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Human Poverty and Millennium Development Goals (MDGs) in Bangladesh

Nazmul Islam*
Md. Reazul Haque**

Millennium Development Goals (MDGs) have given special emphasis on various aspects of human poverty. Education and health status and their related issues measure the incidence of human poverty. Almost all the MDGs are directly or indirectly related to human poverty, but MDGs 2, 3, 4, 5 and 6 focus on human poverty issues directly. The overall record of achievements in health sector in Bangladesh over the late 1990s and early twenties includes decrease in maternal mortality rate (from 554 per 100,000 live births in 1990 to 348 in 2008/2009), decrease in infant mortality rate (from 94 per 1,000 in 1990 to 41.3 in 2009), reduction in under-five mortality rate (from108 per 1,000 live births in 1990 to 53.8 in 2008/2009) [Bangladesh Economic Review, 2010; Mid-Term Bangladesh Progress Report 2007 and The Millennium Development Goals Bangladesh Progress Report 2009], increase in literacy rate from 35 in 1990 to 58.3 in 2008/2009 (Human Development Report 2007/2008 and The Millennium Development Goals Bangladesh Progress Report 2009). The successes of Bangladesh in these sectors have largely been attained through the introduction of public-private collaboration, civic participation while providing access to services. However lack of good governance, weak local government structure, rampant corruption, political instability and bureaucratic hindrances have been incessantly airs threats to further success in falling human poverty reduction to achieve MDGs. Taking all these and the fact that the poor are the most vulnerable to human poverty in Bangladesh, this paper delineates the human poverty scenario of the country and draws some policy recommendations, which will improve the livelihood as well as health status of people who are deprived from basic health services and universal education.

Introduction:

Millennium summit held in September 2000 have launched 8-goals ambitious agenda named Millennium Development Goals (MDGs[1]),

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[1]MDGs are: 1. Eradicate extreme poverty and hunger; 2. achieve universal primary education; 3. promote gender equality and empower women; 4. reduce child mortality; 5. improve maternal

which are a set of numerical and time-bound targets related to key achievements in Human Development (HD). MDGs have focused mainly on the basic needs fulfilment and have posed most priorities on health education and their related issues. Health and education status are universally regarded as important indices of human development. Ill health and illiteracy are both the cause and effect of poverty. Policies regarding human poverty reduction not only raise the income of the people but also improve other components of their standard of living, such as life expectancy, health status, literacy, knowledge and control over their destiny. Health, education and development converge and contribute to each other.

Bangladesh faces some serious challenges in achieving MDGs related to human poverty. These include diverting more investment to primary schooling by, for example, providing monetary and material incentives to retain students beyond enrolment, developing and keeping effective monitoring, prevention and control mechanisms for communicable diseases, reducing maternal mortality, maintaining biodiversity, increasing access to sanitary latrines, and improving service delivery in the rapidly growing urban slums.

This paper is an attempt to examine the progress and challenges to reduce human poverty to attain the MDGs. The paper has been organized as follows. With an introduction in section 1; section 2 discusses the methodology of the study which explores the sources of data and the method followed. Section 3 analyzes the current status of major human poverty indicators in Bangladesh, which indicates that some goals are on track and some are not on track till 2009. Section 4 presents the comparison between Bangladesh with other SAARC countries in terms of health and education status which states that Bangladesh is in a vulnerable position compared to other countries. Section 5 identifies the importance of human poverty reduction to achieve MDGs which emphasizes on the better health and quality education of people that increases their productivity. Section 6 shows the present situation of human poverty reduction financing and existing policies in Bangladesh, and finally section 7 puts forward conclusion and policy recommendations.

Methodology

The data and information used in this research have been obtained from secondary sources like Bangladesh Bureau of Statistics (BBS)

health; 6. combat HIV/AIDS, malaria and other diseases; 7. ensure environmental sustainability; 8. develop a global partnership for development.

publications, different issues of Bangladesh Economic Review (2006, 2007, 2008, 2009, 2010 and 2011); Household Income and Expenditure Survey (HIES) 2005; Millennium Development Goals Mid-Term Bangladesh Progress Report 2007; United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNESCO/UIS (UNESCO Institute of Statistics), including the Education for All 2000 Assessment; Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS); UNICEF, United Nations Population Division and United Nations Statistics Division; First and Second Poverty Reduction Strategy Papers (PRSP), Human Development Report 2007/2008, Bangladesh National Health Accounts 2 and World Development Report 2008. Books, periodicals, journals, paper cutting, internet search, concerned organizations (government and non government organizations) also helped to collect information and analysis of the issue.

Current Status of Major Human Poverty Indicators: Bangladesh Scenario

The trends of some indicators of MDGs related to human poverty are satisfactory, some are not on right trend and some are marginally on track till 2009 considering 2002 as benchmark. Bangladesh has recorded a remarkable success in increasing primary school enrollment (MDG 2), but problems in retaining pupils to completion of primary education, plus relatively low adult literacy rates threaten overall progress.

Table 1 represents health status in Bangladesh. Scrutinizing the table reflects some of the features of the human poverty in Bangladesh.

- In contrast to the required adult literacy rate to achieve MDG 2 is 6.3, the existing rate is only 3.5. We are far behind the target. It was supposed to increase the secondary enrolment rate by 6.1 percentage points over the period 2002-2015 to achieve the goal by 2015, actually it increased by 0.66 percentage points over 2002-2008/2009. It is indeed a disappointing outcome. Additional attention is necessary to reach the target in secondary and adult literacy.

Table 1. Target setting on indicators of MDGs related to human poverty against 2002 Benchmark

Indicators	1990	2002 (Benchmark)	Annual Progress Over 1990-02 (%)*	Target 2015	Targeted Annual Progress Over 2002-15 (%)	2005-06	Annual Progress over 2002-2005/06 (%)	Current Status (2008-2009)	Annual Progress over 2002-2008/2009 (%)	Comments
Adult Literacy (Percent)	35	49.6	3.5	90	6.3	53.7	2.75	58.3 (2007)	3.5	not on track
Primary Enrolment (percent)	56	86.7	4.6	100	1.2	93.7	2.69	91.9	10.68	on track
Secondary Enrolment (Percent)	28	52.8	7.4	95	6.1	42.66	-6.40	54.9	0.66	not on track
Infant Mortality Rate (per 000 Live births)	94	53	-3.6	18	-5.1	45.0	-5.03	41.3	-3.68	not on track
Under - Five child Mortality Rate (per lakh live births)	108	76	-2.5	25	-5.2	62	-6.14	53.8	-4,87	not on track but almost to the target
Maternal Mortality rate (per lakh live births)	554	390	-2.5	98	-5.8	290	-8.55	348	-1.79	not on track

Note: *Annual progress shows simple growth rate

Source: First PRSP, Mid-Term Bangladesh Progress Report, 2007, General Economic Division, Planning commission, GOB; The Millennium Development Goals Bangladesh Progress Report 2009, General Economic Division, Planning commission, GOB; Bangladesh Economic Review 2010; Banbeis; Bangladesh Bureau of Statistics(BBS) and estimated.

- Though Bangladesh's progress in MDG 4 (reducing the under-five child mortality and the infant mortality rate) is particularly encouraging till 2005, the rate of decline was fallen in 2009. It becomes difficult to meet the target before 2015, if recent trend is maintained.

- Maternal mortality rate (per lakh live births) reduced from 390 in 2002 to 290 in 2005. It was expected to achieve MDG 5 (reducing maternal mortality) by 2015. But unfortunately it

increased to 348 in 2009. It's very uncertain whether it would be possible to reach the goal within the time frame.

Bangladesh achieved MDG 3 (gender parity in primary and secondary schooling) in 2005, but the progress of gender parity in tertiary education and the share of women in political leadership will need farsighted and challenging policy interventions.

Bangladesh is in a favorable position for achieving the MDG 6 targets. The incidence of HIV is still low - currently less than 0.1 percent. The rates of condom use among different MARP sub-groups have increased significantly. However, a significant proportion of them are not using it at every high risk sexual encounter creating risk of escalation of HIV infection. Short and long-term trends show a decline in number of malaria cases and deaths through 2009 as a result of major interventions for malaria control. The rate of multidrug-resistant TB, though increasing, appears still low and does not yet have an important impact on the country's epidemiology (The Millennium Development Goals Bangladesh Progress Report 2009).

Cross Country Comparison of Human Poverty Indicators

Maternal Mortality Rates (MMR) is high in countries where women have low status, and in areas with poor access to routine health services in general (Hamid et al 2004).

Table 2 represents education and health status in Bangladesh compared to some other countries in South Asia. Analyzing the table reflects some of the features of the human poverty in Bangladesh:

- Except Bhutan and Pakistan, the adult literacy rate of all other SAARC countries is higher than that of Bangladesh.
- Primary school enrolment in Bangladesh is much higher than that of Afghanistan and Pakistan though it is significantly lower than that of Sri Lanka and Maldives.
- The male youth literacy rate in Bangladesh is considerably low compared to the SAARC countries excluding Afghanistan. In contrast to this the rate is noticeably higher in case of female.
- Infant mortality rate is 41 per thousand in Bangladesh that is the fourth lowest among the countries. Afghanistan holds the highest

figure and the counterpart belongs to Maldives. The similar picture is visible in case of under five child mortality.

Table 2. Current Health Status Indicators in SAARC Countries

Country	Total Adult Literacy Rate (%) 2005-2009	Primary School Net Enrolment (%) 2005-2009	Youth(15-24) Literacy Rate (%), 2004-2008,Male	Youth (15-24) Literacy Rate (%), 2004-2008, Female	Infant Mortality Rate (per 1000 Live births) 2009	Under - Five Child Mortality Rate (per 1000 Live Births) 2009	Maternal Mortality Rate (per 100000 Live Births) 2005-2009	Life Expectancy at Birth (years) 2009
Afghanistan	-	61	49	18	134	199	1600	44
Bangladesh	55	85	73	76	41	52	350	67
Bhutan	53	87	80	68	52	79	260	66
India	63	83	88	74	50	66	250	64
Maldives	98	96	99	99	11	13	140	72
Nepal	58	84	86	75	39	48	280	67
Pakistan	54	71	79	59	71	87	280	67
Sri Lanka	91	99	97	98	13	15	39	74

Source: United Nations Educational, Scientific and Cultural Organization (UNESCO) and UNESCO/UIS (UNESCO Institute of Statistics), including the Education for All 2000 Assessment; Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS); UNICEF, United Nations Population Division and United Nations Statistics Division; www.unicef.org/index.php

- In Bangladesh the maternal mortality rate is 350 per lakh that is the second highest among the SAARC countries. The rate is the highest in Afghanistan whereas the lowest in Sri Lanka. Furthermore, Bangladesh is one of the countries where maternal deaths are highest in the world.
- Life expectancy at birth in Bangladesh is comparable to some other neighboring countries, whereas she lags behind significantly compared to Sri Lanka and Maldives on this account.

The main reason of high maternal and neonatal mortality in Bangladesh is that most of the mothers do not receive modern delivery care; rather they use traditional unsafe delivery care at home. It is established that the most (78%) of the mothers deliver their children without the presence of any trained and expert hand and overwhelming majority (92%) of mothers seek delivery care at home (Hamid et al

2004). Bangladesh lies in the underneath of the use of modern delivery care evidenced from the cross-country comparisons.

During delivery the presence of skilled attendants were found at 14, 62, 99, 46, 35, 36, 45, 90, 8, 18, 53, 94 and 69 percent cases in Bangladesh, Cameroon, Cuba, Egypt, India, Indonesia, Kenya, Maldives, Nepal, Pakistan, Philippines, Sri Lanka, and Zimbabwe respectively (WHO and World Bank 1997). In addition, the percentage of women undergone modern delivery system was found at 98, 54, 35 and 27 in developed, developing, South Asian and least developed countries respectively (UNICEF 2001).

Importance of Human Poverty Reduction to achieve MDGs:

The importance of human poverty reduction is widely recognized in all societies irrespective of the levels of development. Human poverty reduction means to achieve universal education and health. Without achieving universal education and health it's almost impossible to achieve the other Millennium Development Goals. An educated, trained and healthy population can play an important role in improving the quality of life, reducing poverty and attaining sustainable economic growth.

Education is the key to reducing child hunger in terms of educating mothers. In addition, to reduce child mortality, as giving mothers just five years of education can lead to a reduction in child mortality. When it comes to all of the Millennium Development Goals, education is central. A significant per cent of the varying rates between different countries' maternal mortality can be explained by a lack of education. It's going to stop us from defeating AIDS and preventing the spread of AIDS. HIV and poverty are closely intertwined. The poor are the most vulnerable to infection and the hardest hit by the costs and the burden of HIV/AIDS.

Development is related to health outcomes and that poverty and its consequences are related to ill-health. Workers become more efficient, if they have good health, their working hours also increase. Production of the economy increases owing to better health and qualitative education using the same level of labour inputs.

At this instant in measuring the stage of development, human poverty is considered as an important yardstick. Human poverty is receiving increasing attention in determining the global development agenda.

Present Situation of Human Poverty Reduction Financing and Existing Policies in Bangladesh

Health expenditure as a percentage of total public expenditure has increased to 6.86% in 2009/10 from 5.9% in 2001/02. Health spending as a proportion of GDP has also increased to 1.01% in 2009/10 from 0.87% in 2001/02. Education expenditure as a percentage of total public expenditure is 14.16% in 2009/10 and spending as a proportion of GDP is 2.08% in 2009/10 which is really inadequate amount to achieve MDGs within the time frame (Budget Speech 2011-2012). It is disappointing that the health expenditure as a proportion of GDP was almost stagnant over the last decade.

Table 3 shows the total allocation in development and non-development budget in the social sector during FY 2000-01 through 2009-10. It is evident from the statistics that the total allocation for health and education sector in development and non-development budgets shows an increasing trend over the past decade. At the same time it should also be mentioned that the budgetary allocation for health and education is merely sufficient.

Table 3. Allocation (Development and Non-Development) in the Social Sectors of Selected Ministries by Year (Tk. in Crore)

Sector	00-01	01-02	02-03	03-04	04-05-	05-06	06-07	07-08	08-09	09-10
Education, Science & Technology	6079	6063	6736	4878	7381	9373	11057	11654	12535	14387
Health and Family Welfare	2627	2649	2797	3445	3175	4112	4957	5261	6196	6980

Sources: Finance Division, Ministry of Finance, Planning Commission, Ministry of Planning; Bangladesh Economic Review 2010.

In order to reduce human poverty the following steps have been taken by the government of Bangladesh (Bangladesh Economic Review 2010) to attain the MDGs:

- The Second Primary Education Development Program (PEDP-II) is being implemented to develop the quality of primary education. Through various activities under this program, priorities have been given to increase the number of enrolment and attendance of school-going children, reduce drop-out rate, and enhance school contact hour.

- Under the present policy of recruitment of teachers, a 60:40 ratio of female to male is followed. The current ratio of female and male teachers is 52.74:47.26 in government primary schools.

- Decentralization of administrative and financial power in primary education has been implemented. As steps towards decentralization, School Level Improvement Plan (SLIP) and Upazila Primary Education Plan (UPEP) will be implemented in phases. Currently, SLIP is being implemented in 316 Upazilas.

- Improving the living standards of 33 lakh neo-literates of the country by providing various income generating training, based on local market demand.

- In the six divisional cities 2 lakh working children who belong to the age bracket of 10-14 years are being provided with basic education out of which 10 thousand children will be given life-skill based practical training.

- A human resource development plan has been put in place to ensure planned recruitment, promotion, training etc.

- From 2009, primary education terminal examination is being held in grade five using unique questionnaires throughout the country. Jatiyo Mohila Sangstha is implementing a project titled "District Based Women Computer Training (2nd Phase)" with the cost of Tk.1,675.47 to achieve the desired goal of socio economic development of our women. Implementation period of the project is July 2008 to June 2011.

- The process of implementation of the Urban Based Marginal Women Development Project began in February 2009. The duration of the project is between October 2009 to September 2013. The estimated cost of the project is Tk 1881.96 lakh which is being funded by the Government. During the project period, about 27,600 poor and unemployed women of urban areas will be given skill development training through 46 centers of Dhaka city and 25 districts including five other divisional headquarters.

- Under Rural Women Development Project, 70,000 poor distressed rural women have been trained in different agricultural and non-agricultural trades and 10,000 women have been provided with credit for taking up income generating activities,

so that they can improve their status in their family and society. As many as 11,700 women have been imparted training up to March 2009.

- A project titled "Early Learning for Child Development" is being implemented by 'Bangladesh Shishu Academy' in 64 districts to enhance appropriate interactive care and early learning activities for children in safe friendly learning environment in centers, homes, and communities.

- Department of Women Affairs (BWA) has established an "Employment Information Centre" where educated, skilled and unskilled women are registered according to their qualification. As many as 6,777 registered women's applications have been sent to different job agencies by this centre. The number of women who got employed so far is 228.

- Jatiya Mahila Sangstha (JMS) has been imparting skill development training to the poor, backward and unemployed women for their self-employment and economic emancipation. From 1995-96 to 2008-09, a total of 4,054 women were given training in tailoring, embroidery, block batik and tiedie printing and leather crafts. This programme is being implemented at the JMS head office and its district and upazila branches under the revenue budget.

Conclusion and Policy Recommendations

Although the progress towards MDG 2 has been commendable, the challenges remain large in achieving the targets. It is critical that current efforts can be sustained and new initiatives introduced. In terms of the education target, Vision 2021 aims to reach 100% net enrolment in primary schools by 2011, ensure free tuitions up to the degree level soon after 2013, eradicate illiteracy by 2014, and impart skills in Information Technology to all by 2021. Vision 2021 has also made commitments to the development of human resources, which include allocation of a higher proportion of the budget to education, improvement in the quality of education, increase in the salary of teachers and particular attention to disadvantaged groups including urban working children.

A significant partnership between the Government of Bangladesh and development partners has been nurtured and built in the context of the MDG 2 that pertain to education and the six Education for All (EFA)

goals. Progress has been made in increasing equitable access, reducing dropouts, improving completion of the school cycle and implementing a number of quality enhancement measures in primary education. Bangladesh has achieved gender parity in primary and secondary enrolment. To sustain this success government should continue the support in terms of physical and monetary terms.

Health system constraints undermine effective, efficient and equitable health care services. Inadequate coordination between health, family planning and nutrition services prevent the effective use of limited resources and frequently result in inefficiencies, missed opportunities and duplication. There are some geographic pockets where services are not adequate and accessible to the community creating geographical disparity in service utilization.

Significant challenges exist in the way of achieving MDG 3. These include creating effective and efficient linkage between different relevant ministries for addressing women and development issues, and addressing various socio-cultural factors that underpin their vulnerabilities. The promotion of gender equality and the empowerment of women require fundamental transformation in the distribution of power, opportunities, and outcomes for both men and women. Special emphasis needs to be put on formulation, adoption and implementation of laws and policies, bringing social change to reduce vulnerabilities, encouraging evidence based programming, providing well targeted and efficient social protection, and gender mainstreaming.

Although Bangladesh is in a favorable position for achieving the MDG 4 targets, a number of challenges remain. Bangladesh has been implementing the Integrated Management of Childhood Illness (IMCI) strategy since 2003. It has also developed the National Neonatal Strategy and Guidelines to address the urgent needs of improving newborn survival. However, implementation of these policies still lags behind. There is an urgent need to develop, finalize and implement Child and Neonatal Health Actions Plans and address the issue of community case management of pneumonia and sepsis.

Injury is an emerging challenge for children in Bangladesh. This area requires multi-sector collaboration and development of a National Injury Prevention Strategy along with effective and efficient implementation of the strategy.

Reducing substantial differences in health outcomes between regions and socio-economic groups remains a constant challenge. Differences can be tackled through geographical and poverty targeting. Safety net mechanisms must be put in place and provide services in low performing regions and hard-to-reach areas (e.g. haor, hill, char islands, urban slums) through GoB-NGO and public-private collaboration and partnership. The government needs to improve the health and development of children

through universal access and utilization of quality newborn and child health services.

To achieve the MDG 5 goals and targets, Bangladesh must first effectively address the three pillars for reducing maternal deaths within the health care system. These include Family Planning (FP), Skilled Birth Attendants (SBAs) and Emergency Obstetric Care (EmOC). Strengthened sexual and reproductive planning and health care are needed to prevent unintended pregnancies and unsafe abortions. The life-cycle approach should be used to address the general and reproductive health needs of women and to ensure reproductive health and rights in all phases of life. Essential health services should be provided in an integrated manner and vertical service delivery should be avoided. Demand for services should be stimulated through strengthening health promotion at the community level with individuals, family members and the wider community.

Notwithstanding the low incidence of the three diseases (HIV/AIDS, malaria and other diseases) and the progress made Bangladesh face some challenges in maintaining the trend. These include inadequate coverage of MARP, limited technical and managerial capacity and inadequate government funding in the government bodies in charge of control of these diseases, and lack of strategic information management. Future priorities will focus on strengthening coordination in the national response, improving programme management, facilitating scaling up of quality interventions, improving participation of civil society in programme planning/implementation and oversight, and improving access equity for niche populations.

Progress towards the human poverty related MDGs cannot be accelerated without strengthening the delivery of health care services and universal education, especially women and children, the marginalized and poor. What is required is for all partners to lift out of the plans a set of key interventions which if carefully resourced, implemented and monitored, will yield measurable progress towards the MDGs. An added sense of urgency will also be required in the implementation of this key set of interventions. Regular monitoring and reporting of progress towards MDGs to oversight structures should be institutionalized. Similar structures at district levels should be charged to do the same. Good quality and reliable data should be generated to illustrate the gaps in health and education service provision, and used to mobilize more resources for the health and education sector from other sources of funding.