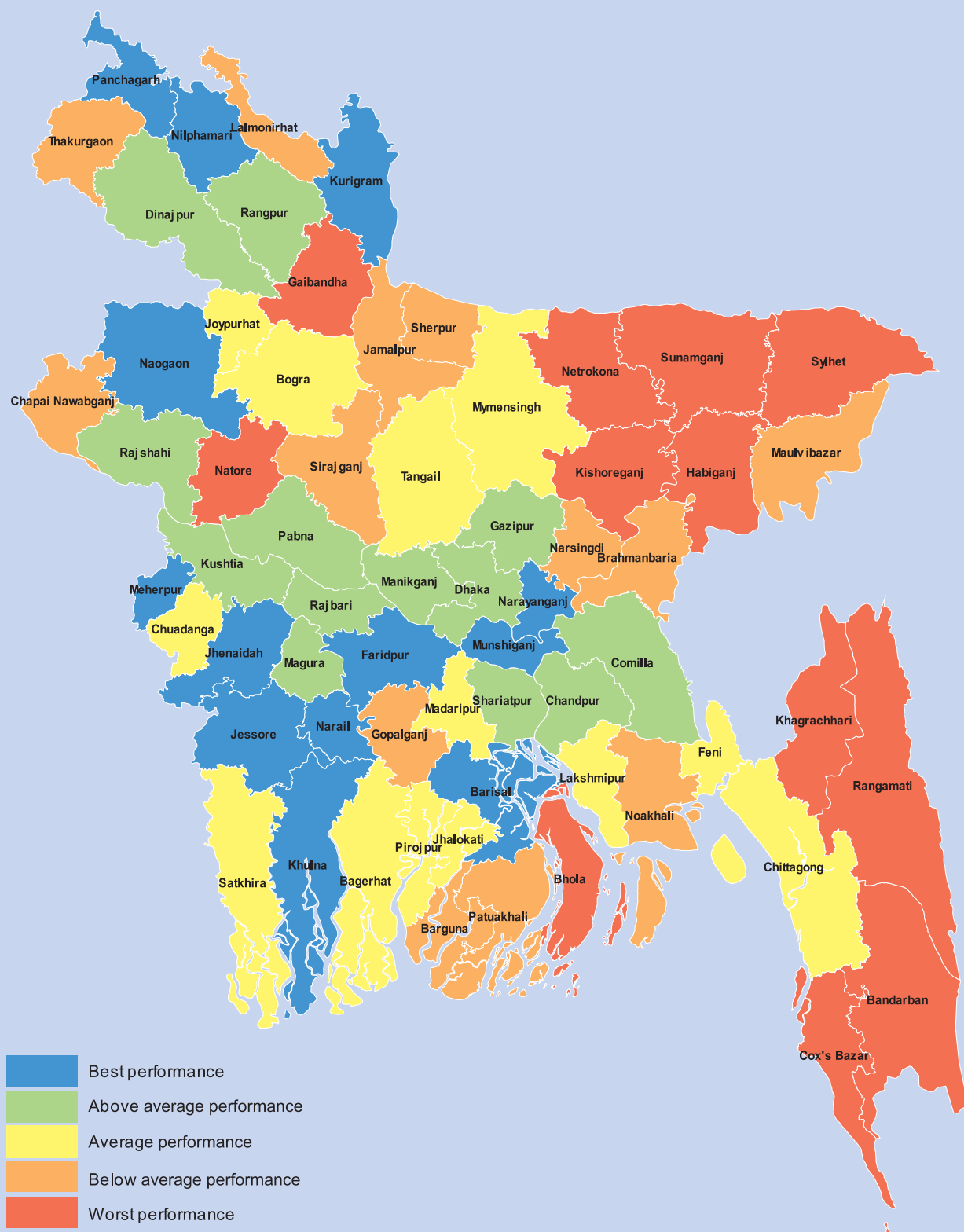
The index of each indicator for each district/*upazila* is calculated as a relative deviation from the national average. The MDG composite index is the sum of the index of each of the nine indicators. A district/*upazila* with a positive value means that it has a comparatively better performance in terms of achieving MDGs than a district with a negative value.

The rank of MDG composite index by district and *upazila* can be found in Table 2 and Table 3 respectively (in the attached CD). In the top quintile regarding MDG performance are the following districts: Jhenaidah, Meherpur, Munshiganj, Panchagarh, Narayanganj, Barisal, Narail, Naogaon, Faridpur, Khulna, Nilphamari and Jessore. The bottom quintile comprises: Bandarban, Khagrachhari, Sunamganj, Rangamati, Cox's Bazar, Sylhet, Gaibandha, Netrokona, Habiganj, Kishoreganj, Bhola and Natore.

The above described composite index is very relevant given the recent publication of a study on child poverty and disparities in Bangladesh that focused upon the measurement of poverty upon deprivation of access to seven basic services instead of the traditional income or expenditure related poverty measure. The basic services considered in this study are: education, health, water, sanitation, nutrition, information and shelter. The study found that people in the lowest poverty quintile are typically deprived of four out of seven basic services, and that as one rises in the poverty ladder to the next quintiles one deprivation less occurs progressively. The question thus arises “*should one await for income/expenditure poverty to be reduced, or should one target the most deprived population with basic services to reduce poverty?*”

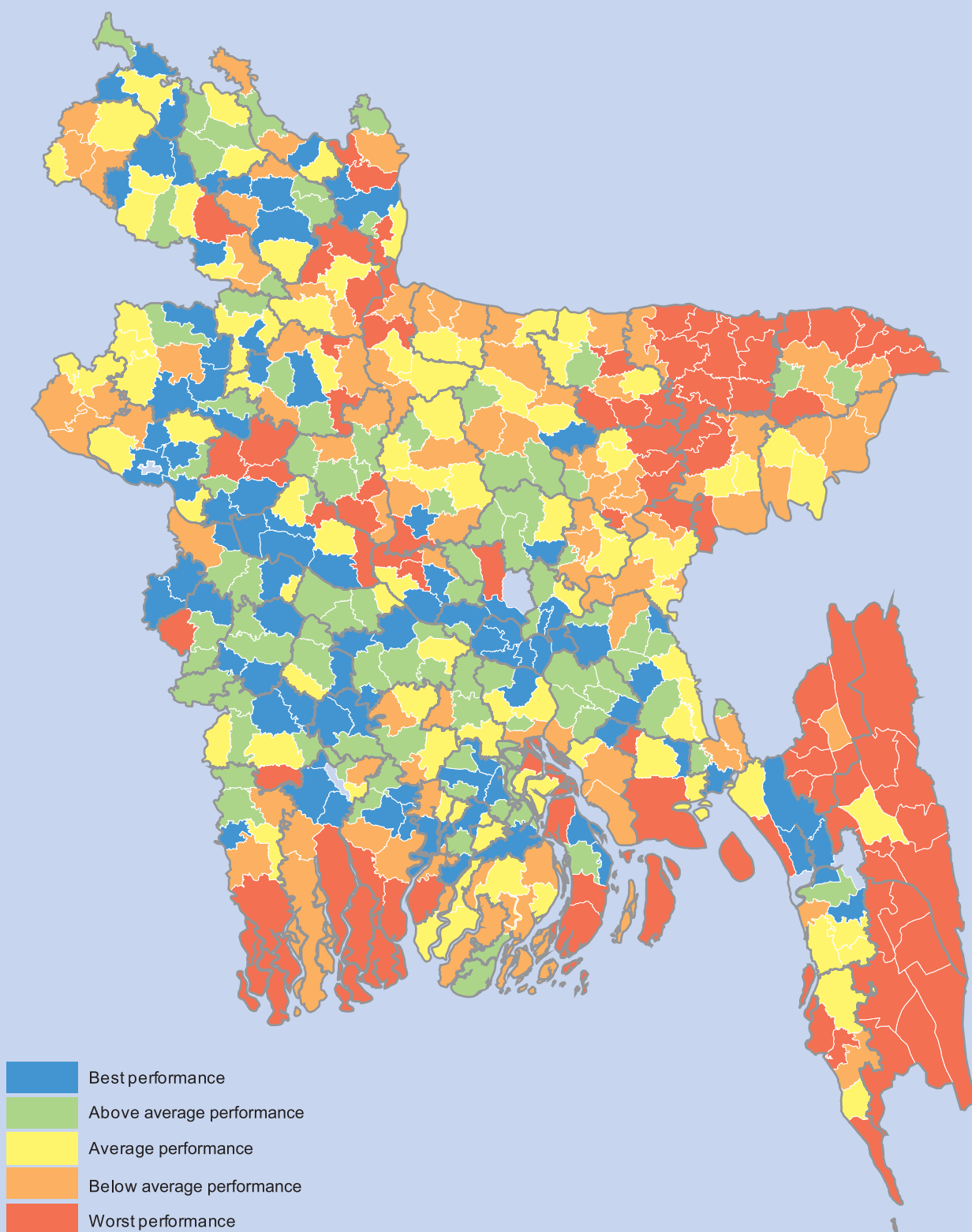
## MAP 1

District performance assessed by using MDG composite index



## MAP 2

*Upazila performance assessed by using MDG composite index*



## PRIMARY SCHOOL PERFORMANCE

Universal access to basic education and the achievement of primary education by the world's children is one of the most important goals of the Millennium Development Goals. Education is a vital prerequisite for combating poverty, empowering women, protecting children from hazardous and exploitative labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and influencing population growth.

Overall, 81.3 per cent of children of primary school age in Bangladesh are attending primary school or secondary school. In urban areas, 83.9 per cent of children attend school while in rural areas 80.8 per cent are in attendance. The highest school attendance was in Mehepur district (91.0 per cent) while lowest school attendance was in Bandarban district (60.6 per cent). At the national level, there is virtually no difference between male and female primary school attendance.

In comparison with the 2006 MICS result, the attendance rate remained at the same level while the rate for boys slightly increased and that for girls decreased marginally.

The proportion of pupils starting grade one who reach grade five is the percentage of a cohort of pupils enrolled in grade one of the primary level of education in a given school year who are expected to reach grade five. The MICS uses the re-constructed cohort method to estimate the rate through attendance by grade of two consecutive school years. The indicator measures an education system's success in retaining students from one grade to the next as well as its internal efficiency.

The proportion of pupils starting grade one who reach grade five was 79.8 per cent in 2009, 78.7 per cent for boys and 81.0 per cent for girls. It increased from 63.6 per cent in 2006.

## MILLENNIUM DEVELOPMENT GOALS 2 AND 3

Achieve universal primary education

**Target:** Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Promote gender equality and empower women

**Target:** Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015

Indicators available in MICS 2009

- ▶ Net attendance rate
- ▶ Proportion of pupils starting grade one who reach grade five
- ▶ Ratio of girls to boys in primary and secondary education



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## MAP 3

Net attendance rate in primary education, 2009

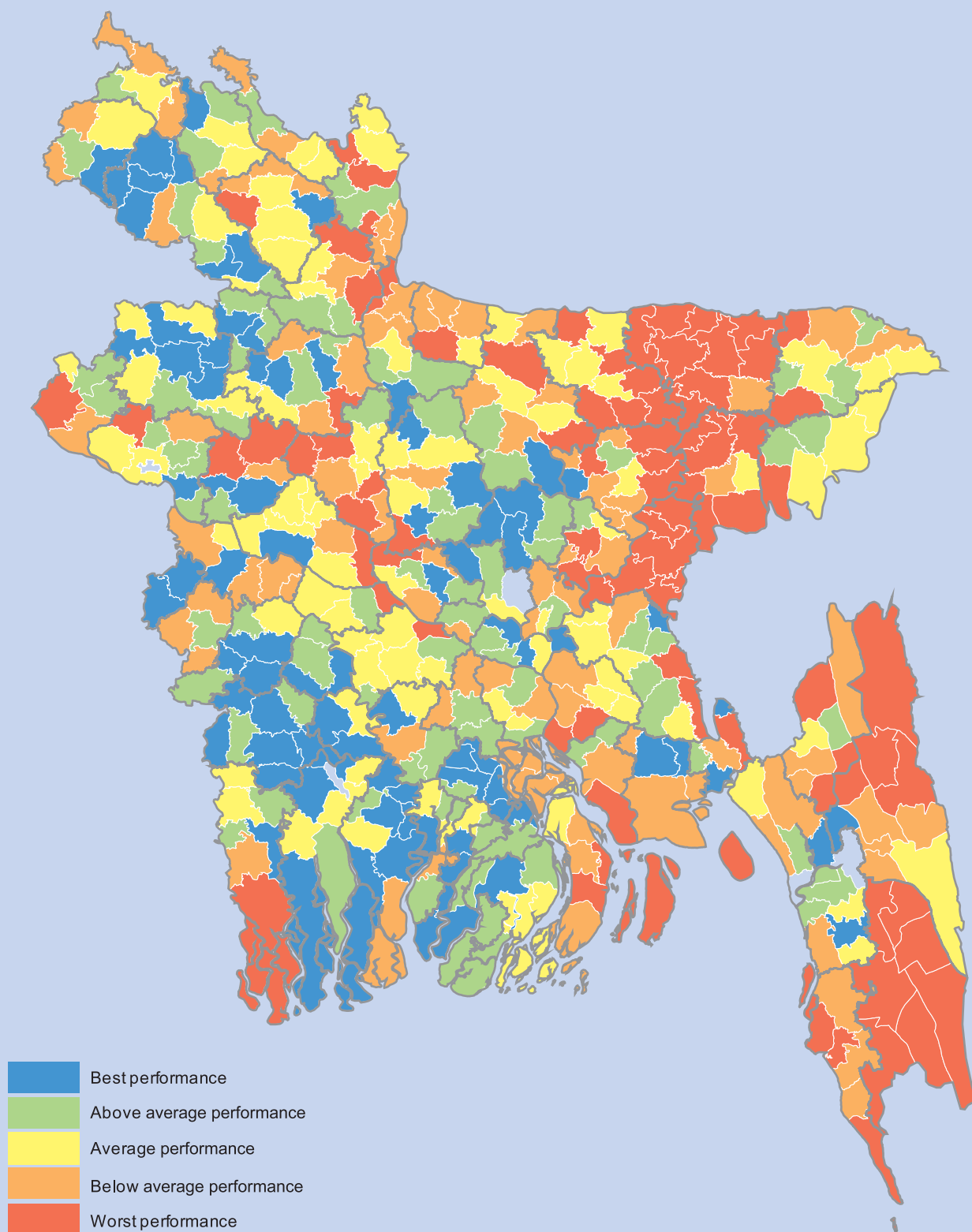
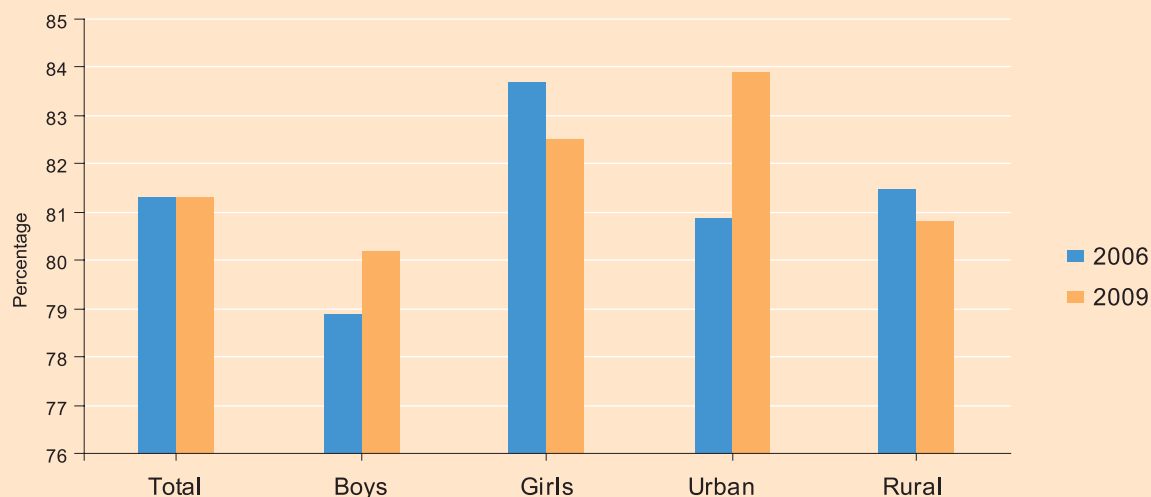


FIGURE 1

Net attendance rate in primary education, 2006 and 2009



## RATIO OF GIRLS TO BOYS IN PRIMARY AND SECONDARY EDUCATION

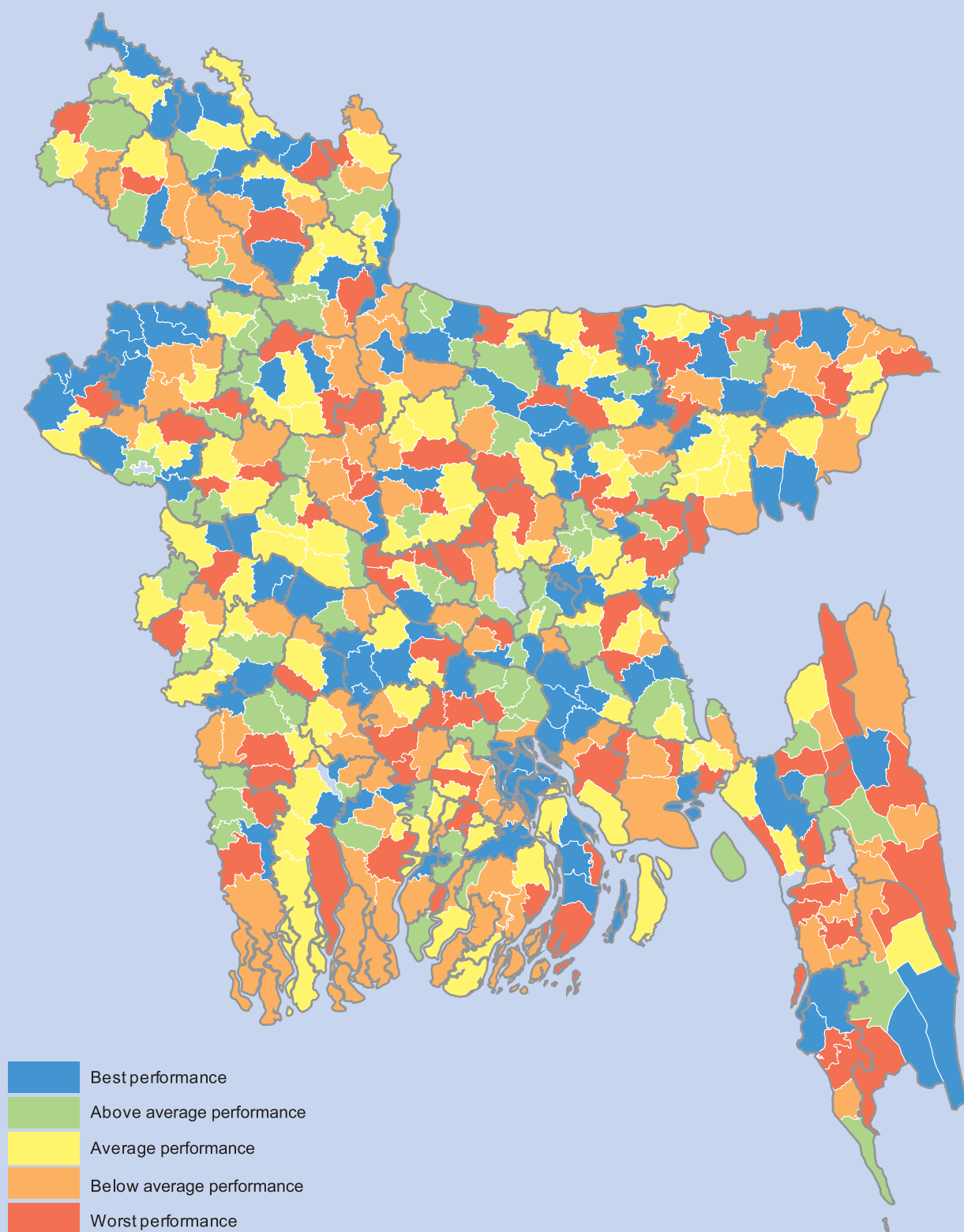
The ratio of girls to boys attending primary and secondary education is provided in Table 6 in the attached CD. The table shows that gender parity for primary school is close to 1.00, indicating no difference in the attendance of girls and boys at primary school.

In 2009 the ratio in primary education decreased from 1.06 to 1.03 while it increased for secondary education, which rose to 1.17 from 1.14 in 2006.



MAP 4

Gender disparity in primary education



## CHILD MORTALITY

Monitoring progress towards MDG 4: “reduce child mortality” is important but challenging. The 2009 Bangladesh MICS used the “indirect method”, by comparing the numbers of children ever born and children who died from women of child-bearing age (15-49 years), to measure childhood mortality. The infant mortality rate (IMR) is the probability of dying before the first birthday. The under five mortality rate (U5MR) is the probability of dying before the fifth birthday.

The IMR is estimated at 45 per 1,000 live births, while the U5MR is around 67 per 1,000 live births. The IMR was the highest in Sunamgonj (75) and lowest in Munshiganj (28). The highest U5MR was in Sherpur (102) and lowest in Pabna (43).

## MILLENNIUM DEVELOPMENT GOAL 4

Reduce child mortality

**Target:** Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Indicators available in MICS 2009

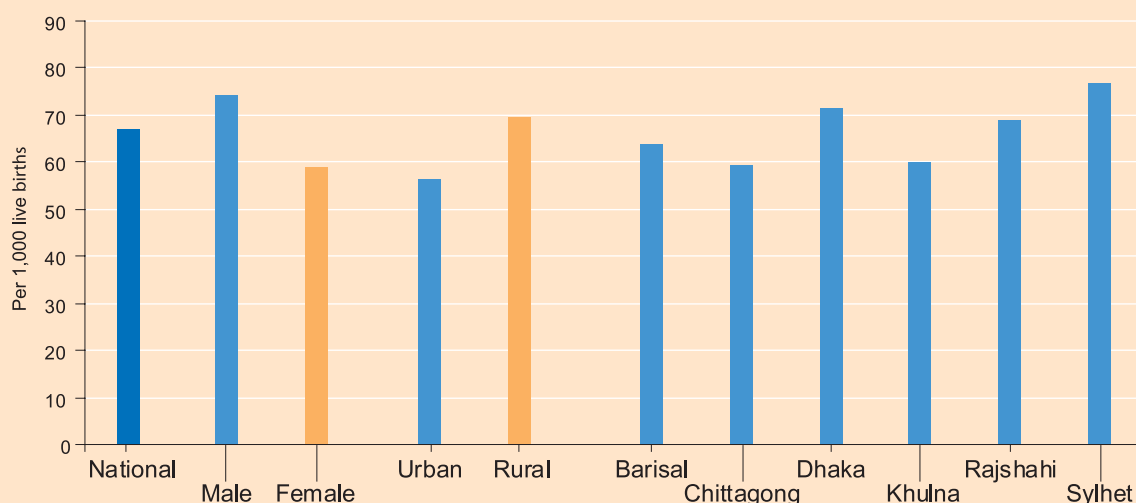
- ▶ Under-five mortality rate
- ▶ Infant mortality rate

FIGURE 2

Under-five mortality rate

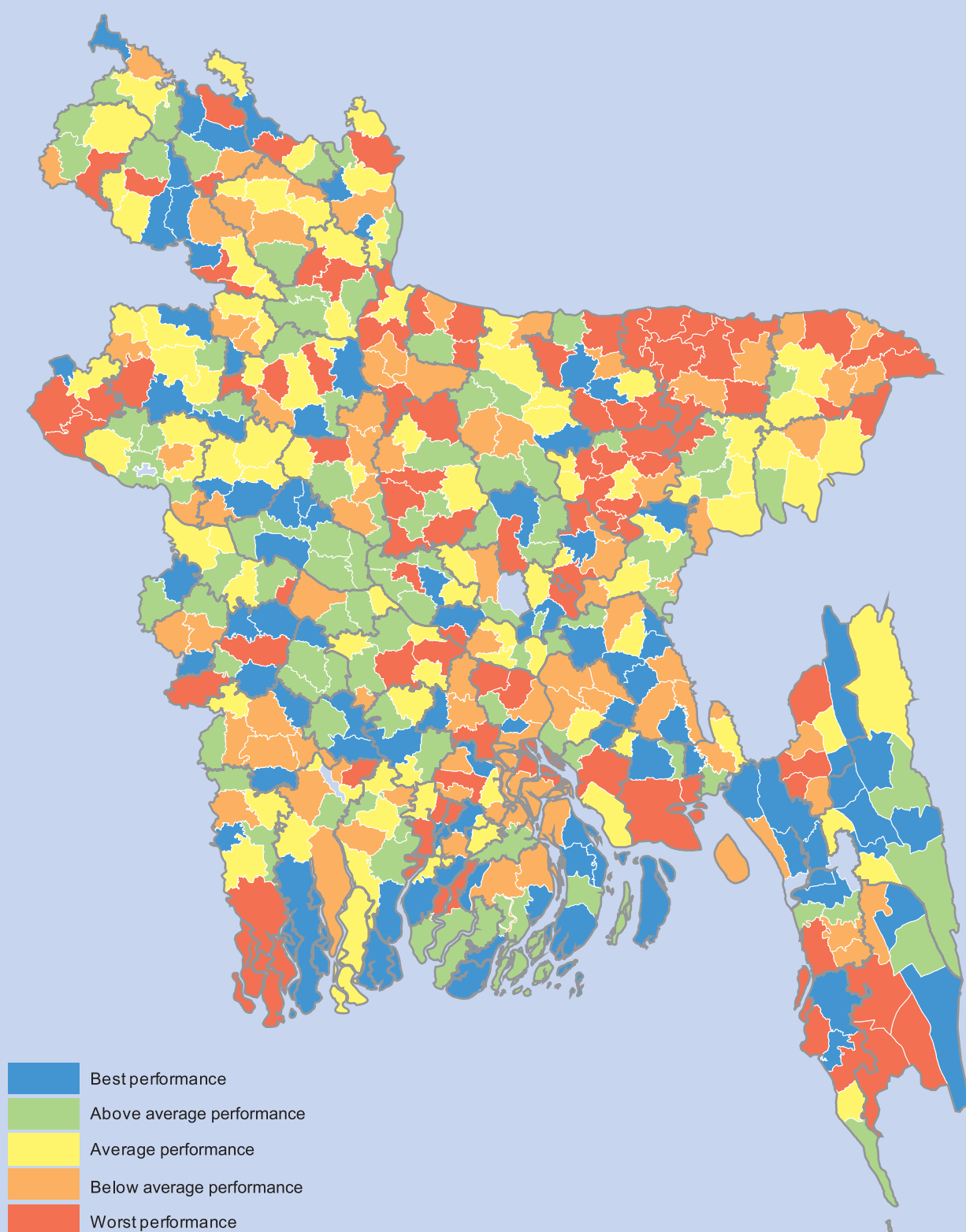


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MAP 5

Under-five mortality rate



## ATTENDANT AT DELIVERY

The provision of delivery assistance by skilled attendants can greatly improve outcomes for mothers and infants by the use of technically appropriate procedures, and accurate and speedy diagnosis and treatment of complications. Skilled attendant at delivery is defined as assistance provided by a doctor, nurse or midwife.

About 24.4 per cent of births occurring in the year prior to the MICS survey were delivered by skilled health personnel. This percentage is highest in Meherpur (61) district and lowest in Bandarban district with only 8 per cent.

The proportion of births attended by skilled health personnel raised to 24.4 per cent in 2009 from 20.1 per cent in 2006.

## MILLENNIUM DEVELOPMENT GOAL 5

Improve maternal health

**Target:** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicator available in MICS 2009

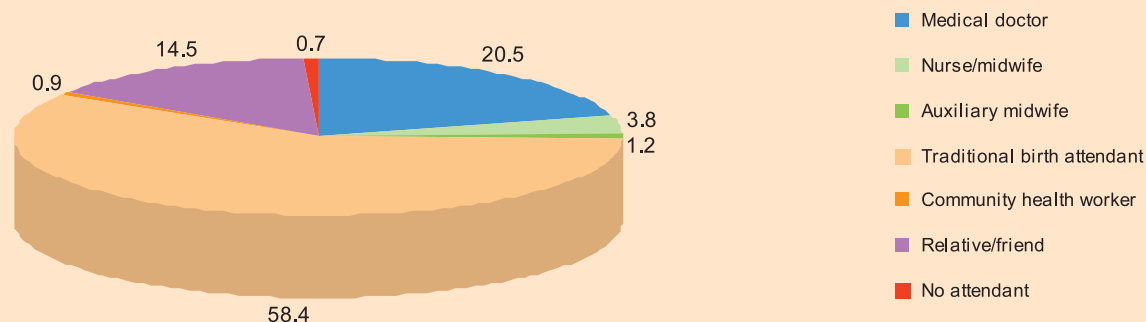
- Proportion of births attended by skilled health personnel



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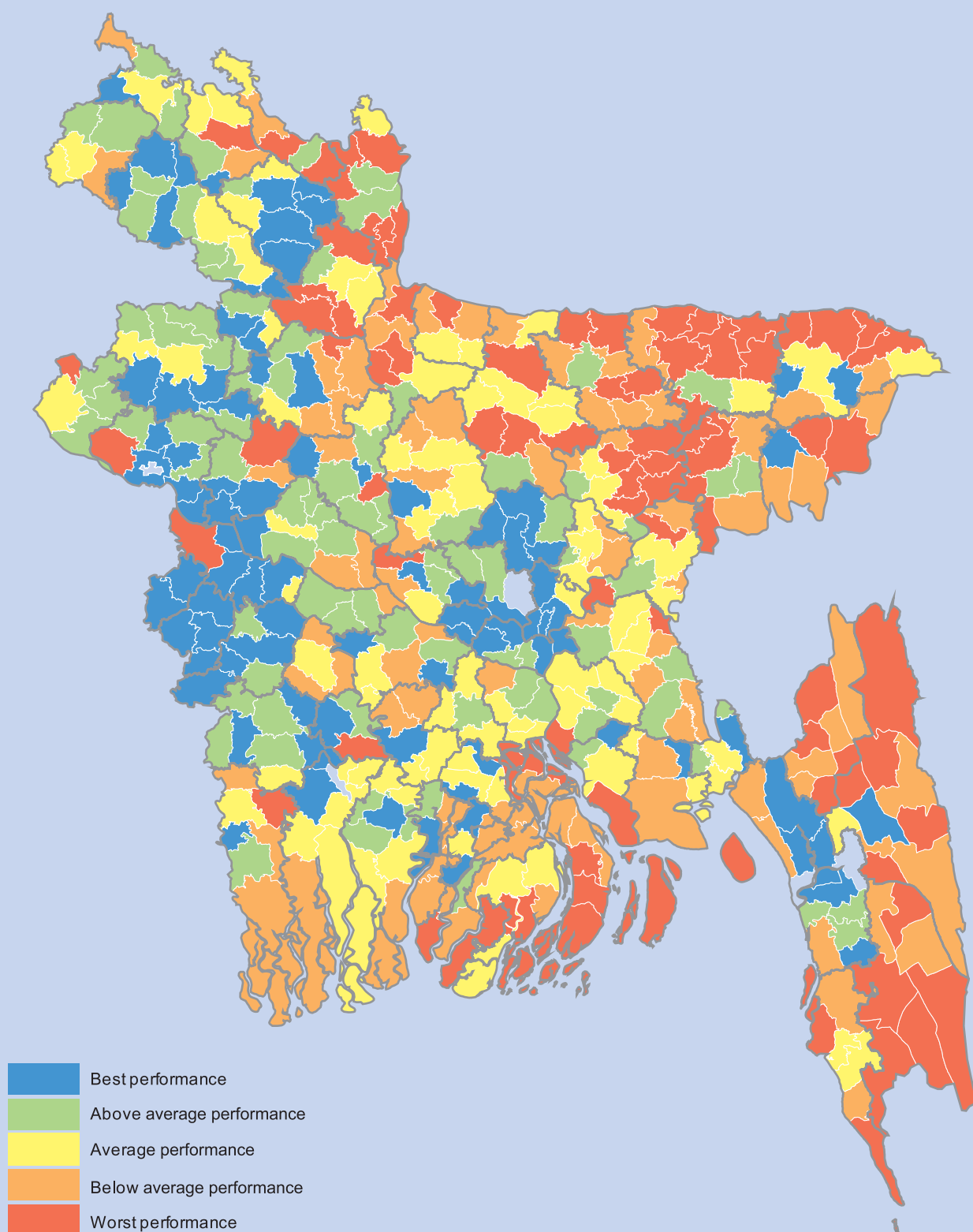
FIGURE 3

Proportion of different types of attendant at delivery



MAP 6

Proportion of births attended by skilled health personnel



## KNOWLEDGE OF HIV AND AIDS TRANSMISSION

One of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is the first step toward raising awareness and giving young people the tools to protect themselves from infection. Misconceptions about HIV are common and can confuse young people and hinder prevention efforts.

A key indicator used to measure countries' responses to the HIV and AIDS epidemic is the proportion of young people aged 15-24 years who know two methods of preventing HIV infection; reject two misconceptions and; know that a healthy looking person can have HIV.

Table 9 shows only 14.6 percent of women aged 15-24 years have comprehensive knowledge of HIV prevention. The knowledge level is higher among urban women than rural women.

The comprehensive correct knowledge of HIV prevention among women aged 15-24 years has decreased from 2006 when it stood at 15.8 per cent.

## MILLENNIUM DEVELOPMENT GOAL 6

Combat HIV/AIDS, malaria and other diseases

**Target:** Have halted by 2015, and began to reverse, the spread of HIV/AIDS

Indicator available in  
MICS 2009

- ▶ Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS

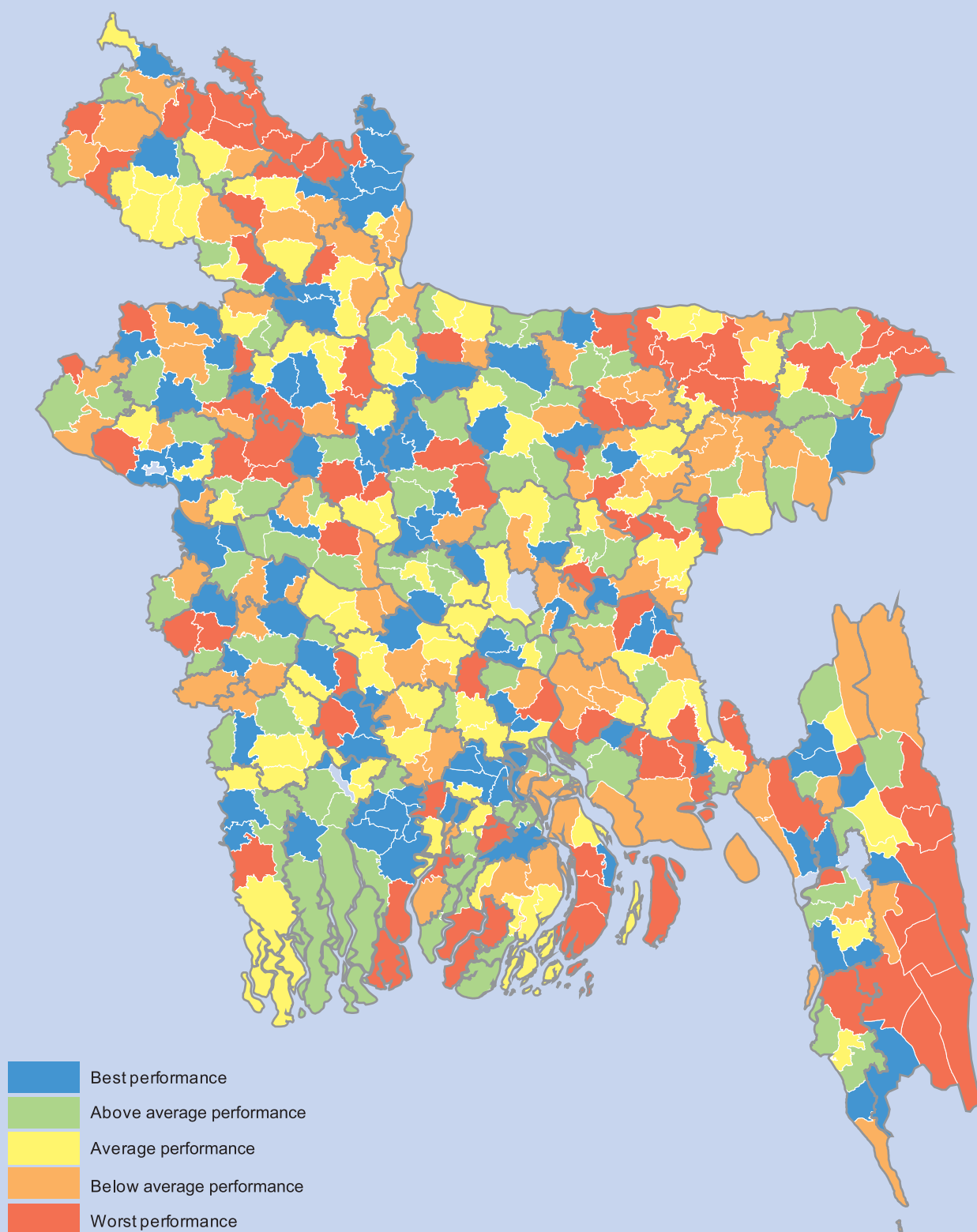


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## MAP 7

Proportion of women aged 15-24 years who have correct comprehensive knowledge of HIV and AIDS



## WATER AND SANITATION

Safe drinking water is a basic necessity for good health. Access to unsafe drinking water can lead to diseases such as diarrhoea, cholera, typhoid, and schistosomiasis. Drinking water can also be tainted with chemical, physical and radiological contaminants with harmful effects on human health.

The population using improved drinking water sources without taking the arsenic contamination into the consideration are those who use any of the following types of supply: piped water, public tap, borehole/tubewell, protected well, protected spring or rainwater. Overall, 97.8 per cent of the population used an improved drinking water source - 99 per cent in urban areas and 97 per cent in rural areas.

Households were requested to provide a glass of drinking water that was tested for arsenic content. The Bangladesh standard is the arsenic content less than 50 parts per billion (ppb), while the World Health Organization's (WHO) guideline is the arsenic content less than 10 ppb. Drinking water in 12.6 per cent (6.2 per cent in urban and 14.0 per cent in rural areas) of households exceeds the Bangladesh standard, while 23.1 per cent (14.3 per cent in urban and 25.1 per cent in rural areas) of households' drinking water exceeds the WHO's guideline. There are 3.3 per cent (1.4 per cent urban and 3.5 per cent rural areas) of households with arsenic contamination higher than 200 ppb, these should be preferentially - and urgently - targeted as they are the most exposed to the negative effects of arsenic consumption.

Taking arsenic contamination into consideration in addressing coverage with improved water sources, 85.2% per cent of population are currently using an improved drinking water source (93.3 per cent in urban and 83.4 per cent in rural areas) following the Bangladesh national standards. However, using the WHO guideline, 74.7 per cent of population are using an improved drinking water source in Bangladesh - 85.2 per cent in urban and 72.3 per cent in rural areas.

## MILLENNIUM DEVELOPMENT GOAL 7

Ensure environmental sustainability

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

**Target:** By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

Indicators available in  
MICS 2009

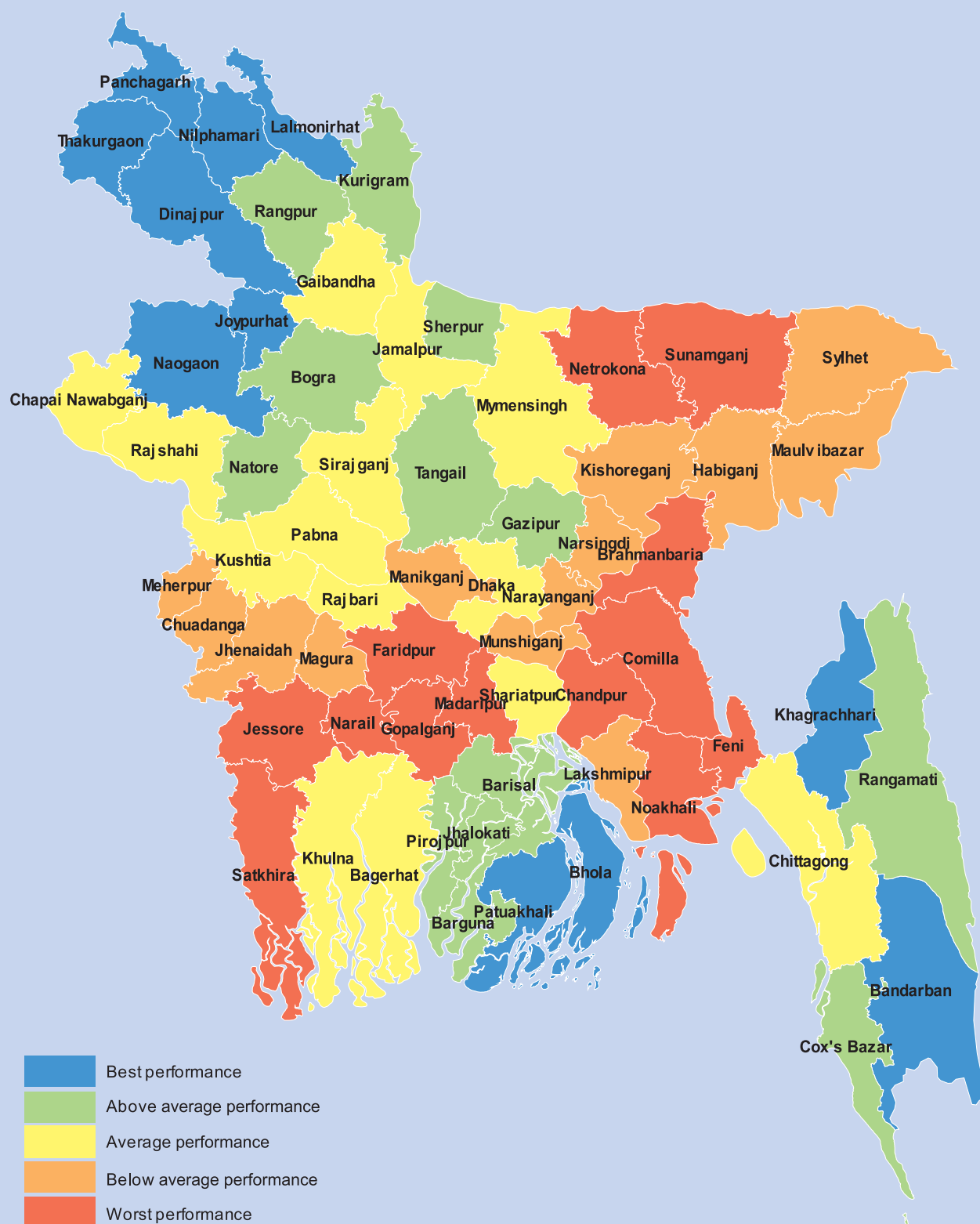
- ▶ Proportion of population using an improved drinking water source
- ▶ Proportion of population using an improved sanitation facility



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MAP 8

Proportion of household drinking water contaminated by arsenic content ( $\geq 50$  ppb)

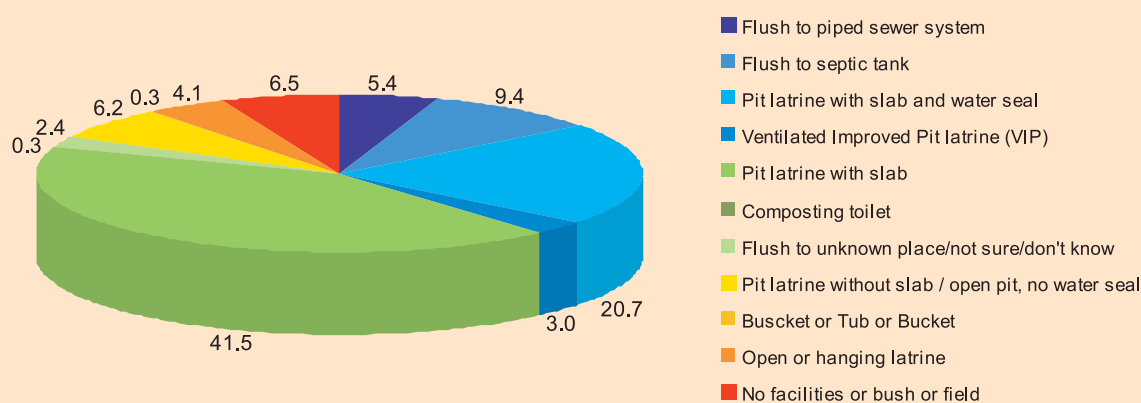


Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including diarrhoea and polio. Improved sanitation facilities include: flush toilets connected to sewage systems, septic tanks or pit latrines, ventilated improved pit latrines and pit latrines with slabs, and composting toilets. About 80 per cent of the Bangladesh population is living in households using improved sanitation facilities. The rates are 86.4 per cent in urban areas and 78.9 per cent in rural areas.

The proportion of population using an improved sanitation facility increased to 80.4 per cent from 39.2 per cent in 2006. However, this “major improvement” is largely attributed to a change in the definition of the sanitation technology types used, combined with training of the MICS surveyors to properly identify each technology and thus align the findings with the UNICEF/ WHO Joint Monitoring Programme used globally. Comparison between 2006 and 2009 MICS data is therefore difficult. In 2006, all pit latrines without a water seal were considered “unimproved” and grouped together with pit latrines without slabs and open pits. After making a correction for this in the 2006 MICS data, the estimated actual progress in terms of improved sanitation coverage is approximately 12 percentage points in the period 2006 to 2009.

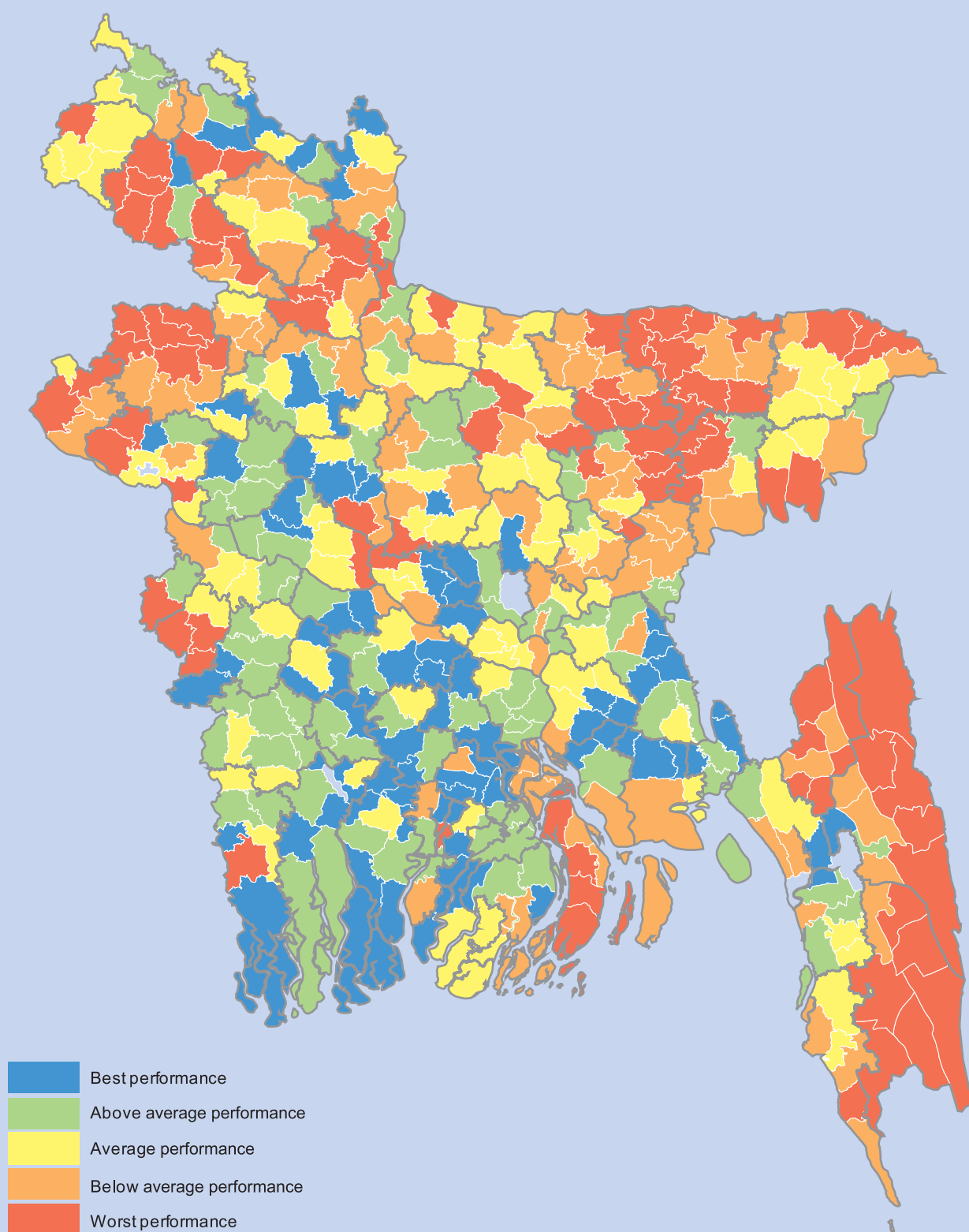
FIGURE 4

Types of household sanitation facilities



## MAP 9

Proportion of population using an improved sanitation facility



## BIRTH REGISTRATION

The International Convention on the Rights of the Child states that every child has the right to a name and a nationality and the right to protection from being deprived of his or her identity. Birth registration is a fundamental means of securing these rights for children.

The births of 53.6 per cent of children under five years of age in Bangladesh have been registered. There are no significant variations in birth registration across sex, age, urban and rural areas. Birth registration rates increased by 43.8 percentage points from 9.8 per cent in 2006.

## MILLENNIUM DECLARATION VI:

Protecting the vulnerable

To encourage the ratification and full implementation of the Convention on the Rights of the Child and its Optional Protocols on the involvement of children in armed conflicts, child prostitution and pornography.

Indicator available in  
MICS 2009

- Proportion of children under-five with birth registration



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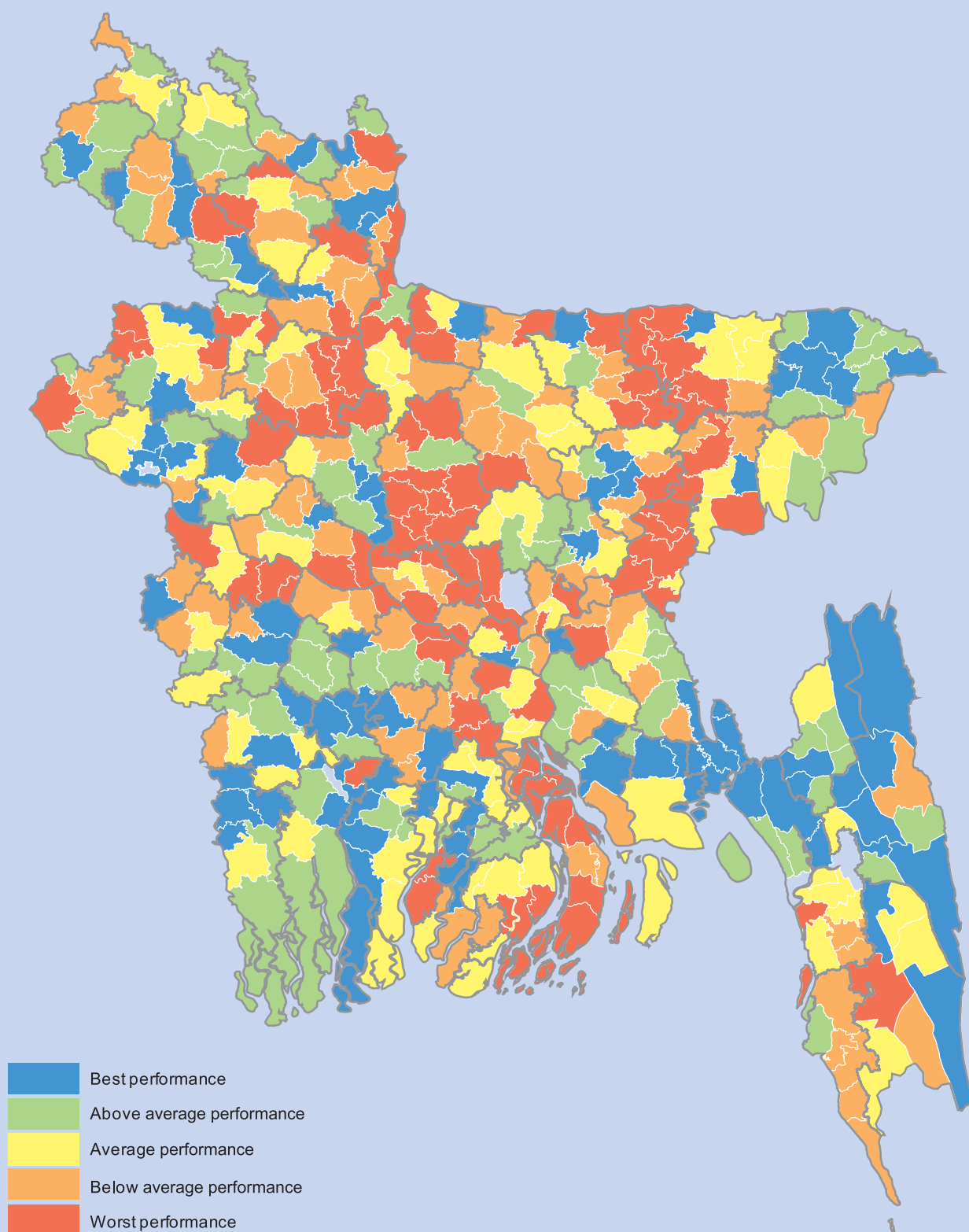
## CONCLUSION

A large range exists in the geographic disparities between the best and worst performing districts for several of the above presented indicators including infant mortality (47 percentage points), skilled attendant at delivery (53 percentage points), under-five mortality (59 percentage points) and, net attendance in primary education (30.4 percentage points). Returning to the previously raised question: “*should one wait for income/expenditure poverty to be reduced, or should one target the most deprived population with basic services to reduce poverty?*”, it is quite obvious from the above that a great potential exists for better geographic targeting of interventions in the least performing districts and *upazilas* - so that progress in MDG achievement can be made while reducing geographic disparities. This could be considered a key poverty reduction strategy when developing the five-year National Development Plan.



MAP 10

Proportion of children under-five who received birth registration







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