Pre-natal to Transition to Schooling in Bangladesh: A Scoping Study of ECCD Status including Early Grades Primary Education

SUBMITTED BY:

Dr. Mohammad Mahboob Morshed

Associate Professor
Institute of Education and Research
University of Dhaka

SUBMITTED TO:

Bangladesh ECD Network
House # 113, Road # 2, Block-A, Niketon
Gulshan 1, Dhaka-1212

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Messages

Chairperson
Bangladesh ECD Network (BEN)

Vice-Chair
Bangladesh ECD Network (BEN)

Acronyms

ADC – Additional Deputy Commissioner

ADHD – Attention Deficit Hyperactivity Disorder

ANC – Antenatal Care

BBS – Bangladesh Bureau of Statistics

BEN – Bangladesh ECD Network

BRAC IED – BRAC Institute of Educational Development

BSA – Bangladesh Shishu Academy

CAMPE – Campaign for Popular Education

CECCD – Comprehensive Early Childhood Care and Development

CIPRB – Centre for Injury Prevention and Research

CPE – Early Childhood Centre (Centre de la petite enfance)

DC – Deputy Commissioner

DSS – Department of Social Services

ECCD – Early Childhood Care and Development

ECCE – Early Childhood Care and Education

ECD – Early Childhood Development

ECE – Early Childhood Education

ELDS – Early Learning and Development Standard

EOC – Emergency Obstetric Care

EPI – Expanded Programme on Immunization

ESDC – Employment and Social Development Canada

ESP – Essential Service Package

FGDs – Focus Group Discussions

GO – Government Organization

GPS – Government Primary School

HPNSP – Health Population and Nutrition Sector Programme

ICBC – Integrated Community-Based Center

ICDDR,B – International Centre for Diarrhoeal Disease Research, Bangladesh

ICDS – Integrated Child Development Services
ICMH – Institute of Child and Mother Health
ICT – Information and Communication Technology
IDIs – In-depth Interviews
IMCI – Integrated Management of Childhood Illness
INGO – International Non-Governmental Organization
ISCED – International Standard Classification of Education
KIIs – Key Informant Interview
M&E – Monitoring and Evaluation
MICS – Multiple Indicator Cluster Survey
MoE – Ministry of Education
MoHFW – Ministry of Health and Family Welfare
MoPME – Ministry of Primary and Mass Education
MoWCA – Ministry of Women and Children Affairs
NCTB – National Curriculum and Textbook Board
NGO – Non-Governmental Organization
NICU – Neonatal Intensive Care Unit
NIMH – National Institute of Mental Health
NIPORT – National Institute of Population Research and Training
NNS – National Nutrition Services
PNC – Postnatal Care
PPE – Pre-Primary Education
PTI – Primary Teachers Training Institute
RMG – Ready-Made Garment
ROSC – Reaching Out of School Children
SBA – Skilled Birth Attendant
SDG – Sustainable Development Goals
SSS-CHT – Social Services in Chittagong Hill Tracts
TBA – Traditional Birth Attendant
UEO – Upazila Education Officer

UHO – Upazila Health Officer

UNESCO – United Nations Educational, Scientific and Cultural Organization

UNICEF – United Nations Children's Fund

UNO – Upazila Nirbahi Officer

URC – Upazila Resource Center

WASH – Water, Sanitation and Hygiene

WHO – World Health Organization

Executive Summary

Early childhood care and development (ECCD) from the prenatal period through transition to early primary education is critical to children's survival, learning, and long-term human development. Global and national evidence consistently demonstrates that investments made during pregnancy and early childhood yield the highest social and economic returns. In Bangladesh, while policy commitment to early childhood is well established, particularly through the Comprehensive Early Childhood Care and Development (CECCD) Policy 2013, implementation across the continuum remains fragmented, uneven, and insufficiently aligned across sectors. In this circumstance, the scoping study to better understand the status of prenatal to transition to schooling, including early primary education, is necessary to further promote and support the young child's holistic growth and development in Bangladesh.

Study Objective:
This scoping study examines the current status of services from prenatal care to early primary education, identifies key system gaps, and proposes strategic directions to strengthen integrated, equitable, and quality ECCD delivery nationwide.

Methodology:
The study employed a mixed-methods scoping approach, combining desk review of policies, programmes, and evidence with surveys, key informant interviews, focus group discussions, and field observations. Data were collected across diverse geographic and socio-economic contexts, including urban and rural areas, urban slums, char, haor, hill tracts, coastal and climate-vulnerable regions, and areas affected by extreme poverty and different government institutions. ECCD service providers, non-governmental organizations, development partners, academics, frontline workers, and parents and caregivers were included.

Mapping of the Key Stakeholders:

Among all the ministries and government agencies that are obliged to contribute to ECCD services and activities, the lead role is expected to be played by the Ministry of Women and Child Affairs (MoWCA). Important complementary roles are played by the Ministry of Health and Family Planning (MoHFW) and the Ministry of Mass and Primary Education (MoPME), along with other initiatives from the Department of Social Services and the Bangladesh Shishu Academy. Significant contribution is made by the development partners in expanding ECCD services across regions. Besides, the ECD networks, research bodies, and academic institutions engage in ECCD-related innovations, interventions, advocacy, and research. Even though the local government is mandated to be involved in implementing ECCD initiatives, ECCD is often absent in local planning. Among the community level stakeholders, mothers are the primary influencers in early childhood (87% at ages 0–3; 78% at 3–6; 81% at 6–8, as per survey undertaken for this study), with fathers also playing a significant role (60%–66%) and extended family members contributing additional support (around 30% across age groups).

The stakeholder mapping highlights that despite clear policy commitments under the CECCD Policy 2013, ECCD service delivery in Bangladesh remains fragmented, with limited multisectoral coordination, significant regional disparities, constrained frontline capacity, and

weak visibility of child protection, disability, and early learning institutions at the community level. The primary caregivers receive minimal structured guidance. NGO-led initiatives add value but remain limited in scale and sustainability. To address these gaps, it is essential to institutionalize functional multisectoral coordination mechanisms and prioritize targeted support for hard-to-reach areas. It is necessary to integrate parenting and early stimulation guidance into existing service platforms, and strengthen workforce capacity across sectors. It is also necessary to formalize government–NGO partnerships for scaling effective models, and establish accessible local-level feedback and accountability systems, which will lead to more integrated, equitable, and responsive ECCD services nationwide.

Status of Prenatal and Perinatal Care Services:

The assessment of prenatal and perinatal services reveals persistent gaps in coverage, continuity, quality, and equity of maternal and neonatal care in Bangladesh. While ANC coverage has improved, completion of 4+ ANC visits, PNC uptake, neonatal ECCD services, and facility readiness, including NICU availability and essential supplement supply, remain inadequate, particularly in haor, char, coastal, and hill tract regions. Almost 53% of the respondents have reported going for ANC visits 1 to 3 times, whereas only 29% and 11% of the respondents went for 4 to 6 times and more than 6 times, respectively. Preconception and prenatal awareness are limited. Maternal mental health is largely neglected, as only 18% of the mothers reported receiving maternal mental health-related instructions. Also, household dynamics often influence care-seeking practices. Trust deficits in public facilities, workforce competency gaps, and the absence of disability-inclusive and equitable service provisions further deepen disparities.

To address these challenges, it is critical to strengthen ANC–PNC continuity through scaled-up community outreach and home visits and to integrate preconception and ECCD awareness into education and counseling platforms. Maternal physical and mental health support should be expanded with family-inclusive approaches, service quality and facility readiness should be improved, and inclusive, culturally responsive outreach should be prioritized for marginalized and underserved populations.

Status of ECCE Services for Children between 0-3:

Institutionalized ECCE service delivery for children aged 0–3 in Bangladesh remains very limited, as one-third of the parents reported having no institutionalized services available within their reach. The available services are predominantly health-focused (71%), with limited integration of early learning, responsive caregiving, and developmental stimulation into routine community platforms. While pilot initiatives link nurturing care messages with health services, frontline workers are overburdened and insufficiently trained, resulting in inconsistent implementation. Daycare utilization remains low due to cultural stigma, infrastructural gaps, workforce shortages, and weak enforcement of quality standards. There is limited inclusion of children with disabilities and inadequate early screening and referral systems. Geographic and socioeconomic disparities further restrict access, particularly in hard-to-reach and climate-vulnerable areas, while the urban middle class and low-income families remain underserved.

To address the deficiencies, it is essential to scale up integrated ECCD models nationwide. This objective calls for strengthening cross-sector coordination, expanding community-based early

learning opportunities, and enforcing quality and inclusion standards in daycare services. These tasks require building a competent ECCD workforce and establishing functional early screening and referral mechanisms. A necessary step in this direction is to introduce targeted outreach strategies to ensure equitable, inclusive, and developmentally supportive services for all children during the critical first three years of life.

Status of Services during Transition to Primary School (Children 3-6 years):

The assessment of services supporting transition to the primary stage for children aged 3–6 reveals limited and uneven access to institutionalized ECCD services. This is evident in extremely low participation in structured early learning for ages 3–5, and significant disparities in quality across providers and regions. Nearly half of parents of children aged 3–6 perceive institutionalized ECCD services as unavailable or only minimally available (49%), yet 71% report utilizing some form of such services, with no single provider dominating overall coverage. This situation suggests scattered, inadequate, and uncoordinated services.

Although universal pre-primary education is widely valued and a well-designed competency-based curriculum exists, implementation gaps persist due to workforce shortages, inadequate infrastructure, weak mentoring, and limited inclusive practices. Children in rural, remote, marginalized, and disaster-prone areas remain particularly underserved. Early identification and support for children with special needs are minimal. To address these challenges, multisectoral ECCD coordination must be strengthened, two-year pre-primary education expanded nationwide, ensuring acceptable quality, and a standardized quality assurance framework introduced across providers. Increased and well-planned investments are needed in infrastructure, workforce professionalization, curriculum-practice alignment, inclusive facilities, and early screening systems. These services should be implemented with targeted outreach for hard-to-reach communities to ensure equitable, high-quality, and developmentally appropriate school readiness for all children.

Status of Services in the Early Grades in Primary School (Children 6-8years):

Almost 98% of the children of appropriate age enter primary school in Bangladesh, according to DPE data. Although there is some dropout (estimated to be around 10% in early grades), early primary education for children aged 6–8 has reached broad national coverage through government, NGO, and private initiatives. However, respondents' survey for this study, focusing on care and development of children, indicates that a fraction of the children receive due care and attention in the transition phase in early grades of primary school, as perceived by respondents (21% in government schools and 16% in NGO-managed schools).

Even though enrollment coverage is relatively high, inadequacies and inequities in quality, infrastructure, health integration, and inclusive support persist across regions and socioeconomic groups. While government and NGO initiatives have expanded service provision in many areas, parental awareness and counseling platforms remain limited and unevenly implemented. At the same time, geographic isolation, poverty, child labor, weak health and nutrition monitoring, infrastructure gaps, and limited teacher capacity continue to affect attendance, learning outcomes, and smooth transitions. Quality also varies significantly across providers, with

persistent shortages of child-friendly learning materials, inclusive practices, and early identification mechanisms for children with special needs.

To address these challenges, equitable and context-sensitive quality improvement and expansion in hard-to-reach areas are needed. Specific attention is needed to the integration of basic health and hygiene monitoring within schools, strengthened teacher professional development, and inclusive classroom support. Also needed are improved child-friendly infrastructure and learning materials, enhanced parental engagement, and reinforced social protection measures. Functional early screening and referral systems are essential to ensure holistic, inclusive, and sustained learning outcomes for all children in early primary grades.

Status of Financing, Monitoring, Evaluation and Research, and Collaboration and Coordination in ECCD:

ECCD in Bangladesh relies heavily on time-bound donor funding, while government financing remains limited, unpredictable, and insufficiently institutionalized. Scarce household contributions, particularly from economically disadvantaged families, further exacerbate inequities in access and participation. Budget allocations are often input-driven (rather than result-focused), lack disaggregated tracking, and fail to respond to local needs, limiting service quality and scalability. Measures needed are strengthening sustainable public financing by introducing need-based and transparent budgeting and providing targeted support. Support for parental awareness initiatives is also critical to ensure equitable, high-quality, and long-term ECCD services.

Current ECCD monitoring and data systems are fragmented, largely administrative, and focused on compliance rather than service quality or child outcomes. Evidence-based research is limited, and data collection and analysis rarely inform planning or decision-making. Establishing an integrated, digitalized child data system, standardized indicators, participatory monitoring frameworks, and a coordinated national research hub would enhance accountability, enable data-driven program improvement, and support scaling of effective ECCD interventions across Bangladesh.

Coordination across ministries, NGOs, private sector actors, and local governments is weak, inconsistent, and often dependent on individual interest and leadership rather than institutionalized systems. Existing policy-level structures remain largely inactive, resulting in fragmented service delivery and gaps in access, especially in hard-to-reach areas. Creating a unified national ECCD framework, elevating oversight to a high administrative authority, formalizing multisectoral partnerships, strengthening referral systems, and institutionalizing parental engagement are essential to ensure integrated, equitable, and sustainable ECCD services nationwide.

Overall, ECCD services in Bangladesh span prenatal to early primary stages, but continuity across these developmental phases remains weak. Interventions are largely sector-driven; health services dominate the 0–3 stage, while education leads the 3–8 stage, with limited referral systems, child tracking, or integration of developmental records. As a result, services operate in parallel rather than as a connected developmental pathway. Although national policies promote a multisectoral approach, the ECCD ecosystem remains fragmented. Whole-of-government

coordination mechanisms are largely inactive, financing and monitoring systems are sectoral, and non-state actors operate outside formal coordination structures, preventing the emergence of a fully integrated whole-of-society ECCD system.

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Chapter One: Introduction

1.1 Background and Context

The first eight years of a child's life play a determinant role in his/her future healthy functioning and holistic development. More specifically, the period from pregnancy to the first thousand days after birth is the most critical, when the brain grows faster than at any other time; 80% of a baby's brain is formed by this time (WHO, UNICEF, and World Bank Group, 2018). The best investment is in quality care for early childhood development from birth to five for disadvantaged children and their families (Heckman, 2012). Every dollar spent on high-quality, birth-to-five programs for disadvantaged children delivers a 13% per annum return on investment (Garcia, Heckman, Leaf & Prados, 2016). To further widen the spectrum, ensuring quality and equitable learning outcomes requires a holistic approach that addresses the entire continuum of early childhood development and early education. This includes the crucial period from prenatal stages through transition to schooling and early primary grades. Therefore, prenatal care services, Early Childhood Care and Education (ECCE) programs, transition to primary school, and early primary education are all critical components of early childhood development. Comprehensive, interconnected policy provisions, programs, services, and interventions for all of these components are crucial to ensure quality early childhood development.

Recognizing the importance of early childhood development, the Comprehensive Early Childhood Care and Development (CECCD) Policy was adopted by the Government of Bangladesh in 2013. Since the adoption of the CECCD policy, the Ministry of Women and Children Affairs (MoWCA) has initiated relevant acts and regulations, plans and projects, activities and committees, and Early Learning and Development Standards (ELDS) for the advancement of ECCD in Bangladesh. The Ministry of Health and Family Welfare (MoHFW), with support from UNICEF, has adopted a Comprehensive Integrated ECCD Strategy (under-3 children). The Ministry of Primary and Mass Education, through the Directorate of Primary Education and with leadership of the National Curriculum and Textbook Board (NCTB), has developed a two-year pre-primary national curriculum (4+ and 5+ year-old children) and has been piloting this in selected locations along with 5+ universal Pre-primary Education (PPE) since 2013. The Ministry of Chittagong Hill Tracts Affairs and the Ministry of Religious Affairs have also been engaged in significant work in ECCD. Development partners and NGOs are also carrying out important work in the field of early childhood development in Bangladesh.

Internationally, various developments in early childhood care and development have relevance for Bangladesh. These include the inclusion of the early childhood development agenda in Sustainable Development Goals (SDG, 2030) in 2015 and the Nurturing Care Framework for Early Childhood Development, developed by WHO, UNICEF, and the World Bank Group in 2018. The WHO (2020) guideline for Improving Early Childhood Development complements the Nurturing Care Framework. Tashkent Declaration and Commitments to Action for Transforming Early Childhood Care and Education (November 2022) brings together commitments of global leaders for young children. Given these national and international policy and programmatic contexts, it is important to look at services and interventions such as those for pregnant mothers; perinatal stage care for

both fetus and mother; health, nutrition, and psycho-social care for both mothers and babies at pre-, peri-, and post-natal stages; services for infants and toddlers; early childcare from 0 to age 3; preschool and transition to school (4-6 years); and special care for children's induction into school and curricular and pedagogic considerations in the first two grades of primary school (ages 6-8).

Bangladesh ECD Network (BEN), which is a forum of stakeholders including government, non-government, and international organizations working in early childhood development (ECD), has initiated this scoping study through its ongoing project, 'Enhancement of Favorable Environment for the Promotion of ECCD (EFEP-ECCD) in Bangladesh,' with support from Porticus. This scoping study contributed to mapping the key stakeholders; exploring the existing knowledge and evidence on institutional arrangements, programs, capacities, resources, and interventions; identifying key gaps; and formulating evidence-based recommendations for strengthening prenatal to early primary education in Bangladesh.

1.2 Study Objectives

The objective of this scoping study is to:

- Map and analyze the current landscape of services and interventions related to prenatal and postnatal care, ECCD, ECCE, and transition to schooling, including early primary education, in Bangladesh.
- Assess the quality, accessibility, equity, and effectiveness of these services and interventions.
- Identify key stakeholders, their roles, and coordination mechanisms.
- Identify common barriers and facilitators that affect the developmental progress of children during the prenatal to early primary school period.
- Provide evidence-based recommendations for strengthening the prenatal to early primary education continuum in Bangladesh.

1.3 ECCD in Regional and Global Context

This section builds upon the previously mentioned objectives by placing Bangladesh's prenatal to early primary education continuum within a broader regional and global context. By examining international policy frameworks, service delivery models, and outcome patterns, this section offers an analytical perspective to understand the current landscape in Bangladesh. These comparative insights help to identify the country's strengths and weaknesses while guiding evidence-based strategies to enhance coordination, access, quality, and equity across the early childhood years continuum.

1.3.1 Policy and Legal Frameworks regarding ECCD in Regional and Global Contexts

In this section, the diverse policy and legal frameworks that govern early childhood care and development across varying economic and geographic landscapes are discussed.

Table 1: *ECCD Policy and Legal Frameworks in Selected Countries*

Country	Policy/Legal Framework	Sources
Bangladesh	Comprehensive Early Childhood Care and Development (CECCD) Policy (2013); CECCD Operational and Implementation Plan	MoWCA, 2013
India	National ECCE Policy (2013); India Newborn Action Plan (2014); National Plan of Action for Children (2016)	Malik & Behera, 2024
Thailand	Early Childhood Development Act (2019)	Office of the Education Council, 2019; Rodriguez & Chua, 2021
Cambodia	National ECCD Policy; National Costed Action Plan	Ministry of Information, 2022; Rodriguez & Chua, 2021
Philippines	National ECCD Strategic Plan (2019–2030); First 1,000 Days Law	Ulep et al., 2024; Rodriguez & Chua, 2021
Indonesia	National ECD Policy; Holistic-Integrated ECD Action Plan	Rodriguez & Chua, 2021
Finland	Act on Early Childhood Education and Care (540/2018)	Alexiadou et al., 2024
Canada	Canada Early Learning and Child Care Act (2024); Multilateral Early Learning and Child Care Framework; Indigenous Early Learning and Child Care Framework	UNESCO, 2024; ESDC, 2017; ESDC, 2018

Policy and Legal Approaches Shaping ECCD Implementation Across Country Contexts: ECCD in low- and middle-income countries relies on interministerial committees and community-based delivery with limited quality assurance, while high-income countries enforce legal mandates, professional standards, and systematic monitoring to ensure consistent, high-quality early childhood services.

Across regional and global contexts, Early Childhood Care and Development (ECCD) policies are articulated within complete legal and policy tools that acknowledge early life as a key era for cognitive, social, and physical development. Countries in low- and middle- as well as high-income settings have adopted national ECCD, or early childhood education and care policies, often supported by costed action plans or standalone legislation, to institutionalize government responsibility for early childhood services. These policy frameworks commonly reflect a life-cycle approach, addressing the needs of children from conception through early primary years.

ECCD incorporates health, nutrition, education, social protection, and their interlinked roles for the development of a child, and thus, across all countries, the establishment of formal coordination mechanisms led by a designated ministry or authority is identified as a common practice. In the Asian and South Asian countries like Cambodia, Indonesia, India, and Bangladesh, the National ECD policies are implemented through an integrated coordination mechanism, led by a designated ministry and operationalized through inter-ministerial committees or task forces spanning national and sub-national levels (Rodriguez & Chua, 2021; Malik & Behera, 2024; MoWCA, 2013). Similarly, the Philippines relies on cross-sector coordination through local government units and ECCD Councils, reflecting a decentralized approach that integrates ECCD into local development planning (Ulep et al., 2024). In contrast, Thailand and Finland exhibit more institutionalized coordination, where inter-sectoral collaboration is mandated by law and embedded within formal governance and accountability structures (Office of the Education Council, 2019; Alexiadou et al., 2024). In Canada, coordination is similarly anchored in legislation through the Canada Early Learning and Child Care Act and operationalized via intergovernmental agreements under the Multilateral Early Learning and Child Care Framework, which establishes shared principles of quality, affordability, accessibility, and inclusivity while recognizing provincial and Indigenous jurisdiction, including through the Indigenous Early Learning and Child Care Framework (UNESCO, 2024; ESDC, 2017; ESDC, 2018).

Despite these shared coordination arrangements, key implementation strategies differ notably across contexts. Low- and middle-income countries predominantly emphasize integrated service delivery models, often using community-based platforms to deliver health, nutrition, parenting support, and early learning services in a coordinated manner. Examples include Cambodia's national ECCD action plans, Indonesia's holistic-integrated ECCD guidelines, the Philippines' First 1,000 Days initiative, and India's Integrated Child Development Services (ICDS), all of which align with the principles of the Nurturing Care Framework (Rodriguez & Chua, 2021; Ulep et al., 2024; Malik & Behera, 2024). Bangladesh follows a similar trajectory through its life cycle

and equity-focused CECCD implementation framework, operationalized through coordination committees extending to the Upazila level (MoWCA, 2013). In comparison, high-income contexts such as Finland and Canada place stronger emphasis on quality assurance, workforce qualifications, and publicly funded systems tied to long-term capacity building and equity objectives, while Thailand combines legal mandates with results-based local implementation and national monitoring systems (Office of the Education Council, 2019; Alexiadou et al., 2024; UNESCO, 2024).

Overall, the comparative analysis indicates that while coordination mechanisms are broadly similar across countries, the depth, institutionalization, and implementation focus of ECCD systems vary, shaped by governance capacity, resource availability, and policy maturity. These distinctions provide valuable insights for strengthening ECCD coordination and implementation in Bangladesh by learning from both regional peers and advanced systems.

1.3.2 Status of Pre-natal and Perinatal Services in Regional and Global Contexts

Globally, ECCD frameworks increasingly recognize the prenatal and perinatal period as foundational for lifelong health, cognitive development, and learning outcomes. International evidence emphasizes the role of skilled antenatal care, maternal nutrition, safe delivery, and early postnatal support.

Status of Antenatal Care Coverage in Regional and Global Contexts

In this section, antenatal care coverage, along with the socioeconomic and institutional factors that affect ANC utilization in various national contexts, is discussed.

Table 2: *Antenatal Care Coverage in Different Countries*

Country	Percentage of Pregnant Women Receiving 4+ ANC Visits	Source
Bangladesh	43.3%	BBS, 2025
India	59.25%	Girotra et al., 2023
Philippines	Urban 88.7%, Rural 85.0%	Wulandari et al., 2021
Indonesia	88.4%	Andriani et al., 2022
Zimbabwe	75.72%	Tessema & Minyihun, 2021

Socioeconomic and Institutional Factors Drive Antenatal Care Utilization:
Completion of four or more antenatal care visits is strongly associated with maternal education,

household income, urban residence, lower parity, partner support, and access to health information. Countries with stronger financial protection, community outreach, and integrated primary healthcare systems achieve higher ANC coverage, while contexts marked by poverty, limited female autonomy, and weaker service access experience lower utilization, underscoring the need for targeted, equity-focused interventions.

Antenatal care (ANC), particularly the completion of at least four visits during pregnancy, is widely recognized as a critical entry point for ensuring safe motherhood and improving maternal and neonatal outcomes. But there are several factors across countries that influence antenatal care visits among women. ANC utilization has been identified to be positively associated with maternal education, household income, and socioeconomic background, availability of healthcare services, mass media exposure, parity, and partner's education and financial situation among the reviewed countries.

Studies from India, Zimbabwe, Indonesia, and the Philippines demonstrate that women with secondary or higher education are significantly more likely to complete four or more ANC visits compared to women with little or no formal education (Andriani et al., 2022; Girotra et al., 2023; Tessema & Minyihun, 2021; Wulandari et al., 2021). Education enhances women's health literacy, awareness of pregnancy-related risks, and ability to navigate health systems, thereby facilitating timely and adequate care-seeking. Bangladesh reflects a similar pattern, where lower educational attainment among women remains a major barrier to adequate ANC coverage (Bangladesh Bureau of Statistics, 2025). Higher ANC coverage in Indonesia (88.4%) and the Philippines (above 85% in both urban and rural settings) is closely linked to improved financial capacity, reduced out-of-pocket expenditures, and better access to healthcare facilities (Andriani et al., 2022; Wulandari et al., 2021). Conversely, in Bangladesh, where only 43.3% of pregnant women receive four or more ANC visits, economic constraints significantly limit access to both prenatal and postnatal services, particularly among poorer households (BBS, 2025).

Geographical location and physical access to health facilities also play a crucial role in determining service utilization. Urban residence is consistently associated with higher ANC uptake in India, Indonesia, the Philippines, and Bangladesh due to the concentration of healthcare infrastructure, availability of skilled providers, and improved transportation networks (Andriani et al., 2022; Girotra et al., 2023; Wulandari et al., 2021; BBS, 2025). Women with lower parity, particularly during their first pregnancy, are more likely to be more regular about ANC visits, as observed in India, Zimbabwe, Indonesia, and the Philippines (Andriani et al., 2022; Girotra et al., 2023; Tessema & Minyihun, 2021). Planned pregnancies are also associated with higher ANC attendance, reflecting greater preparedness and intentional engagement with maternal health services. In contrast, women with multiple previous births often perceive less need for repeated care, which contributes to lower service utilization, especially in resource-constrained settings such as Bangladesh. In Zimbabwe and Indonesia, along with women's autonomy in decision-making, the education and employment status of husbands or partners significantly affect women's use of ANC services, underscoring the role of household decision-making dynamics and male involvement in maternal health (Andriani et al., 2022; Tessema & Minyihun, 2021).

In the Philippines, supportive health financing mechanisms and community-based policies have contributed to relatively high ANC coverage even in rural areas (Wulandari et al., 2021). This suggests that strong local governance, integration of maternal health services into primary healthcare, and financial protection mechanisms can mitigate traditional access barriers. In India, Indonesia, and Bangladesh, access to television, radio, or community health messaging improves awareness of recommended ANC schedules and danger signs during pregnancy (Andriani et al., 2022; BBS, 2025; Girotra et al., 2023).

To sum up, the regional and global comparison indicates that while socioeconomic status, education, parity, and access to health facilities universally influence ANC service utilization, institutional capacity, family dynamics, and policy effectiveness play a decisive role in shaping national outcomes. Bangladesh's relatively low ANC coverage underscores the need for targeted interventions addressing education, economic vulnerability, timely care initiation, and health information exposure. Lessons from higher-performing countries suggest that strengthening community-based outreach, improving financial protection, and promoting women's autonomy are critical for advancing equitable and comprehensive antenatal care.

Status of Accessing Skilled Birth Attendants, Maternal Health, and Prenatal and Perinatal Care in Different Countries

In this section, the status of skilled birth attendance and maternal health outcomes across different national contexts, alongside the systemic factors that ensure quality and respectful perinatal care, are examined.

Table 3: *Global and Regional Trends in Skilled Birth Attendants, Maternal Health, and Prenatal and Perinatal Care*

Country	Key Trends	Sources
Bangladesh	Low trust in providers and sociocultural barriers to quality care	Khan et al., 2012; Dynes et al., 2011; Bogren et al., 2018; Gamage et al., 2022
India	Poor quality of respectful maternity care and weak postnatal support	Sudhinaraset et al., 2016; Varghese et al., 2014; Dey et al., 2017
Nepal	Limited SBA availability and accessibility for vulnerable groups	Baral et al., 2016; Devkota et al., 2018; Khatri et al., 2017; Mehata et al., 2017
Pakistan	Cost barriers, gender bias, and preference for TBAs	Hameed & Avan, 2018; Maheen et al., 2020; McNojia et al., 2020; Waqas et al., 2020
Philippines	Higher SBA use, driven by awareness, autonomy, and affordability	Bhowmik et al., 2020

Finland	Integrated, community-based, midwife-led perinatal care	Schmidt & Bachmann, 2021
United States	Fragmented, physician-centered care with access inequities	Schmidt & Bachmann, 2021

Quality, Equity, and Respectful Care Determine Maternal Health Outcomes:
Although skilled birth attendance is widely used to measure maternal health performance, utilization, and satisfaction depend heavily on respectful care, affordability, gender norms, and health system integration. In many South Asian settings, poor interpersonal care, rural access gaps, and sociocultural barriers weaken trust despite rising facility deliveries, whereas systems that ensure continuity of care, financial protection, and women-centered approaches achieve more equitable and higher-quality maternal outcomes.

Across low-, middle-, and high-income countries, there is substantial variation not only in service coverage but also in the quality, equity, and experience of care received during the prenatal and perinatal period. While increased SBA coverage is often used as a key indicator of maternal health system performance, evidence suggests that structural, sociocultural, and health system factors significantly influence women's utilization and satisfaction with these prenatal and postnatal services.

Across South Asian countries such as India, Nepal, Pakistan, and Bangladesh, persistent challenges related to respectful maternity care and service quality emerge as common concerns. In India, multiple studies document experiences of verbal abuse, exclusion of women from decision-making, lack of dignity, and inadequate postnatal care, which undermine trust in facility-based childbirth despite increased institutional delivery rates (Dey et al., 2017; Sudhinaraset et al., 2016; Varghese et al., 2014). These findings suggest that expanding SBA coverage alone is insufficient without parallel improvements in interpersonal care and accountability mechanisms. In Nepal, limited availability of skilled birth attendants in rural and remote areas remains a major barrier, compounded by inadequate infrastructure and the absence of inclusive services for women with disabilities (Baral et al., 2016; Devkota et al., 2018). Similar patterns are observed in Pakistan, where shortages of female doctors, high service costs, and discriminatory practices, particularly related to the gender of the newborn, contribute to continued reliance on traditional birth attendants (TBAs), who are often perceived as more respectful and culturally sensitive than SBAs (Hameed & Avan, 2018; Maheen et al., 2020). Bangladesh reflects many of these regional challenges, with studies emphasizing low trust in healthcare providers, limited maternal participation in decision-making, and excessive workload among health workers that restricts meaningful communication during prenatal and postnatal periods (Bogren et al., 2018; Dynes et al., 2011; Gamage et al., 2022). Deeply embedded religious, social, and gender norms further shape care-seeking behaviors and reinforce dependence on TBAs, particularly in rural and underserved communities (Khan et al., 2012). These factors collectively compromise the perceived and actual quality of prenatal and perinatal care, despite improvements in service availability.

In contrast, higher-performing systems such as Finland demonstrate how health system design and philosophy of care influence maternal health outcomes. Finland's decentralized, community-based, midwife-led perinatal care model emphasizes continuity, extended prenatal consultations, and postnatal home visits, addressing both physical and psychosocial needs of mothers (Schmidt & Bachmann, 2021). Universal access and strong primary healthcare integration contribute to high satisfaction and equitable outcomes. The United States presents a contrasting high-income context, where maternal care remains largely physician-centered and fragmented. Despite advanced medical infrastructure, barriers such as high healthcare costs, transportation challenges, and inconsistent prenatal care utilization contribute to inequities in maternal outcomes (Schmidt & Bachmann, 2021). This highlights that resource availability alone does not guarantee effective or equitable perinatal care. The Philippines offers an important middle-ground example, where relatively higher SBA utilization is driven by improved health awareness, women's autonomy in decision-making, and financial capacity to access skilled delivery services (Bhowmik et al., 2020). This suggests that empowering women and reducing financial barriers can significantly enhance skilled care uptake even in resource-constrained settings.

The regional and global evidence indicates that effective maternal and perinatal care depends much on respectful care, gender-sensitive service delivery, affordability, trust, and health system integration, along with skilled care. Lessons from higher-performing countries underscore the importance of community-based models, continuity of care, and women-centered approaches, which are mostly missing in South Asian prenatal and postnatal health systems.

1.3.3 Status of the ECCE Services (0-3 years) and Services for Transition to Primary Stage (3-6)

In line with UNESCO's ISCED Levels 01 and 02, early childhood education spans from birth through the transition to primary education. However, the nature, coverage, and quality of ECCE services differ significantly across age groups. To capture these distinctions more clearly, this section separately examines ECCE provision for children aged 0–3 years and services supporting early learning and transition to primary education for children aged 3–6 years.

Status of ECCE Services for Children Aged 0-3 in Different Countries

In this section, the current landscape of ECCE services for children aged 0-3 is examined alongside the global imbalance between foundational health interventions and integrated early learning.

Table 4: *ECCE Services for Children Aged 0–3 Years in Regional and Global Context*

Country	Types of Services	Key Characteristics	Sources

Banglades h	Community-based health services	Primary health-oriented services for young children with limited integration of early stimulation and nurturing care	Bhatta et al., 2020; Hossain et al., 2025
India	Integrated Child Development Services (ICDS)	Government-led community-based program integrating nutrition, health, and early learning, with uneven coverage and workforce capacity	Kumar et al., 2022; Chathukulam & Joseph, 2025; Gopalakrishnan et al., 2025
Malaysia	Nursery/Childcare/TASKA	Public-private partnership in childcare with low institutional participation among under-3 children due to reliance on home-based care	Iwabuchi, 2024; Kong, 2022
Singapore	Infant and Toddler Care Services	Regulated center-based services combining care and early development under national standards	Wu & Perisamy, 2021; MCYS, 2023
Philippine s	Health-focused services	Early childhood interventions concentrated on health and nutrition during the first 1,000 days, with minimal structured learning opportunities	Ulep et al., 2024
Indonesia	Posyandu (Community-Based Health Care Services)	Community-based health and nutrition-focused platform with limited integration of early learning	Suparto et al., 2021; Iskandar, 2020;
Finland	Family day care & Day care centers	Universally accessible, publicly financed early childhood care emphasizing holistic development, play-based learning, and inclusion	Salminen, 2017; Narvi et al., 2020; Niu et al., 2024
Canada	Daycare centers, preschools, or centers de petite enfance (CPE)	The child care system presents challenges for many families due to limited local options and high costs, while Indigenous children experience significant health disparities.	Findlay, 2019; Halseth & Greenwood, 2019

Imbalance Between Foundational Health Care and Early Learning in Services for Children Aged 0–3:
Globally, services for children aged 0–3 largely prioritize health and nutrition, with limited

integration of early learning and responsive caregiving. While high-income countries adopt universal, rights-based models with strong public investment, many low- and middle-income contexts rely on targeted, health-focused approaches constrained by weak integration and workforce capacity, underscoring the need for more holistic nurturing care systems.

Globally, ECCE services for children aged 0–3 years are characterized by a predominant focus on survival, health, and nutrition, with comparatively limited attention to early learning and stimulation. Across low- and middle-income countries in South and Southeast Asia, early childhood interventions during this age period are largely delivered through community-based health platforms, such as Posyandu in Indonesia, ICDS in India, and primary healthcare services in Bangladesh and the Philippines (Bhatta et al., 2020; Iskandar, 2020; Suparto et al., 2021; Ulep et al., 2024). This pattern reflects global prioritization of the first 1,000 days as a critical window for reducing mortality, malnutrition, and stunting, often at the expense of structured early learning opportunities.

A common feature across most countries reviewed is the fragmentation between care, health, and early learning services for children below three years. While health and nutrition interventions are relatively well institutionalized, systematic integration of nurturing care, early stimulation, and responsive caregiving remains limited in practice (Bhatta et al., 2020; Hossain et al., 2025; Iskandar, 2020). Workforce capacity constraints further exacerbate this gap, as frontline workers in community-based programs often lack training in early childhood development beyond basic health and nutrition (Gopalakrishnan et al., 2025; Suparto et al., 2021). Low participation in institutionalized ECCE services for children aged 0–3 is another shared trend, particularly in Malaysia, India, Bangladesh, and the Philippines, where care responsibilities are largely assumed by families, informal caregivers, or domestic helpers (Iwabuchi, 2024; Kong, 2022; Ulep et al., 2024). This reliance on informal care reflects both cultural norms and limited public investment in age-appropriate childcare infrastructure.

Clear differences emerge between high-income and lower-income country models. Finland represents a comprehensive and rights-based approach to ECCE for children aged 0–3, characterized by universal entitlement, strong public financing, inclusive practices, and a deliberate emphasis on play-based, child-centered development (Salminen, 2017; Närvi et al., 2020). In contrast, countries such as India, Indonesia, and Bangladesh adopt programmatic and targeted approaches, where services are primarily designed to address vulnerability rather than universal child development outcomes (Iskandar, 2020; Kumar et al., 2022). Singapore occupies an intermediate position, combining regulated centre-based childcare services with market participation, supported by national standards for staff–child ratios and caregiver qualifications (MCYS, 2023; Wu & Perisamy, 2021). However, evidence suggests that quality varies across centers, particularly due to workforce skill disparities and reliance on minimum qualification thresholds for educators working with infants and toddlers (Wu & Perisamy, 2021). Even in high-income contexts such as Canada, where early learning and child care are framed within a publicly funded, rights-based system, families often face shortages of spaces, affordability pressures, and inflexible service hours, while persistent inequities, particularly among Indigenous children, are reflected in poorer health and nutrition outcomes compared to national averages (Findlay, 2019; Halseth & Greenwood, 2019).

Health-centric models in the Philippines, Bangladesh, and Indonesia demonstrate limited incorporation of early learning, caregiver interaction, and psychosocial stimulation into routine service delivery (Bhatta et al., 2020; Suparto et al., 2021; Ulep et al., 2024). India's ICDS program represents one of the more explicit attempts at integration; however, inconsistent implementation, uneven urban coverage, and limited worker competence constrain its effectiveness for early learning and developmental screening (Chathukulam & Joseph, 2025; Kumar et al., 2022).

The regional and global landscape of ECCE services for children aged 0–3 years reveals a persistent imbalance between survival-oriented interventions and holistic early childhood development goals. While health and nutrition services are relatively well established, early learning, responsive caregiving, and integrated nurturing care remain underdeveloped across most contexts.

Status of Services during Transition to Primary Stage for Children between 3-6 in Different Countries

In this section, the expansion of preschool provision and the persistent quality and equity gaps affecting children aged 3-6 are discussed.

Table 5: *Services for Children Aged 3-6 in Regional and Global Context*

Country	Types of Services	Key Characteristics	Sources
Bangladesh	Baby Class / PPE	Limited ECCE participation with quality variation across providers, constrained public financing, and partial adoption of play-based pedagogy	Bhatta et al., 2020; Rashid & Akkari, 2020
India	Preschools and Playschools	Diverse preschool landscape with state-wise variation, historical influences, and persistent infrastructure and quality disparities	Kouser & Popat, 2022; Malik & Behera, 2024
Vietnam	Pre-primary Education	Expanding pre-primary provision, emphasizing child-centered pedagogy and diversified delivery models	Vu, 2021; Iwabuchi, 2024
Malaysia	Preschool	Largely government-led preschool system promoting holistic development, with challenges in policy and practice alignment	Kong, 2022; Tang et al., 2022; Iwabuchi, 2024
Singapore	Preschool (Nursery & Kindergarten)	Highly regulated preschool sector with strong academic orientation and parental and meritocratic pressure	Ang et al., 2021; Yang et al., 2021; Iwabuchi, 2024

Philippines	Kindergarten	Compulsory kindergarten with growing enrollment, yet limited access for younger age groups	Ulep et al., 2024; Iwabuchi, 2024
Indonesia	PAUD (ECD & Education Services)	School readiness-focused ECCE with play-based intent, with fragmented governance and coordination	Iskandar, 2020; Siagian & Adriany, 2020; Iwabuchi, 2024
Finland	Preschool (Pre-primary Education)	Universal, compulsory pre-primary education blending care, play, and learning, supported by strong teacher professionalism, but with lower participation of younger children	Alexiadou et al., 2024; Von Suchodoletz et al., 2022; Laaninen et al., 2024
Australia	Kindergarten or Preschool	National Quality Framework with widespread preschool access, yet hindered by teacher shortages and inconsistent service quality.	Cohrssen et al., 2023; Cahill et al., 2022
Canada	Daycare centers, preschools, or centers de petite enfance (CPE)	Pre-primary education focuses on creative and social skill development, yet it is marked by socioeconomic and gender-based developmental gaps in school readiness.	Enns et al., 2019; Kauts et al., 2025

Expanding Preschool Access Amid Persistent Quality and Equity Gaps: Although most countries have expanded preschool provision for children aged 3–6 and embedded ECCE within education systems, disparities in governance coherence, workforce capacity, pedagogical quality, and service integration continue to produce uneven access and outcomes, particularly in lower-income contexts.

Across regional and global contexts, services for children aged 3–6 years are primarily structured around preschool or pre-primary education, with increasing recognition of this stage as a critical foundation for school readiness and lifelong learning. While policy commitments to ECCE have expanded globally, significant differences persist in coverage, quality, governance, and pedagogical orientation.

A shared feature across most countries is the formalization of ECCE within the education system, particularly through compulsory or near-universal kindergarten or pre-primary programs, as seen in Finland, the Philippines, Viet Nam, Malaysia, and Singapore (Alexiadou et al., 2024; Iwabuchi, 2024; Ulep et al., 2024; Vu, 2021). These services typically emphasize holistic child development, integrating cognitive, social, emotional, and physical domains, at least at the policy level. However, while play-based and child-centered approaches are frequently articulated as guiding principles, their translation into classroom practice remains uneven. Evidence from Singapore,

Malaysia, and Bangladesh suggests that schoolification, parental expectations, and early academic competition often constrain meaningful play-based pedagogy (Ang et al., 2021; Rashid & Akkari, 2020; Yang et al., 2021). In Canada, most children show positive developmental outcomes before starting school, supported by creative and social learning environments. However, developmental vulnerabilities remain in specific areas, particularly communication skills and general knowledge, with noticeable differences based on socioeconomic status, parental education, and gender (Enns et al., 2019; Kauts et al., 2025). Another shared challenge across contexts is inequitable access, particularly for children from low socioeconomic backgrounds. In Indonesia, India, the Philippines, and Bangladesh, participation in ECCE services for children aged 3–5 remains uneven, with disparities linked to parental awareness, household income, geographic location, and provider type (Bhatta et al., 2020; Iskandar, 2020; Kouser & Popat, 2022; Ulep et al., 2024). Even in Australia, where preschool access is widely available, participation and quality vary for children in regional, remote, and disadvantaged communities (Cohrssen et al., 2023; Cahill et al., 2022).

Significant differences are evident in governance structures and coordination mechanisms. Finland exemplifies a highly integrated ECCE system characterized by coherent policy alignment, strong public financing, and clear institutional responsibility, resulting in consistent service quality and strong practitioner accountability (Alexiadou et al., 2024; Von Suchodoletz et al., 2022). Australia's Early Childhood Education and Care operates under the National Quality Framework, encompassing government, nonprofit, and for-profit providers; however, persistent shortages of degree-qualified early childhood teachers and reliance on staffing flexibility measures contribute to uneven quality, particularly outside metropolitan areas (Cohrssen et al., 2023; Cahill et al., 2022). In contrast, countries such as Indonesia, India, and Bangladesh exhibit fragmented governance, where ECCE responsibilities are distributed across multiple ministries and providers, often leading to duplication, gaps in service delivery, and uneven quality assurance (Iskandar, 2020; Malik & Behera, 2024; Rashid & Akkari, 2020). Workforce capacity also marks a major point of divergence. High-income contexts prioritize professionalization of ECCE practitioners, including formal qualifications, continuous professional development, and manageable child–teacher ratios (Alexiadou et al., 2024). Conversely, many South and Southeast Asian countries face persistent shortages of trained practitioners, high workloads, and limited institutional support, which adversely affect the quality of classroom interactions and learning environments (Siagian & Adriany, 2020; Tang et al., 2022).

Although ECCE policies increasingly acknowledge the importance of integrated child development, practical linkages between education, health, nutrition, and protection services remain limited in many contexts. Indonesia and the Philippines demonstrate partial integration through policy intent, yet implementation gaps persist due to weak inter-sectoral coordination and resource constraints (Iskandar, 2020; Ulep et al., 2024). In Bangladesh, ECCE services for children aged 3–6 are largely education-centric, with minimal systematic integration of nutrition or health interventions, despite evidence of persistent child development vulnerabilities (Bhatta et al., 2020; Rashid & Akkari, 2020).

The regional and global review highlights a pronounced policy–practice gap in ECCE services for children aged 3–6 years. While most countries have expanded preschool provision and articulated progressive policy goals, challenges related to equity, workforce capacity, pedagogical quality, and system integration continue to shape uneven outcomes.

1.3.4 Status of Services in the Early Primary Education Stage for Children Aged 6-8

In this section, the status of early primary education for children aged 6 to 8 across various economic and geographic contexts is discussed. This discussion focuses not only on the enrollment rate but also on the quality of education.

Table 6: *Services for Children Aged 6-8 in Regional and Global Context*

Country	Types of Services	Key Characteristics	Sources
Bangladesh	Compulsory Primary Education	High enrollment with gender parity, but major quality gaps due to poverty, weak supervision, under-trained teachers, and inadequate school infrastructure	Roy et al., 2020; Ahad et al., 2021; Alam et al., 2021; Alam et al., 2023
India	Compulsory Primary Education	Near-universal enrollment but persistent learning crisis, early academic pressure, weak adherence to age-appropriate progression, and strong influence of parental demand and private schooling on quality	Alcott et al., 2020; Das & Biswas, 2021
Vietnam	Compulsory Primary Education	System-wide curriculum reform emphasizing teacher quality and active learning, supported by strong professional commitment, but uneven capacity to deliver age-appropriate, progressive, and holistic early primary education	Hoang et al., 2020; Nguyen et al., 2022
Malaysia	Compulsory Primary Education	Near-universal access with strong public investment and well-qualified teachers, but emerging quality risks from primary-level workload pressures and gaps in inclusive and international-standard infrastructure	UNICEF Malaysia, 2023; Mahanani et al., 2022
Singapore	Compulsory Primary Education	High-performing, well-resourced system with strong teacher quality, but intense meritocratic pressures, early academic stress, and structurally reinforced inequalities that limit holistic and inclusive early learning	Heng & Lim, 2021; Ro, 2020; Chiong & Dimmock, 2020; Debs & Cheung, 2021
Philippines	Compulsory Primary Education	Severe foundational literacy gaps in early grades, uneven infrastructure and classroom congestion, weak reading readiness and mother-tongue implementation, and persistent disparities in remote and marginalized communities	Librea et al., 2023; Navarro, 2024; Eduardo & Gabriel, 2021
Indonesia	Compulsory	High access and completion with expanding coverage, but uneven learning quality driven by	Sukmayadi & Yahya, 2020;

	Primary Education	teacher capacity gaps, rural isolation, absenteeism, and exclusion of children with disabilities	Susanti et al., 2020; UNICEF Indonesia, 2025
Finland	Compulsory Basic Education	Universal, high-quality provision with strong curricular equity, but contested inclusion practices and varied teacher readiness for supporting children with special needs	Jahnukainen et al., 2023; Saloviita, 2020; Eskelä-Haapanen et al., 2023
Australia	Compulsory Primary Education	Nationally guided but state-implemented system focused on standardized learning outcomes, digital integration, and the cross-curricular development of general capabilities.	(Bahri et al., 2024)
Canada	Compulsory Elementary Education	Provincially governed framework with localized curricular adaptation, prioritizing core competencies and holistic development through compulsory physical and life skills integration.	(Kauts et al., 2025)

Unequal Learning Quality and Developmental Gaps in Early Primary Education: While access to early primary education for children aged 6–8 is high globally, learning quality and equity remain uneven. Teacher shortages, limited training, inadequate infrastructure, and excessive academic pressure hinder foundational literacy, numeracy, and socio-emotional development, especially for disadvantaged children. Strengthening this stage requires inclusive, developmentally appropriate pedagogy and well-supported learning environments.

Across regional and global contexts, services for children aged 6-8 years, typically corresponding to the early primary grades, are widely recognized as a critical stage for establishing foundational literacy, numeracy, learning habits, and socio-emotional development. Most countries reviewed have achieved substantial progress in expanding access to early primary education, with near-universal enrollment reported in Finland, Malaysia, Singapore, Indonesia, India, and the Philippines. However, the evidence consistently shows that high enrollment has not translated into uniformly strong learning outcomes, particularly in low- and middle-income settings where quality, equity, and age-appropriate pedagogy remain persistent challenges.

A common pattern across countries is the strong policy emphasis on foundational skills, especially reading and mathematics, during the early primary years. In Finland and Vietnam, national curricula explicitly frame Grades 1-2 as a period for gradual, developmentally sensitive learning supported by formative assessment and teacher autonomy. These systems emphasize progression, feedback, and holistic child development, at least at the policy level (Eskelä-Haapanen et al., 2023; Hoang et al., 2020). Similarly, Canada's provincially governed curricula combine core academic

subjects with arts, physical and health education, and cross-cutting competencies such as critical thinking, creativity, communication, and personal well-being, reflecting a student-centered and holistic orientation despite inter-provincial variation (Kauts et al., 2025). Australia, through a nationally guided but state-implemented curriculum, integrates general capabilities, including literacy, critical and creative thinking, and intercultural understanding, across core subjects, balancing national standards with contextual flexibility (Bahri et al., 2024). In contrast, in India, Bangladesh, the Philippines, and Singapore, early primary education is frequently shaped by the formalization of early learning and academic pressure, where children are expected to master formal literacy and numeracy at an early pace. This often results in grade repetition, stress, and misalignment between children's developmental needs and classroom practices (Alcott et al., 2020; Roy et al., 2020; Librea et al., 2023; Heng & Lim, 2021).

Equity emerges as a central concern across all contexts, though it manifests differently. In Bangladesh, India, Indonesia, and the Philippines, early primary learning outcomes are strongly influenced by socioeconomic status, parental education, geographic location, and school type. Children from poorer households, rural and remote areas, and marginalized communities face greater risks of overcrowded classrooms, weak infrastructure, underqualified teachers, and limited instructional support, contributing to low literacy and numeracy achievement in the early grades (Das & Biswas, 2021; Susanti et al., 2020; Navarro, 2024). In Indonesia, children with disabilities experience significantly lower attendance and completion rates, highlighting gaps in inclusive provision even within systems that have achieved high overall access (UNICEF Indonesia, 2025). In Singapore, inequity is less visible in access but embedded in system design, where school choice mechanisms and merit-based sorting advantage families with greater social and cultural capital from the point of school entry (Debs & Cheung, 2021). In Canada and Australia, regional disparities and differences in implementation capacity shape variations in learning quality, particularly across provinces, states, and remote communities (Kauts et al., 2025; Bahri et al., 2024).

Teacher capacity and support play a decisive role in shaping early primary experiences. High-income systems such as Finland, Singapore, Canada, Australia, and Malaysia prioritize teacher qualification, professional standards, and continuous development, though tensions remain between accountability demands and responsiveness to diverse learner needs. In Singapore, early primary teaching is influenced by a productivity-oriented understanding of teacher quality, creating tensions between standardized performance expectations and teachers' efforts to address children's diverse learning needs and well-being (Ro, 2020). In Vietnam, teachers demonstrate strong professional commitment and actively seek practical, grade-specific professional development to meet the demands of curriculum reform, although uneven implementation capacity limits consistent classroom practice (Nguyen et al., 2022). In contrast, Bangladesh, Indonesia, India, and the Philippines face persistent challenges related to under-trained teachers, high workloads, weak supervision, and teacher absenteeism, which directly undermine instructional quality and student learning in the early grades (Alam et al., 2021; Susanti et al., 2020; Das & Biswas, 2021).

Learning environments and school infrastructure further shape early primary outcomes. Adequate facilities and resources in Finland and Malaysia support attendance and engagement, though gaps remain in inclusive and disability-friendly infrastructure (UNICEF Malaysia, 2023). In

Bangladesh, Indonesia, and the Philippines, shortages of classrooms, seating, teaching materials, WASH facilities, electricity, and playgrounds are widespread, particularly in rural and "last mile" schools. These conditions contribute to irregular attendance, early dropout, and weak foundational learning during the critical 6-8 age period (Alam et al., 2023; Susanti et al., 2020; Navarro, 2024).

Overall, the regional and global review highlights a consistent policy-practice gap in services for children aged 6-8 years. While early primary education is widely recognized as foundational and most countries have succeeded in expanding access, learning quality and equity remain uneven. Early academic pressure, insufficient attention to developmental appropriateness, unequal teacher capacity, and infrastructure gaps continue to shape divergent experiences for young learners. Strengthening early primary education for this age group requires shifting from a narrow focus on enrollment and test-oriented achievement toward developmentally aligned pedagogy, inclusive systems, well-supported teachers, and learning environments that respond to children's diverse needs.

Conclusion

This chapter demonstrates that although most countries recognize ECCD as foundational to human development, significant disparities persist in policy institutionalization, service integration, and quality assurance. High-income contexts tend to embed ECCD within strong legal mandates, professional standards, and monitoring systems, whereas many low- and middle-income countries rely on fragmented coordination and resource-constrained implementation. In maternal and perinatal care, utilization is not determined by access alone but by respectful, gender-sensitive, and financially protected service delivery. For children aged 0–3, survival-focused health and nutrition interventions remain dominant, with limited integration of early learning and responsive caregiving. Preschool expansion for 3-6-year-olds has improved access globally, yet equity, workforce capacity, and pedagogical quality continue to constrain outcomes. Similarly, early primary education (6-8 years) shows high enrollment but uneven learning quality and developmental appropriateness. Across all stages, a consistent policy-practice gap emerges as a central challenge. Strengthening ECCD systems therefore requires integrated governance, sustained public investment, workforce professionalization, and equity-focused strategies that ensure continuity of care and learning from pregnancy through the early primary years.

Chapter Two: Research Methodology

This chapter outlines the methodological approach adopted to examine the status of Early Childhood Care and Development (ECCD) in Bangladesh from a systems perspective. Guided by a robust conceptual framework, the study employed a parallel mixed-methods design to capture both breadth and depth across policy, service delivery, and stakeholder engagement. Multiple data sources and methods were used to explore access, quality, equity, coordination, and system functioning across developmental stages. The chapter details the research design, data sources, sampling strategies, instruments, analytical procedures, ethical considerations, and methodological limitations.

2.1 Research Design

This study followed a multistrand QUAL + QUANT parallel mixed method design, combining both qualitative and quantitative components simultaneously. Parallel design allowed simultaneous exploration of confirmatory and exploratory questions, where one component also helped triangulate the data from the other component (Teddlie & Tashakkori, 2009). Besides, the parallel design was a feasible one considering the limited time available for the study. Since the study aimed to map the key stakeholders, services, and interventions, a survey was used for Early Childhood Practitioners/ Facilitators to obtain a breadth of data on this. Key Informant Interviews (KIIs), In-depth Interviews (IDIs), Focus Group Discussions (FGDs), and Observation were used to gain in-depth qualitative insight on the quality, accessibility, equity, and effectiveness of these services and interventions. Scoping review of relevant research, policies, acts, program and planning documents offered both breadth and depth on the topic by providing qualitative and quantitative insights.

2.2 Study Participants and Sampling Strategy

This study engaged diverse participants, including experts from government, NGO, academia, and the development sector, upazila level education officers, PTI instructors, ECCD service providers, and parents. The key informants were selected through purposive sampling, and the ECCD providing organizations, Upazila Education Officers, and PTI Instructors were selected based on convenience. Apart from experts for KII and service providers/ facilitators for online surveys, the remaining participants were drawn from the field site.

Sample and Sampling

The study used a combination of purposive and convenience sampling approaches to capture perspectives from different ECCD stakeholders.

- **KII Participants:** Experts from government ministries and agencies, NGOs, development partners, universities, and leading research institutes were purposively identified based on their involvement in ECCD and early primary education. A list of relevant experts was prepared, and 18 respondents participated based on availability and willingness.

- **Online ECCD Practitioners' Survey Participants:** The survey was circulated among practitioners from ECCD service-providing organizations to capture implementation-level insights from program staff and service providers. Although the survey targeted broader participation, 17 practitioners completed the survey during the data collection period.
- **IDI Participants:** Program personnel and field-level officials involved in ECCD service delivery were selected from the study sites using purposive sampling to gather detailed insights on implementation practices and challenges.
- **FGD Participants:** FGDs were conducted with parents across different child developmental stages, from prenatal to early primary, as they remain directly involved in childcare. The final number of groups was shaped by field feasibility across selected locations and included diverse parent groups.
- **Parents' Survey Participants:** The survey sample size was estimated using the standard formula for unknown populations: $n = (Z^2 \times p \times (1 - p)) / e^2$, where $Z = 1.96$ (95% confidence level), $p = 0.5$, and $e = 0.05$, which yields a minimum sample of approximately 384 respondents. The study collected 412 responses to ensure adequate representation and diversity despite site selection being guided by field accessibility.
- **Observation Sites:** Observations were conducted in daycare centres, pre-primary education (PPE), and early primary classrooms across the field sites. While the initial plan aimed to observe multiple programmes across locations, 22 service settings were observed based on availability during field visits.

Figure 1: *Selection of the Field Sites*

To maximize the diversity of the field data, the locations were selected based on socio-economic, cultural, climatic, and environmental contexts. These categories included:

1. Plain land urban area
2. Plain land rural area
3. Urban slum area
4. Extreme poverty-affected area
5. Char/ river island
6. Haor regions
7. Hill tracts
8. Coastal natural disaster-prone area

One upazila for each of these categories mentioned above was selected based on convenience for the study.

2.3 Data Collection Methods and Instruments

The study relied on a mix of both primary and secondary data sources to explore the current status of prenatal to transition to schooling to early primary education in Bangladesh. Primary data were directly collected through Key Informants Interviews with the stakeholders, In-depth-Interview with the ECCD practitioners, Focus Group Discussions with the Parents, Observation of Daycare centers, Pre-Primary/ Primary Classrooms, Survey with Parents and ECCD Practitioners where the policy-practice gaps, lived experiences of the parents, contribution of families, access and quality of services, equity and inclusion scenario, collaboration among stakeholders etc. were explored**.** Additionally, secondary data were collected through a desk review that included national policies, frameworks, acts and regulations, strategic plans, research papers, services and interventions on ECCD in Bangladesh, along with relevant international declarations and frameworks. This data contributed to developing a ground for the study with necessary insights into the current context, frameworks, policies, and strategies.

The methods and instruments involved in the data collection process are discussed below:

- **Key Informants Interview**

Key Informant Interviews (KIIs) are in-depth qualitative interviews conducted with individuals who possess specialized knowledge, professional experience, or strategic insights about a particular issue, program, or system. KIIs are commonly used in policy research, program evaluations, and system-level analyses to capture expert perspectives that may not emerge through surveys or quantitative methods. They are particularly useful when exploring complex and multisectoral issues where institutional arrangements, coordination mechanisms, financing structures, and implementation challenges require informed interpretation. In this study, KIIs were relevant for gaining a holistic and system-level understanding of ECCD in Bangladesh. Given the study's focus on policy frameworks, governance structures, access, quality, equity, inclusion, monitoring and evaluation, research, collaboration, and financing across different age groups, key informants were able to provide contextualized insights beyond surface-level findings. KIIs were used to explore strategic gaps, institutional bottlenecks, stakeholder roles, and expert recommendations for strengthening ECCD as an integrated system. A semi-structured KII guide was used as the primary data collection instrument.

KII Guide - The KII guide was designed to ensure both structure and flexibility. It included thematic sections aligned with the study objectives, covering policy and regulatory frameworks, service delivery mechanisms, equity and inclusion (including disability responsiveness), inter-sectoral coordination, workforce capacity, monitoring and data systems, financing patterns, and research gaps. Open-ended questions allowed informants to elaborate on systemic challenges, practical experiences, and reform priorities, while probing questions ensured depth and clarity. The semi-structured format enabled consistency across interviews while allowing adaptation based

on each informant's expertise and institutional role. According to the guide, it took 40 to 60 minutes to conduct the KIIs in both online and offline settings.

- **Online Survey for ECCD Practitioners**

An online survey is a structured quantitative data collection method administered through digital platforms to gather standardized information from a defined group of respondents. Online surveys are widely used in primary research due to their efficiency, cost-effectiveness, broader geographic reach, and ability to generate quantifiable and comparable data. They are particularly useful when researchers aim to collect data from diverse participants across locations while maintaining uniformity in questions and response formats. In this study, an online survey questionnaire was developed for capturing the perspectives of ECCD practitioners working across different geographic and socio-economic contexts. Given the study's objective to understand variations in access, quality, equity, inclusion, monitoring, financing, and coordination mechanisms, the online format enabled the collection of systematic and comparable data from practitioners associated with various ECCD initiatives.

Online Survey Questionnaire for ECCD Practitioners - The survey questionnaire consisted of 42 items organized into seven thematic sections. These sections covered service delivery practices, workforce capacity, inclusion and equity, monitoring and evaluation mechanisms, inter-sectoral coordination, financing patterns, and implementation challenges. The structured design facilitated quantitative analysis of trends, patterns, and systemic gaps across ECCD settings. It was disseminated through Google Forms to ECCD practitioners based on convenience and took approximately 25 to 30 minutes to complete the survey.

- **In-Depth Interview**

In-depth interviews (IDIs) are designed to explore detailed personal experiences, professional insights, and contextual realities. IDIs are widely used in research when the aim is to obtain a comprehensive and nuanced understanding of complex issues that cannot be fully captured through structured surveys. This method is particularly valuable for exploring implementation processes, institutional challenges, and lived experiences. In this study, IDIs were conducted with ECCD practitioners and relevant officials from selected field sites to capture field-level implementation experiences. Given the study's emphasis on access, quality, equity, inclusion, monitoring systems, financing, stakeholder coordination, and service effectiveness, IDIs allowed exploration of operational realities across public, private, and NGO-run ECCD initiatives. The method enabled participants to elaborate on institutional bottlenecks, contextual constraints, and practical solutions based on their direct involvement in service delivery through the use of a semi-structured interview guide.

IDI Guide - A semi-structured IDI guide was used to ensure consistency across interviews while allowing flexibility to probe context-specific issues. The guide included key questions related to access, quality standards, inclusion practices, monitoring mechanisms, financing structures, stakeholder roles, and overall effectiveness of ECCD services, along with follow-up probes to deepen the discussion. The IDIs duration ranged mostly between 60-90 minutes in both online and offline settings. Using a semi-structured format enabled consistency across interviews with ECCD

practitioners from public, private, and NGO-run initiatives, education officers, and PTI instructors, while allowing adaptation based on each informant's expertise, role, responsibility, and engagement.

- **Focus Group Discussion (FGD)**

Focus Group Discussion (FGD) is a qualitative research method that involves guided discussions with a small group of participants to explore shared experiences, perceptions, attitudes, and social norms related to a particular issue. FGDs are commonly used in research when the objective is to understand collective viewpoints, community dynamics, and socially constructed meanings. The interactive nature of FGDs allows participants to respond to and build upon each other's ideas, generating richer and more nuanced data than individual interviews alone.

In this study, FGDs with parents were conducted to explore shared experiences and collective perceptions regarding ECCD services across different phases of early childhood. Since parental awareness, cultural beliefs, social norms, and community-level barriers significantly influence access to and utilization of ECCD services, FGDs provided deeper contextual insights that complemented the survey findings. This method was particularly useful in identifying common challenges, misconceptions, expectations, and support needs among parents.

FGD Guide for Parents - The FGD guide consisted of open-ended questions focusing on access, quality, equity, inclusion, parental awareness, service effectiveness, and perceived barriers and facilitators. Probing questions were used to encourage participation and deeper reflection. The discussions created a space for parents to share both common and divergent experiences, thereby enriching the qualitative understanding of ECCD realities at the community level. Although the estimated duration for each Focus Group Discussion (FGD) was approximately 60-90 minutes, the actual length varied depending on contextual factors and participant engagement. In some cases, discussions concluded within 40 minutes due to parents' work commitments or limited availability. Conversely, in settings where participants were more engaged and willing to share their experiences in greater depth, discussions extended up to 120 minutes. This flexibility allowed the research team to balance practical constraints while ensuring meaningful and comprehensive data collection.

- **Face-to-Face Survey**

A face-to-face self-administered survey is a structured data collection method in which respondents complete a questionnaire in the physical presence of the researcher or data collection team. This method is widely used to collect standardized, reliable, and comparable primary data while ensuring higher response rates and clarity of questions. Face-to-face surveys are particularly appropriate in contexts where digital access may be limited or where literacy levels vary, as researchers can provide clarification or assistance when needed. Since the research aimed to capture parental experiences regarding access, quality, equity, effectiveness, and engagement in ECCD services across different phases of early childhood, direct interaction allowed better rapport, improved response accuracy, and minimized non-response bias. Thus, in this study, the face-to-face survey method was selected to ensure inclusive participation of parents from diverse socio-

economic and educational backgrounds. Additionally, conducting the survey in person ensured the participation of parents who might not have access to or familiarity with online platforms.

Parents' Survey Questionnaire - The parents' questionnaire was developed, consisting 20 main questions along with several sub-questions, and was organized into six sections reflecting the four phases of ECCD: prenatal and postnatal, 0–3 years, 3–6 years, and 6–8 years. Parents were instructed to respond only to sections relevant to their child's age group. The tool collected data on service access, perceived quality and equity, parental participation in monitoring and evaluation, effectiveness of available services, and barriers and facilitators to ECCD utilization across the country. The survey was primarily self-administered and took approximately 30 minutes to complete. In cases where parents had limited literacy skills, trained research assistants provided structured support by reading out the questions and recording responses without influencing answers. For research assistant-supported surveys, the duration ranged between 25 to 35 minutes, depending on the level of assistance required. The surveys were conducted face-to-face in daycare centers, early learning centers, primary schools, and, where necessary, through home visits to ensure broader coverage and inclusivity.

- **Observation**

Observation is a systematic data collection method in which researchers directly examine settings, behaviors, interactions, and environmental conditions to gather objective evidence. Observational methods are commonly used in educational and program evaluation research to assess real-time practices, validate self-reported data, and measure quality indicators. This method is particularly effective when evaluating service environments, practitioner competencies, and participant well-being. In this study, observation was conducted to assess the actual implementation environment of ECCD services and to triangulate findings from surveys and interviews. Since the research focused on quality, practitioner competence, infrastructural conditions, children's well-being, and parental involvement, direct observation provided concrete evidence of service delivery realities across different settings.

Observation Protocol - An observation protocol consisting of 32 structured items, excluding basic institutional information, was used in daycare centers, pre-primary education (PPE) classes, and primary classrooms. The tool captured both quantifiable indicators and qualitative field notes related to infrastructural setup, availability of learning materials, practitioner competence, child engagement and wellbeing, parental involvement, and overall quality practices. This systematic approach strengthened the validity and reliability of the study findings.

- **Desk Review**

A desk review is a research method that involves systematic analysis of existing secondary data, including policy documents, reports, research studies, administrative records, and program evaluations. Desk reviews are commonly used in policy and systems research to establish contextual background, identify existing frameworks, assess trends, and map institutional arrangements. This method is particularly useful for understanding macro-level structures, financing mechanisms, and governance arrangements before collecting primary data.

In this study, the desk review was conducted to analyze the policy landscape, strategic frameworks, institutional structures, and financing mechanisms related to ECCD. Given the study's system-level focus on access, quality, equity, inclusion, monitoring and evaluation, stakeholder coordination, and research gaps, the desk review provided essential contextual grounding. It helped identify existing policies, regulatory frameworks, national strategies, and documented challenges, thereby informing the design of primary data collection tools. Relevant national policies, strategic plans, government reports, research publications, and documents from public, private, and development partners were reviewed systematically. The findings from the desk review were used to triangulate primary data and strengthen the overall analytical framework of the study.

Instrument Validation

To ensure the validity, usability, and feasibility of the data collection instruments designed for the scoping study, a pilot study was conducted involving all the primary data sources. The Parent Survey was piloted face-to-face with ten parents each from urban and rural settings, representing diverse socioeconomic and educational backgrounds. Additionally, pregnant women and new mothers participated through online sessions, where the questionnaire was read aloud, and their feedback on that was recorded. Urban parents mostly self-administered the survey, while rural participants received assistance based on their literacy levels. The ECCD Practitioner Survey was piloted with the head teachers of rural primary schools that also had pre-primary sections and urban ECCD service providers, managing well-established daycare and preschools. Furthermore, In-depth Interviews (IDIs) were conducted with pre-primary and primary teachers from rural schools, as well as with urban ECD practitioners experienced in delivering daycare and preschool services for children aged 0 to 8 years, both face-to-face and through online sessions. In addition, playroom and classroom observations were carried out in both daycare and pre-primary settings to assess the physical environment, learning materials, and interaction patterns. Based on the feedback of the parents and ECCD service providers, minor adjustments were made in question wording, item sequencing, and clarity enhancement. Rigorous field testing and subsequent reviews confirmed the clarity of the questions, the appropriateness of the thematic areas, and the operational feasibility of the tools across different contexts.

Table 7: Data Collection Methods, Participants, Sample, and Instruments Matrix

<table>
<tr><th>Methods</th><th>Participants</th><th>Sample Size</th><th>Sampling Strategy</th><th>Instruments</th></tr>
<tr><td>Key Informant Interview (KII) for experts</td><td>Experts from Government Ministries and Agencies, NGOs, Development Partners, Universities, and Leading Research Institutes</td><td>18</td><td rowspan="3">Purposive and Convenience Sampling</td><td>KII Guide</td></tr>
<tr><td>Online survey for ECCD Practitioners</td><td>Practitioners from the ECCD Service Providing Organization</td><td>17</td><td>Survey Questionnaire</td></tr>
<tr><td>In-depth Interview (IDI)</td><td>ECCD program personnel and officials at the field level</td><td>31</td><td>IDI Guide</td></tr>
</table>

Parents' Focus Group Discussion (FGD)	6-8 parents per FGD	25		FGD Guide
Parents' Survey	Parents from Different Geographic locations	412		Survey Questionnaire
Observation	Daycare/ PPE class/ Primary class visit	22		Observation Protocol

2.4 Data Analysis

Both quantitative and qualitative data analysis were executed for this study, followed by a metanalysis integrating both types of analysis.

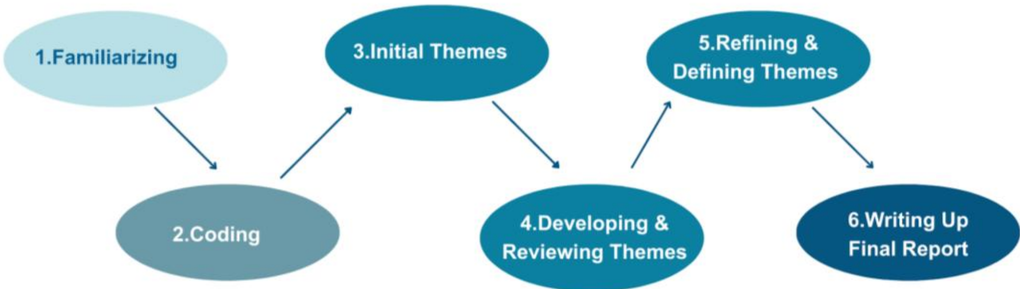
Quantitative Data Analysis

The quantitative survey data collected through the ECCD Practitioners' Survey, Parents' Survey, and Observation were entered and processed in Microsoft Excel and SPSS. Descriptive data, such as frequency and percentage, and measures of central tendency, such as means, were applied to analyze the data. Inferential statistics was used to draw inferences and decisions from the data. Parametric statistics was applied to maintain the power and rigor of quantitative analysis.

Qualitative Data Analysis

Qualitative data, collected through the KIIs, FGDs, IDIs, and description of the site observation, were transcribed using a coding framework. Inter-coder reliability was ensured through checking of the coding by more than one coder and regular discussion and agreement between the researcher and coders. Analysis of qualitative data was done through thematic analysis (Braun & Clarke, 2006). The thematic data analysis process entailed six main steps:

Figure 2 *The Thematic Data Analysis Process*



Meta-Inference

Once the quantitative and qualitative data analysis were completed, inferences from both components were integrated or synthesized to draw meta-inferences. This meta-inference helped generate conclusions and summarize key findings, drawing on both qualitative and quantitative

data (Teddlie & Tashakkori, 2009). The figure below provides a visual illustration of the data analysis and inference process of the study.

Figure 3 *Data analysis and inference process in a multistrand parallel mixed-method design*

Qualitative
Conceptualization Stage
Methodological Stage
Analytical Stage
Inferential Stage

Quantitative
Conceptualization Stage
Methodological Stage
Analytical Stage
Inferential Stage

Meta-inference

(adapted from Teddlie & Tashakkori, 2009, p. 152)

2.5 Conceptual Framework

The conceptual framework for the study was drawn from a range of mutually compatible sources. The Comprehensive Early Childhood Care and Development (CECCD) policy was at the center of its conceptualization. It was also drawn from the Nurturing Care Framework (WHO, UNICEF, and World Bank Group, 2018). Using these, the study focused on the overarching question - whether a holistic approach for ECCD is followed, where different interventions add up to a comprehensive programming and different stakeholders are engaged in a synchronous manner to create a supportive ecosystem for ECCD.

Within this conceptual orientation, the study examined ECCD interventions across key developmental stages, including prenatal and perinatal care, early childhood care and education, transition to primary education, and early primary schooling. Across these stages, the analysis focused on critical dimensions such as access, quality, coverage, and continuity of services related

to health and nutrition, responsive caregiving, safety and security, early learning, and school readiness. In addition to these service components, the framework incorporated several cross-cutting dimensions essential for effective system functioning and equity. These included inclusion of marginalized and vulnerable groups, financing and resource allocation, monitoring and evaluation systems, data and research, innovation, and coordination among government and non-government actors. The study reviewed both policy provisions and implementation practices, aiming to generate a system-level understanding of the ECCD landscape in Bangladesh rather than conducting an in-depth assessment of individual program components.

The conceptual framework also guided the overall research design, development of data collection instruments, and analytical approach of the study. The mixed-method design was structured to examine ECCD services and systems through multiple lenses, aligning with the key domains of the Nurturing Care Framework and the policy and operational priorities outlined in the CECCD policy. Accordingly, the data collection tools, including the Key Informant Interview guide, In-Depth Interview guide, Focus Group Discussion guide, survey questionnaires and observation protocol were developed to capture information across the core components of nurturing care framework and CECCD policy as well as cross-cutting system-level dimensions, such as access, quality, equity, inclusion, financing, monitoring and evaluation, stakeholder coordination, and service delivery practices. The desk review was also guided by the framework, ensuring that national, regional, and global ECCD policies, strategies, and literature were analyzed to situate Bangladesh's ECCD landscape within a broader international context. The framework further guided the thematic analysis of qualitative data and interpretation of quantitative findings, enabling the study to assess whether ECCD interventions collectively function as an integrated system.

2.6 Ethical Consideration

The study complied with the standard ethical practices of research with human participants. Ethical guidelines outlined in the '*UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis*' were followed in the proposed study (UNICEF, 2021). Standards in relation to respect for persons, beneficence, and justice were maintained (Hemmings, 2006). Consent was obtained electronically for online surveys and interviews. Verbal or written consent was obtained for in-person KIIs, FGDs, IDIs, and site observations. Consent forms had detailed information on the purpose and procedure of the study, the methods to be used, probable time commitment, and information on how data would be used. It was also outlined how confidentiality and anonymity would be assured. It further described the voluntary nature of their participation, mentioning any benefits or risks (no known harm or risk is anticipated as a result of participating in the study) involved in participation. The consent form outlined how the data, including any audio-recordings (if used), and written transcriptions would be processed, stored, and preserved. The form stated how confidentiality would be ensured while the data is transcribed, and while writing the research or any publication based on the data. To ensure confidentiality and protect participants' identities, all personal identifiers were removed during transcription and analysis. Participants were assigned anonymized codes indicating the data source and participant number, such as FGD (Focus Group Discussion), KII (Key Informant Interview), and IDI (In-depth Interview), followed by a participant number (e.g., FGD 2, P3; KII, P1; IDI, P2). This coding system allowed the use of quotations in the report while maintaining participants' anonymity. Even

if the participants provided consent to participate in the study, it was made clear that their participation was entirely voluntary and they might leave at any moment and/or choose not to answer any particular questions if they wished.

Besides these procedural ethical aspects, 'ethics in practice' (Guillemin & Gillam, 2004) was to be paid attention to in the study. 'Ethics in practice' calls for researchers to be reflexive and pay close attention to their own identity, thoughts, and feelings to guide their action, communication, and understanding as they are involved in research (Etherington, 2007). Qualitative researchers need to be aware of their own associations with the topic and participants, subjectivity and bias, and take note of how these might affect their interaction with the research participants and interpretations of data. This was particularly important for engaging with participants from underprivileged or socio-culturally diverse communities who are often subjected to bias and prejudice. Data enumerators were oriented on the ethical standards and protocols of the study. They would also be provided with training on safeguarding in research.

2.7 Limitations of the Study

- **Low Response Rate in the ECCD Practitioners' Survey**
  Although the study targeted a larger sample of ECCD practitioners through an online survey, only 17 completed responses were obtained. This limited the representativeness of practitioner perspectives and reduced the strength of quantitative comparisons across different service types and implementing agencies. As the sample size is very limited, the findings from here have not been extensively used for reaching any conclusion regarding the ECCD status and early primary grade education.

- **Uneven Coverage of ECCD Service Modalities**
  Due to time, access, and resource constraints, all ECCD service modalities (e.g., health-based ECCD, daycare, early learning, pre-primary, and early primary education across public, private, and NGO-run initiatives) were not covered with equal depth. In particular, data from the health sector at the community level were less available compared to the education sector. This limited the ability to fully capture variation in service delivery across all sectors and contexts. Through conducting KIIs with multiple health sector experts, the insights into frontline health system governance and health sector integration with ECCD at the subnational level were collected.

- **Convenience-Based Selection of Field Sites and Participants**
  The study relied on a practical selection of one upazila per context and convenient access to parents and ECCD practitioners for surveys and interviews. While this approach facilitated data collection across diverse geographic, socio-economic, and ecological settings, it may limit the full representativeness of findings. Parents were reached both through home visits and ECCD service providers to enhance diversity within these constraints.

Chapter Three: Mapping of the Key Stakeholders

This chapter introduces the stakeholder landscape of ECCD in Bangladesh, examining how policy commitments outlined in the CECCD Policy 2013 translate into practice at national and community levels. While the policy envisions a multisectoral framework led by MoWCA, MoHFW, MoPME, DSS, local governments, and supported by NGOs, the reality is marked by fragmented coordination, uneven regional presence, and limited accountability. By mapping the roles, visibility, and influence of different actors, including government ministries, health workers, NGOs, local institutions, and parents, the chapter highlights systemic gaps in service delivery, regional inequities, and the absence of functional monitoring and grievance mechanisms. This analysis provides a foundation for understanding how stakeholder dynamics shape ECCD outcomes and underscores the urgent need for integrated, government-led mechanisms to ensure equity, sustainability, and quality in early childhood services.

3.1 Government Ministries & Agencies

The Comprehensive Early Childhood Care and Development Policy 2013 by the Ministry of Women and Child Affairs recognized 19 government ministries and agencies as the major stakeholders in implementing the CECCD Policy 2013, which are :

1. Ministry of Women and Children's Affairs
2. Health Services Division, Ministry of Health and Family Welfare
3. Medical Education and Family Welfare Division, Ministry of Health and Family Welfare
4. Ministry of Primary and Mass Education
5. Secondary and Higher Education Division, Ministry of Education
6. Technical And Madrasha Education Division, Ministry of Education
7. Ministry of Cultural Affairs
8. Ministry of Social Welfare
9. Local Government Division, Ministry of Local Government, Rural Development and Co-operatives
10. Rural Development & Co-operative Division, Ministry of Local Government, Rural Development and Co-operatives
11. Ministry of Chittagong Hill Tracts Affairs
12. Ministry of Religious Affairs
13. Ministry of Food
14. Ministry of Disaster Management and Relief
15. Ministry of Information and Broadcasting
16. Ministry of Youth and Sports
17. Ministry of Labour and Employment
18. Security Service Division, Ministry of Home Affairs
19. Public Security Division, Ministry of Home Affairs

All these ministries and agencies have their own roles and responsibilities outlined both in the policy and the operational and implementation plan. Health, nutrition, education, safety, security, care, and development all fall under ECCD, and so, it requires inter-agency coordination among different government ministries and agencies. To ensure the collaboration and coordination among

them, a National ECCD Committee has also been formed, along with district, upazila, and union-level coordination committees with representation from the government ministries and agencies.

Here are the policy provisions and strategic guidelines concerning the roles of these ministries and agencies, their implementation status, and any limitations that hinder their effectiveness:

3.1.1 Ministry of Women and Children Affairs (MoWCA)

Policy Provisions and Strategic Guidelines on MoWCA's Role

The Comprehensive Early Childhood Care and Development (CECCD) Policy 2013 places MoWCA as the lead ministry responsible for coordinating ECCD services across the life cycle. The policy outlines that MoWCA should ensure a holistic, multi-sectoral approach, strengthen early stimulation and parenting interventions, and create a unified platform involving education, health, nutrition, and protection services (MoWCA, 2013a).

The Operational and Implementation Plan further specifies MoWCA's role in awareness building, training, curriculum revision, and establishing ECCD

service standards (MoWCA, 2013b)

Current Status of MoWCA's Role in ECCD Implementation

However, practice shows that MoWCA's leadership has not fully translated into widespread community-level implementation. Parents and caregivers reported receiving almost no structured orientation on early stimulation and parenting. Local MoWCA representatives are largely absent in routine service delivery; as a result, parents often perceive ECCD responsibility as lying mainly with health workers or NGOs rather than the lead ministry. Key informants also highlighted frequent changes of government officials and weak inter-ministerial follow-up, which obstructed MoWCA's ability to sustain monitoring and coordination.

3.1.2 Ministry of Health and Family Welfare (MoHFW)

Policy Provisions and Strategic Guidelines on MoHFW's Role

MoHFW plays a crucial role in prenatal, perinatal, and early childhood health services, as reaffirmed in the National Comprehensive Integrated ECCD Strategy (Under-3), which assigns MoHFW responsibility for maternal nutrition, antenatal care, newborn health, growth monitoring, and early stimulation at health facilities (MoHFW, 2022).

The CECCD Policy 2013 similarly highlights health as a foundational component of ECCD and encourages strong linkages between MoWCA and MoHFW to support children from conception onward (MoWCA, 2013a).

Current Status of MoHFW's Role in ECCD Implementation

In practice, health workers across regions act as some of the most visible stakeholders, providing home visits, prenatal counseling, vaccinations, and health camps, though the reach and quality vary significantly. Parents frequently reported shortages of doctors, long waiting times, irregular home visits, and inadequate counseling, which contradict the policy's vision of accessible maternal and child health services. In some areas, particularly coastal and hill regions, community clinics and centers are the only operational structures, yet their capacity remains limited. These gaps reflect insufficient staffing, inconsistent supervision, and limited awareness among health workers about ECCD-sensitive counseling.

3.1.3 Ministry of Primary and Mass Education (MoPME)

Policy Provisions and Strategic Guidelines on MoPME's Role

MoPME is responsible for pre-primary education, early learning, and parenting engagement for children aged 3–6, as mandated by the CECCD Policy 2013, which calls for age-appropriate pedagogy, play-based learning, and smooth transition from home to school (MoWCA, 2013a).

The operational and implementation plan of CECCD Policy 2013 also expects MoPME to integrate ECCD principles into textbooks and teacher training modules (MoWCA, 2013b).

Current Status of MoPME's Role in ECCD Implementation

There is currently a significant lack of awareness-building initiatives for parents aimed at promoting pre-primary education. Many existing pre-primary education services are not effectively addressing children's needs, such as cultural activities and play-based, creative teaching-learning methods. While early primary education is available through government, NGOs, and private initiatives, there is a notable absence of parental awareness regarding activities, and most of the institutions lack quality education programs necessary for holistic development at this level. Additionally, the Ministry of Primary and Mass Education (MoPME) and the Ministry of Women and Children Affairs (MoWCA) often operate independently rather than in a coordinated manner. This lack of collaboration can lead to duplicated efforts in some areas and a shortage of services in others.

3.1.4 Department of Social Services (DSS)

Policy Provisions and Strategic Guidelines on DSS's Role

The Department of Social Services is mentioned in national documents as a stakeholder for special needs support, child protection, daycare regulation, and services for disadvantaged children. The CECCD Policy 2013 calls for inclusive ECCD services and emphasizes that children with disabilities should access therapeutic and developmental support (MoWCA, 2013a).

Current Status of DSS's Role in ECCD Implementation

In reality, DSS services remain limited, fragmented, and largely known only to families who actively seek assistance. Key informants expressed concerns that therapeutic services are predominantly provided within DSS rather than being integrated into the broader health system. This separation leads to conflicts over mandates and accessibility. Furthermore, parents did not mention DSS as a regular service provider, which suggests its low visibility.

3.1.5 Bangladesh Shishu Academy (BSA)

Policy Provisions and Strategic Guidelines on BSA's Role

Bangladesh Shishu Academy is mandated by the CECCD Policy 2013 to support early stimulation, parenting programs, and culturally-grounded learning practices (MoWCA, 2013).

The National Comprehensive Integrated ECCD Strategy (Under-3) identifies BSA as a key contributor through community-based centers that facilitate play and early learning activities (MoHFW, 2022).

Current Status of BSA's Role in ECCD Implementation

Field data show that BSA's community centers are present only in limited locations, and many parents have never interacted with BSA services. Coverage is low, and coordination with NGOs and local governments is inconsistent. Despite strong potential, BSA is unable to reach most rural, hill, and coastal communities, leaving a gap in accessible cultural and cognitive development programs for children in these regions. Expanding BSA-supported Integrated Community-Based centers (ICBCs), ensuring dedicated staffing, and linking their activities with school and health programs would enhance their role

3.1.6 Limited Field-Level Visibility of Designated ECCD Ministries

Although the CECCD Policy 2013 formally recognizes 19 government ministries and agencies as key stakeholders, ranging from health, education, and social welfare to food, disaster management, religious affairs, labour, youth, culture, and security, field-level evidence suggests a significant gap between this comprehensive policy design and actual implementation. Findings from FGDs, IDIs, and KIIs reveal that parents, teachers, caregivers, and even frontline service providers are familiar with the roles of only a few ministries, mainly the Ministry of Health and Family Welfare, the Ministry of Women and Children's Affairs, and, to some extent, the Ministry of Primary and Mass Education. Other ministries identified in the policy, such as the Ministry of Religious Affairs, the Ministry of Cultural Affairs, the Ministry of Youth and Sports, the Ministry of Disaster Management and Relief, the Ministry of Food, the Ministry of Labour and Employment, and security-related divisions, remain largely invisible in day-to-day ECCD service delivery. This absence does not necessarily indicate complete non-involvement, but rather reflects the lack of clear operational mandates, weak inter-ministerial coordination, and limited translation of policy roles into field-level actions. In practice, most of these ministries do not have dedicated ECCD programs, identifiable community-level entry points, or regular interaction with families and children. As a result, ECCD implementation becomes concentrated within a small number of sectors, undermining the multisectoral and integrated approach envisioned in the policy. This disconnect explains why many stakeholders working on the ground have never heard of several listed ministries in connection with ECCD, highlighting a critical need for clearer role definition, visible programs, and stronger coordination mechanisms at local levels.

3.2 Development Partners

Here are the policy provisions and strategic guidelines for the roles of development partners in ECCD, along with the status of their implementation and limitations hindering their effectiveness:

> **Policy Provisions on Development Partners' Role**
>
> National ECCD policies repeatedly emphasize the importance of development partners in capacity building, piloting models, and supporting national roll-out of ECCD programs (MoWCA, 2013a; MoWCA l, 2013b).

Current Status of Development Partners' Roles in ECCD Implementation

Organizations such as UNICEF, BRAC, Save the Children, ActionAid, and CAMPE have made significant contributions to early childhood initiatives in Bangladesh, particularly through early stimulation programs, parenting models, play labs, and home-based support services. Despite these efforts, their overall impact remains limited relative to the scale of national needs. Field data suggest that one of the key challenges is the absence of a unified coordination platform, resulting in different ministries, departments, and organizations operating according to their own priorities and program goals. This lack of coordination was also evident during the implementation of pre-primary education. As one key informant noted,

> We fought hard over the implementation plan for the GO–NGO guideline on the pre-primary curriculum. However, the government ultimately decided not to provide any funding to NGOs, stating that while NGOs could continue to work, it would have to be through voluntary support without financial assistance. [KII, P5]

The statement reflects the tensions that emerged between government and non-government actors regarding collaboration. Despite NGOs having extensive experience, trained personnel, and established program models in early childhood education, the government decided not to formally involve them in the implementation process, largely due to financial considerations. Consequently, the quality of pre-primary education has been affected, and opportunities to leverage the resources, expertise, and learning materials developed by NGOs within government schools have largely been missed.

3.3 ECCD Networks, Research Bodies & Academic Institutions

Here are the policy provisions and strategic guidelines for the roles of ECCD networks, research bodies & academic Institutions in ECCD, along with the status of their implementation and limitations hindering their effectiveness:

> **Policy Provisions on ECCD Networks, Research Bodies & Academic Institutions' Role**
>
> The CECCD Policy 2013 and its Operational and Implementation Plan highlight the importance of research, knowledge generation, and network-based collaboration as essential components for strengthening ECCD standards and ensuring evidence-based national planning (MoWCA, 2013a; MoWCA, 2013b).

Current Status of ECCD Networks, Research Bodies & Academic Institutions' Roles in ECCD Implementation

Bangladesh hosts a wide range of institutions contributing to ECCD research, training and advocacy, including the Bangladesh ECD Network (BEN), BRAC Institute of Educational Development (BRAC IED), icddr,b, Institute of Child and Mother Health (ICMH), National Institute of Mental Health (NIMH), National Institute of Population Research and Training (NIPORT), research units of universities, and ECD-focused organizations engaged in child development, early stimulation and parenting interventions. These institutions regularly produce high-quality evidence, pilot innovative parenting and early stimulation models, and provide training and advocacy support to government and NGO actors as they regularly conduct research on early learning, parenting, health, nutrition, and child development.

However, in reality, this research ecosystem has limited influence on national ECCD programming. Key informants noted that although ministries acknowledge the value of research, research findings rarely shape large-scale government planning, and collaboration between researchers and ministries remains mostly project-dependent rather than institutionalized. Parents and frontline workers who participated in this study also reported minimal exposure to research-

based tools or guidelines, indicating that evidence generated by national institutions seldom reaches communities or becomes part of routine service delivery. As a result, many successful models, such as play-based parenting interventions, early stimulation packages, or disability screening tools, remain confined to pilot settings and are not scaled across districts, despite strong policy encouragement.

This disconnect points to the absence of a formal and continuous research policy coordination mechanism, even though the CECCD Implementation Plan calls for evidence-based planning and stronger partnerships with academic bodies (MoWCA, 2013). Without a structured platform to review findings, synthesise evidence, and guide ministries, policy updates remain slow and fragmented, and decision-making relies more on sectoral priorities than on the substantial research already available in the country.

3.4 Local Government Institutions (Union Parishad, Upazila Parishad, Municipalities)

Here are the policy provisions and strategic guidelines for the roles of local government institutions in ECCD, along with the status of their implementation and limitations hindering their effectiveness:

Policy Provisions and Strategic Guidelines on Local Government Institutions' Role

The CECCD Policy 2013 and its Operational and Implementation Plan place local government institutions at the core of ECCD implementation. Union Parishads, Pourashavas, and Upazila administrations are expected to coordinate ECCD services, support community-level awareness activities, facilitate inter-sectoral collaboration, and ensure monitoring and accountability at the grassroots level (MoWCA, 2013a; MoWCA, 2013b).

Current Status of Local Government Institutions' Involvement in ECCD Implementation

In practice, the role of local government in ECCD remains limited. Parents across rural, coastal, and northern regions rarely identified Union Parishads or Upazila offices as sources of ECCD-related support. Their interaction with local government was mostly confined to administrative services such as birth registration or safety-net enrolment, rather than parenting guidance or child development support. One mother explained,

> "We visit the Union Parishad only for registration purposes, not for any advice on childcare."

Key informants confirmed that ECCD does not receive regular attention in local planning, and ECCD coordination committees recommended in policy are often inactive or non-existent. As a

result, responsibility for ECCD is informally left to health workers or NGOs, especially in hard-to-reach areas such as haor, char, coastal, and hill regions.

3.5 Community-Level Stakeholders: Parents and Other Family Members, ECCD Practitioners, Community & Religious Institutions

Here are the policy provisions and strategic guidelines for the roles of community-level stakeholders in ECCD, along with the status of their implementation and limitations hindering their effectiveness:

Policy Provisions and Strategic Guidelines on Community-Level Stakeholders' Role

CECCD Policy 2013 identifies parents as the primary caregivers and emphasizes their crucial role in early stimulation, nutrition, protection, and early learning (MoWCA, 2013a).

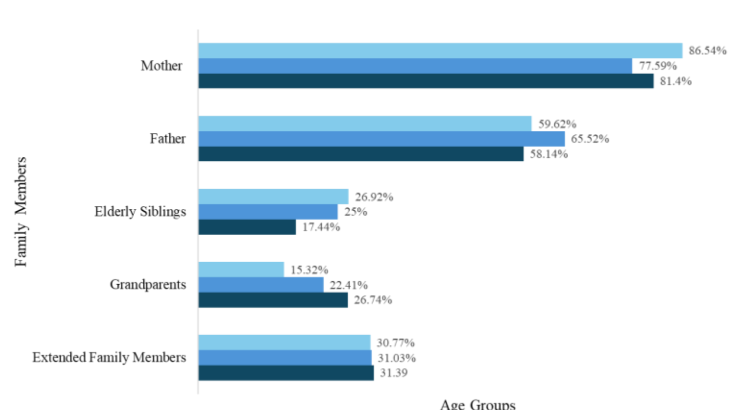
The Child Daycare Centre Act, 2021, also acknowledges families' central role in children's development.

Current Status of Community-Level Stakeholders' Involvement in ECCD Implementation

The role of community-level stakeholders varies across regions. In most areas, family members play the most crucial role in prenatal and postnatal care, as well as in early childhood care and development, most often without any prior knowledge or training on ECCD. In urban areas, the popularity of daycare centers is increasing among families for receiving ECCD services, as most of the family is nuclear and parents are involved in work. Community and religious institutions were mentioned as potential sources of support, but are not involved in ECCD activities in most areas.

Findings from the parents' survey indicate that both mothers and fathers play critical roles in children's early development, with additional support from extended family members. Here's a breakdown of their involvement in child care and development:

Figure 4 *Primary and Extended Family Involvement in Child Caregiving*



- Mothers are the most consistent and dominant caregivers across all stages of early childhood, with the highest influence recorded during the 0-3 year period (86.54%), remaining high through the 3-6 year (77.59%) and 6-8 year (81.40%) stages.
- Fathers maintain a steady presence in children's development, with their influence peaking at 65.52% during the 3-6 year preschool period, compared to 59.62% in infancy (0-3 years) and 58.14% in the early primary stage (6-8 years).
- Furthermore, the support from extended family members remains active throughout early childhood. Extended family support averages around 31%, with grandparents contributing an average of 27%, and older siblings providing support emerging at 25% during the 3-6 year stage.

The parents' survey findings also indicate that knowledge among stakeholders, excluding parents, varies significantly in ECCD across different age groups and different aspects of ECCD. Stakeholder awareness in different areas of ECCD is presented below:

- Awareness of basic health and protection is strong for children aged 0-3 (72.12%), and remains high for the 3-6 age group (72.41% for nutrition, 71.55% for safety). However, knowledge declines sharply for the 6-8 age group (52.32% for nutrition, 51.16% for health).

- Understanding of responsive caregiving is consistently low, ranging from 29% to 31%. Knowledge of early learning opportunities shows a slight increase to 36.21% for preschool-aged children, but remains low at 18.27% for 0-3 and drops to 30.23% for 6-8 years.

Overall, the data suggest that while basic survival and protection needs are relatively well understood among non-parent stakeholders, significant gaps persist in awareness of early learning, responsive caregiving, and educational aspects as children grow older.

ECCD practitioners, such as teachers and health workers, play a major role in ECCD services. However, most of them lack structured training on ECCD. Guardians in urban, rural, poverty-stricken, and hilly areas report that health workers make significant contributions in maternal pregnancy and childbirth, and in early childhood care and development. In addition, when children start going to school, teachers contribute to their holistic development, focusing on physical, cognitive, social, and emotional development. Moreover, they build necessary awareness among parents related to child care and development through meetings. However, the quality and contribution of health workers and teachers differ across regions due to training quality and opportunity, uneven resource allocation, inconsistent policy enforcement, lack of accountability, and structured monitoring and supervision.

Highlights of Findings on Stakeholder Mapping

- **Fragmented Stakeholder Engagement and Limited Integrated Service Delivery**

  Although the national ECCD framework designates 19 ministries and multiple stakeholders, engagement is primarily seen in the health and education sectors. Many ministries have limited presence, leading to fragmented implementation and poor cross-sector coordination. Despite the CECCD Policy 2013 outlining clear roles, service delivery often operates separately. Health workers, teachers, local representatives, and NGOs tend to work independently, resulting in limited community coordination. Parents often receive isolated services, like vaccination reminders, lacking awareness of broader support for parenting and early learning. This shows that multisectoral collaboration has not yet led to integrated ECCD services locally.

- **Limited Visibility of Child Protection, Disability, and Early Learning Institutions**

  Institutions responsible for child protection, disability support, and early learning promotion, such as the Department of Social Services, Bangladesh Shishu Academy, and local government bodies, have limited visibility in community-level ECCD experiences. Promising initiatives, such as Integrated Community-Based centers, operate in limited areas and are not widely known among families.

- **NGO-Led ECCD Services Provide Added Value but Remain Limited in Scale**

  NGO coverage is geographically concentrated and dependent on project funding. Limited financial and institutional support restricts the expansion and sustainability of effective NGO-led models, reducing their potential contribution to national ECCD goals.

- **Parents as the Primary Caregivers with Limited Institutional Support**

  Parents are the main providers of care, stimulation, and early learning support for young children across all settings. Despite policy emphasis on parental empowerment, structured

and accessible parenting education mechanisms are largely absent. Without formal guidance, parents rely on personal experience, family practices, or informal sources of information, which vary in quality and consistency.

- **Active but Fragmented Engagement of ECCD Networks and Academic Institutions**

  ECCD networks, research bodies, and academic institutions play an important role in advocacy, research, training, and pilot interventions. While universities and specialized institutes enhance professional development and generate evidence, their interactions are often project-based and urban-focused, lacking integration with government planning and implementation. Consequently, research findings are not consistently translated into policy reforms or practical application, leading to underutilization of evidence and expertise.

Major Recommendations

- **Activate and Institutionalize Multisectoral ECCD Coordination Mechanisms**

  The multisectoral coordination committees outlined in the CECCD Policy 2013 should be reactivated and made functional at national, district, and upazila levels. This is necessary because fragmented implementation across ministries has limited the translation of policy commitments into integrated community-level services. Regular coordination among MoWCA, MoHFW, MoPME, local government, and NGO partners would support joint planning, monitoring, and accountability for ECCD service delivery.

- **Strengthen Parenting Support and Early Stimulation through Existing Service Platforms**

  Early stimulation, responsive caregiving guidance, and basic maternal mental health support should be systematically integrated into existing health and education platforms, particularly ANC-PNC services, community clinics, and schools. This is important because parents are the primary ECCD providers but lack structured guidance. Developing and disseminating a simple, nationally endorsed parenting guideline in accessible formats would help operationalize policy commitments at the household level.

- **Build Workforce Capacity across Sectors to Deliver Holistic ECCD Services**

  ECCD-related competencies should be embedded into regular training and professional development systems for teachers, health workers, and social service staff. Limited understanding of early stimulation, child development, disability identification, and responsive caregiving constrains service quality. Strengthening frontline capacity will help ensure more consistent and child-centered ECCD support across regions and institutions.

- **Formalize and Scale Government-NGO Partnerships for Proven ECCD Models**

A clear and structured government-NGO partnership framework should be established to expand effective ECCD models already implemented by NGOs. While NGO-led initiatives provide valuable parenting education and play-based learning, their reach remains limited. Formal partnerships, resource sharing, and co-financing mechanisms would enable scaling of successful approaches beyond project areas.

- **Strengthen Local-Level ECCD Support, Feedback, and Accountability Mechanisms**

  Local government structures should play a more active role in ECCD by facilitating parenting sessions, referrals, and basic record-keeping at the community level. At the same time, accessible feedback and complaint mechanisms should be introduced through clinics, schools, and local offices. This is necessary because families currently lack clear channels to voice concerns, limiting service responsiveness and continuous improvement.

- **Institutionalize Collaboration Between Government and ECCD Knowledge Actors**

  Establish formal platforms for regular engagement between ministries, ECCD networks, and academic institutions to ensure research findings systematically inform policy, planning, and budgeting processes. Structured representation within national and local coordination mechanisms can strengthen evidence-based decision-making.

Conclusion

This chapter highlights that while Bangladesh's ECCD policies are ambitious and multisectoral in design, their translation into practice remains fragmented, uneven, and weakly monitored. Health workers and NGOs continue to carry the visible burden of service delivery, but their reach and scope are limited, leaving parents as the primary ECCD providers without structured support. Children with disabilities and families in remote areas are most disadvantaged, while accountability and grievance mechanisms are absent at the community level. These findings underscore the urgent need for stronger coordination among ministries, equitable resource distribution, formalized GO-NGO partnerships, and parental empowerment strategies to ensure that ECCD services are inclusive, sustainable, and aligned with the policy commitments of CECCD 2013.

Chapter Four: Status of Prenatal and Perinatal Care Services

Prenatal and perinatal care services are critical components of maternal and child health, directly influencing survival, growth, and long-term development outcomes. In Bangladesh, successive national health policies and programs have emphasized safe motherhood, antenatal care, skilled birth attendance, and postnatal follow-up as essential priorities. This chapter reviews the overall state of prenatal and perinatal care services in Bangladesh, focusing on how national policies and programs translate into practice.

4.1 Access and Coverage of Services

The section examines the policy commitments related to Early Childhood Care and Development (ECCD) services during the prenatal and perinatal period and the actual picture of access and coverage at the community level. It reviews both the policy provisions guiding maternal and newborn care and the current implementation realities, highlighting variations in service utilization, awareness, and quality. The analysis also identifies key social, institutional, and systemic factors that influence access to and continuity of prenatal and perinatal care services.

4.1.1 Service Coverage

The strategic guidelines and policy provisions for prenatal and perinatal service coverage and the status of service coverage are discussed here:

Policy Provisions and Strategic Guidelines on Service Coverage during the Prenatal and Perinatal Stage

The National Children Policy 2011 outlines comprehensive provisions for safe childbirth through improved nutrition, essential health care, and integrated prenatal, natal, and post-natal services (MoWCA, 2011).

The CECCD Policy 2013 further strengthens this commitment by emphasizing enhanced community clinic services, adequate maternal and infant nutrition, attention to mothers' physical and mental well-being, rest during pregnancy, and continuous fetal care. Additionally, during delivery and the postnatal period, the policy highlights quality healthcare services, breastfeeding counselling, food and nutrition guidelines, parenting support, and maternity leave. (MoWCA, 2013a).

Status of Service Coverage during the Prenatal and Perinatal Stage

Access to essential Early Childhood Care and Development (ECCD) services during the neonatal period is critical for ensuring healthy survival, early stimulation, and timely developmental support. But findings from the parents' survey indicate notable variation in service coverage at this stage.

- **Respondents' own children:** 68.75% of 16 neonates were reported to have access to necessary ECCD services.

- **Neonates in wider social networks of the respondents:** Only 33.33% of 45 neonates (friends' and relatives' children) were reported to have similar access.

This disparity suggests that while surveyed households may experience relatively better access or awareness of neonatal ECCD services, coverage remains uneven across the broader community.

Also, despite strong policy commitments, national data indicate that implementation of maternal health services remains inconsistent. While antenatal care (ANC) coverage has reached 80% and skilled birth attendance stands at 70%, postnatal care coverage remains low at 55% within two days of delivery. Persistent inequities between urban and rural areas limit access to professional healthcare during delivery, and the health system remains under-resourced, with one healthcare worker serving an estimated 1,500 people (Agarwala et al., 2024, p. viii). The MICS 2025 Preliminary Report aligns with these findings, showing that 75.7% of mothers receive essential ANC tests, 71% rely on institutional deliveries, and 77% are supported by skilled attendants during childbirth (BBS, 2025). These figures suggest improvements in service uptake but also highlight gaps in service quality and consistency.

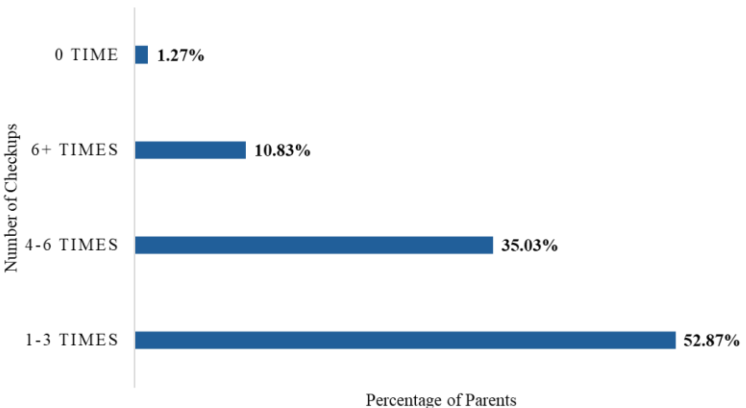
Implementation experiences at the community level revealed significant variations in the reach and continuity of maternal health interventions**.** Under the 4th Health, Population and Nutrition Sector Program (HPNSP), community clinics in only 16 upazilas promoted awareness on essential ANC, maternal and newborn nutrition, early breastfeeding, and skin-to-skin contact. However, coverage remained limited, and activities have remained suspended for 1.5 years since the program's completion.

Field inputs showed geographic disparities as parents in Haor and Char regions reported dissatisfaction due to limited facilities and trained staff, whereas families in urban slums, hill tracts, and coastal areas expressed relatively positive experiences with community clinics. Despite wide geographic availability, evidence indicated low awareness and low service-seeking from community clinics among pregnant mothers, particularly during the antenatal stage. Focus group discussions with parents also highlighted that home visits by community health workers were more effective and better received than clinic-based sessions.

Historically, maternal mortality in Bangladesh was largely driven by limited knowledge of prenatal and postnatal complications, particularly in rural areas. Although access to skilled healthcare providers has increased over time, many women still used to rely on untrained traditional birth attendants when complications arose during pregnancy or childbirth. The current survey conducted with parents reflects a similar pattern - while most mothers attend the first antenatal care (ANC) visit, few complete the recommended four visits, with many returning only for delivery.

- **ANC visits according to the Parents' Survey:** 52.87% of parents attended 1–3 times, while only 29.41% attended 4–6 times, and 10.83% attended more than 6 times.

Figure 5: *Number of Health Checkups during Pregnancy*



Key informants and ECCD service providers emphasized that insufficient follow-through on ANC, limited trust in formal services, and reliance on traditional providers continued to undermine safe childbirth and newborn wellbeing.

In the parents' survey, the mothers particularly identified some other services that they receive till the first month of childbirth for themselves and for their children. But these services are unevenly accessed by the mothers, as shown in the table.

Table 8 *Postnatal Services Received within 1 Month of Childbirth*

Types of Services	Percentage of Mothers Receiving these Services
Nutritional advice for mother and child	65.21%
Breastfeeding instructions	54.34%
Childcare-related instructions	39.13%
Child safety-related instructions	23.91%
Postnatal home visits by health workers	39.13%

Maternal mental health-related instructions	18.47%
Mothers' personal safety and hygiene-related instructions	21.74%
Instructions related to early stimulation	18.47%
Instructions on creating child friendly environment at home	10.87%

N.B. total respondents=92

Although national policies outline comprehensive provisions for maternal care, the implementation remains uneven due to limited program coverage, insufficient staffing, and geographical disparities. The suspension of HPNSP community-level activities has further weakened the continuity of maternal health promotion. Inadequate follow-through in ANC attendance, low postnatal care uptake, and weak linkages between community clinics and families indicate gaps in translating policy commitments into practice. Additionally, mothers in hard-to-reach regions continue to face structural barriers, including poor facility availability, distance, transportation challenges, and cultural norms that favor traditional, untrained providers.

4.1.2 Major Factors Affecting Access and Coverage of Prenatal and Perinatal Care Services

The policy provisions and strategic guidelines for various major factors influencing access and coverage in prenatal and perinatal services, as well as the current status of these factors, are addressed here:

Preconception and Prenatal Awareness

Policy Provisions & Strategic Guideline on Preconception and Prenatal Awareness

According to the Comprehensive Early Childhood Care and Development Policy 2013 by the Ministry of Women and Child Affairs, the Early Childhood Care and Development services need to start even before conception through providing the necessary guidelines regarding pregnancy. During this phase, the policy recommended that the focus of the services should mostly be on awareness building. The policy suggested having specific strategies for ensuring access to ECCD services for teenagers, youths, parents, caregivers, and children, starting from the preparational phases of pregnancy to childbirth through awareness campaigns, knowledge sharing activities, maternal health care services, nutrition programs, child development programs, and parenting training (MoWCA, 2013a).

The operational and implementation plan of CECCD Policy 2013 provides a guideline of necessary initiatives to be taken along with the ongoing activities, such as creating awareness regarding pregnancy among the young generation and newlyweds through both public and private forums, marriage registrars, regular media programs, awareness campaigns, curriculum revision, training modules development, and counselling along with law enforcement (MoWCA, 2013b).

This is aligned with the Bangladesh National Maternal Health Strategy 2019-2030, which also recommends awareness building regarding early marriage, early pregnancy, reproductive behavior, unsafe abortion, and various diseases, followed by antenatal, delivery, and postnatal care services during adolescence and the preconception phase (MoHFW, 2019).

The Nurturing Care Framework for Early Childhood Development similarly emphasizes the need for building awareness from adolescence about delaying pregnancy and being well-prepared physiologically, psychologically, and financially to ensure appropriate support for the baby (WHO et al., 2018).

Status of Preconception and Prenatal Awareness

Although policy directions strongly support preconception and prenatal awareness, the translation into practice remains inconsistent. None of the parents from the different geographic locations, from urban to rural, from hills to coast, reported that they had any kind of orientation regarding reproductive health, conception, or any other concept related to early childhood development. The healthcare service providers in a few communities claimed to do home visits regularly for creating awareness, but that is completely focused on pregnant women and their families about antenatal checkups and institutionalized childbirth. But the parents during FGDs voiced their need for such awareness-building initiatives targeting young boys and girls.

The urban parents particularly appreciated the basic knowledge about reproductive health that is disseminated through the implementation of the curriculum, but also identified how the teachers are reluctant to discuss those topics in the classroom. They demanded an intensive program starting from the adolescent period to create awareness in the communities, and it should be ensured that every man and woman is adequately aware of conception, parenting, and early childhood development of their children. A parent, who had experienced the severe sickness of his child during the perinatal period, voiced,

> I would highly appreciate it if there were any courses for us. Becoming a parent should not be so simple. Because of our ignorance, our children suffer a lot. The government should set a rule that without having knowledge about ECCD, one can not get married and start a family. If it could be imposed, the challenges we face when we give birth to a child would be reduced to a great extent. [FGD 9, P3]

The key informants for the study also suggested a life-cycle approach for creating awareness regarding ECCD from a very early age, if possible, through disseminating relevant knowledge in a more detailed way through textbooks. One of the key informants expressed,

> ECCD should be addressed from the adolescent period onward. If we start from adolescence, the students will be oriented about ECCD in schools. This knowledge will later support proper practices during conception, pregnancy, and also gradually contribute to encouraging mothers to attend regular antenatal check-ups. [KII, P4]

The lifecycle approach described in the CECCD Policy 2013 and echoed by key informants and parents is not yet fully integrated into the education system. There remains a huge gap in awareness building among adolescents. The incorporation of ECCD concepts in the curriculum is not adequate at all. As a result, awareness efforts remain insufficient across the country. The lack of institutionalized, school-based, and community-level mechanisms limits the sustained reach of prenatal awareness messages.

Family Dynamics

Policy Provisions & Strategic Guidelines on Nurturing Care and Family Involvement

The CECCD Policy 2013, Nurturing Care Framework, and Bangladesh National Strategy for Maternal Health 2019-2030 acknowledge the importance of taking care of maternal health and emphasize antenatal and postpartum care. The operational and implementation plan of CECCD Policy 2013 provides a guideline for undertaking awareness-raising activities under existing programs. It emphasizes the involvement of family members in child health and nutrition services, particularly encouraging the participation of fathers to prevent superstitions, maltreatment, and domestic violence (MoWCA, 2013b).

Status of the Influence of Family Dynamics

Evidence shows that despite having general awareness about the importance of nutritious food and supplements, women often experience limited access due to family dynamics and low awareness among household members regarding maternal well-being. In some cases, misconceptions are unintentionally reinforced by both mothers and field-level healthcare providers, which further worsens micronutrient deficiencies (Kraemer, 2023).

Experiences shared by mothers in this study illustrate a mixed reality of support and gaps in knowledge within families. Many pregnant women reported being cared for by both their parental relatives and in-laws, reflecting positive support systems. However, a concerning pattern emerged as most of these women had not attended any formal awareness or counselling sessions targeted toward pregnant mothers. Instead, they primarily relied on advice from elderly family members.

While well-intentioned, these traditional practices, often based on limited knowledge or superstition, cause risks to maternal and newborn health if inaccurate or outdated.

Family members' lack of awareness frequently creates barriers to adopting recommended prenatal and postnatal practices. Both in urban and rural contexts, parents highlighted that ignorance within extended families often leads to discouragement, misguidance, or interference during pregnancy and after childbirth. One urban father described facing resistance when attempting to follow proper maternal care practices, saying,

> Other family members, like my child's grandparents, my brothers and sisters, could have helped take care of the mother and the fetus if they were aware. But the lack of awareness among them is so great that they create problems at every step. When my wife was pregnant, I knew how to take care of her in this situation. But when I wanted to do these things in my way, I got bullied by the rest of the family. [FGD 8, P6]

Another rural mother also expressed frustration while talking about the superstition among the elderly members of the family and how it creates problems in motherhood and childcare. She exclaimed,

> Just a few days after birth, my son's entire body got covered in measles. I was going to take him to the hospital, to the district town. His father was coming with me. And in the middle of it, my mother-in-law said he would get better if we gave him **'batash pora'**. We could not ignore her and ended up doing it. It worsened the situation for us. Later, my son had to be admitted to the hospital for 15 days. [FGD 10, P1]

These testimonies reflect broader community-level patterns of misinformation that shape maternal care behaviour across households. ECCD providers and health workers also identified the powerful influence of husbands and in-laws in shaping maternal health decisions in the rural areas. According to service providers, resistance toward supplements, vaccinations, and immunization persisted among segments of the rural population due to fears of side effects and deep-rooted superstitions. One provider noted that mothers often miss essential doses or supplements because their husbands or mothers-in-law oppose them. In such situations, mothers' individual awareness becomes insufficient to ensure service uptake, as they are unable to challenge family decisions.

Negligence towards the Mental Well-being of the Mothers

Policy Provisions & Strategic Guidelines on Maternal Mental Well-being

The Nurturing Care Framework explicitly highlights the importance of supporting parents' mental health alongside their physical wellbeing to promote optimal child development (WHO et al., 2018).

The operational and implementation plan of CECCD Policy 2013 emphasizes ensuring the inclusion and effective implementation of maternal mental well-being activities within existing programs (MoWCA, 2013b). The other policies targeting mothers and children also acknowledge taking care of the mental well-being of the mothers.

Status of Maternal Mental Health Support

Despite the critical role of maternal mental well-being in supporting child development, very few initiatives address this aspect in practice. Discussions with mothers in this study revealed that none had access to psychosocial support or mental health services, and many experienced postpartum depression as a consequence.

Mothers' experiences underscored the lack of mental health support during critical adjustment periods. One new mother shared,

> From conception till today, I felt mentally unstable and overwhelmed with responsibilities. But I did not know how to get rid of it. I wish I had immediate counseling by mental health professionals just after I gave birth so that the adjustments would have been much easier for me. [FGD 21, P4]

Similarly, mothers expressed frustration over the absence of structured services, noting,

> We talk a lot about mental well-being these days, but what about a mother's well-being? Counseling should also be provided for coping with postnatal depression. This is definitely needed for all the mothers. But did I receive any? No! [FGD 9, P2]

These accounts highlighted a critical gap in maternal healthcare. While physical health during and after pregnancy receives attention, mental health support for mothers remains largely absent. Mothers experience stress, anxiety, and postnatal challenges without access to counseling or structured services, underscoring the need for integrating mental health interventions into postnatal care.

The survey with parents also revealed a similar result.

- **Maternal mental well-being support:** Only 49.04% of parents reported receiving necessary mental health support during pregnancy and the postpartum period.

Although the CECCD Policy 2013 recognizes maternal mental well-being as essential, there is no visible evidence of implementation in the field, leaving mothers unsupported during a critical period. There appears to be minimal urgency or structured interventions targeting this need at the community or health facility level.

The lack of structured mental health interventions across the country represents a significant gap in maternal health services. While policies acknowledge the importance of maternal psychosocial well-being, no dedicated counselling, screening, or follow-up mechanisms exist at the community or facility level. The ECCD service providers also revealed in the IDIs that there is no intervention for addressing the mental health issues of the mothers, and it is beyond their capacity. Mothers often experience postpartum stress, anxiety, or depression without any professional guidance, and reliance on family support is inconsistent due to low awareness. Limited training of health workers in mental health, the absence of standardized protocols, and the lack of integration with routine maternal and child health services further exacerbate this gap, leaving maternal mental health largely unaddressed.

4.2 Quality of Services

This section reviews the quality of prenatal and perinatal services by examining both policy commitments and the realities of service delivery on the ground. It highlights challenges related to workforce competency, facility readiness, and the availability of essential medicines, equipment, and specialized care. It also reflects community experiences and provider perspectives on gaps in human resources, infrastructure, and supply systems that affect the overall quality of maternal and newborn care services.

4.2.1 Insufficient Service Quality and Workforce Competence

The policy provisions regarding the quality of prenatal and perinatal services, as well as the current status of service quality, are discussed here:

Policy Provisions on Prenatal and Perinatal Service Quality

The **CECCD Policy 2013** highlights strategies for supporting mothers from conception to childbirth and explicitly emphasizes improving workforce quality in community clinics and healthcare centers (MoWCA, 2013a)

Status of Prenatal and Perinatal Service Quality and Workforce Competence

Despite these policy provisions, parents across urban, rural, and hill tract regions reported widespread dissatisfaction with the quality of healthcare services. This dissatisfaction reflects a lack of trust in government facilities and perceptions of low competency among healthcare providers. Mothers' experiences illustrated how service delivery gaps undermine confidence in public healthcare. One mother, residing in an urban area, exclaimed,

> When my child was born, I noticed my child was constantly sweating. Being concerned, I asked for suggestions from the medical officer, and he said that I might have mostly stayed in air-conditioned rooms during my pregnancy, and that's why the child is taking time to adjust to this environment. But when we shifted to a private hospital, it was found that my child had a lung infection. Since then, I lost all my trust in the public healthcare system for the infants. [FGD 9, P5]

Similarly, a mother from the hill tracts highlighted systemic failures, noting that hospitals lack adequate observation, poor management deters service-seeking, and so, families often prefer private facilities despite higher costs. In private clinics, there are also concerns about unnecessary interventions, such as forced cesarean sections, indicating problems with both service ethics and clinical decision-making. From the service providers' point of view, the shortage of skilled personnel, high doctor-to-patient ratios, and inconsistent provider attitudes exacerbate challenges in delivering quality prenatal and postnatal care. Even when mothers seek services at community clinics or health centers, limited workforce capacity, inadequate training, and insufficient oversight compromise care quality. These issues collectively prevent the effective implementation of prenatal and postnatal programs envisioned in the CECCD Policy and hinder mothers from receiving timely, reliable, and quality care. The key informants also highlighted significant gaps in both the availability and competency of maternal health service providers, especially in the hard-to-reach regions, such as haors, chars, coastal areas, and hills.

Public healthcare facilities suffer from shortages of doctors, nurses, and support staff, leading to long wait times and inadequate monitoring of pregnant women. Weak managerial systems, low adherence to clinical guidelines, and inconsistent attitudes among providers further reduce service quality. Private facilities, on the other hand, while better resourced, often prioritize profit over patient-centered care, resulting in unnecessary procedures and interventions. These structural and human resource limitations create inequities in access and compromise maternal and neonatal health outcomes.

4.2.2 Lack of Facility Readiness and Inadequate Supply of Essential Supplements

The policy provisions and strategic guidelines for essential healthcare resources regarding prenatal and perinatal services are discussed here:

Policy Provisions & Strategic Guidelines for Essential Healthcare Resources

The CECCD Policy 2013 emphasizes the need to ensure a consistent supply of medicines, healthcare equipment, and the introduction of web-based monitoring systems to maintain service quality (MoWCA, 2013a).

The operational and implementation plan of CECCD Policy 2013 provides a guideline to ensure the supply of manpower, equipment, medicine, and the development of institutional infrastructure for maternal and child healthcare. It emphasizes the importance of providing these resources for basic Emergency Obstetric Care (EOC) services at the union and upazila levels, as well as for comprehensive EOC services at the district level (MoWCA, 2013b).

The Bangladesh National Strategy for Maternal Health 2019-2030 similarly highlights deficits in healthcare facilities, clean and hygienic environments, and modern medical equipment required for maternal and neonatal care and advocates for improved facilities (MoHFW, 2019).

Status of Healthcare Infrastructure and Facilities

It was found while conducting the study that most community clinics and health complexes are still inadequately prepared to meet the healthcare needs and provide counseling support to the mothers and newborns, particularly in the char and haor areas. Supporting these facts, the mothers from char areas of Bangladesh claimed,

> The facility for providing healthcare, counseling, or needed guidance through dedicated sessions to pregnant mothers is not ready yet. The most we can do is seek advice over the phone if we ever feel unwell or need any kind of suggestions. [FGD 24, P1]

It reflects the limited readiness of community clinics and health complexes in remote areas to provide structured maternal care and counseling. The reliance on phone-based advice indicates a gap in accessible, in-person support, which may delay timely interventions and affect maternal well-being during pregnancy and postnatal periods.

Also, limited neonatal intensive care facilities (NICUs) further compromise the quality of newborn care. Even in urban areas, NICU availability is extremely restricted. One father explained,

> When my child was born, he needed NICU support. There were no NICUs available at the Government Hospital. Only one private hospital had this facility, and so, we rushed with a fear of not getting it available as well. Despite living in a town and having the financial ability to bear medical expenses for my child, I felt helpless due to the lack of facility readiness. Now, think about the parents from disadvantaged backgrounds. Their child may also need to be admitted to the NICU. How will they bear the cost if the government facilities are limited? [FGD 9, P3]

It underscores critical shortcomings in neonatal care infrastructure, even in urban settings. This gap in neonatal care is particularly critical for children born prematurely or with complications and disproportionately affects families from disadvantaged backgrounds who cannot access or afford private care, thereby exacerbating health inequities.
Even though the parents criticized the prenatal and perinatal care services during FGDs, the findings from the practitioners' survey show a different result.

- **Parental Satisfaction:** Most respondents rated prenatal and postnatal services positively, with 55.41% describing them as good and 10.19% as very good, while 29.30% considered them medium and only 5.10% rated them as bad.

Maternal nutritional support during pregnancy also remains insufficient despite existing programs. Supplements such as vitamins, iron, folic acid, and calcium, which are vital for preventing malnutrition and supporting maternal health, are often unavailable at health complexes. Mothers who can afford supplements must source them externally. One mother reported,

> We only got a free supply of paracetamol (Napa) during our pregnancy from the health centers. [FGD 14, P1]

Service providers confirmed the situation, admitting the inadequacy of services against the demand. One of them described,

> It is not like there are no such services for mothers to take care of their health and nutrition. There is a program for nutritional services for pregnant mothers in this area, but no one in the community knows about it. The female officials of the health complex do not inform about it, since they are not able to provide service to all the mothers. It's beyond their capacity. And so, they decide not to take any trouble. [IDI, P15]

Many health complexes lack essential medicines, supplements, and specialized units like NICUs, limiting access to critical care. Furthermore, inconsistent communication by service providers results in mothers remaining uninformed about available services. These infrastructure and supply deficiencies compromise both maternal and neonatal outcomes and reduce trust in government healthcare services.

4.3 Equity and Inclusion

This section explores the extent to which prenatal and perinatal services are delivered equitably and inclusively across different population groups. It reviews existing policy commitments aimed at ensuring equal access to maternal and newborn care and examines the realities of financial, geographic, gender-based, and social disparities that influence service utilization. It also highlights the challenges faced by marginalized communities and mothers with disabilities in accessing appropriate care services.

4.3.1 Financial, Geographical, and Gender Disparities in Accessing Equitable Care Services

The policy provisions and strategic guidelines for equitable and inclusive prenatal and perinatal care services, as well as the status of equity and inclusion in these services, are discussed here:

Policy Provisions and Strategic Guidelines for Equitable and Inclusive Prenatal and Perinatal Care Services

The CECCD Policy 2013 emphasizes that every mother and fetus deserves quality ECCD services regardless of socio-economic background, and highlights strategies for establishing dedicated healthcare services for mothers and children from hard-to-reach communities during the prenatal and perinatal phases (MoWCA, 2013a).

Additionally, the operational and implementation plan of the CECCD Policy 2013 provides a guideline taking into account hard-to-reach areas and underserved populations. It highlights the launch of delivery services at selected Community Clinics and also emphasizes the establishment of basic EOC services at selected Union Health and Family Welfare centers, as well as comprehensive EOC services at selected Upazila Health Complexes. To provide specialized care to these populations, it focuses on constructing infrastructure with the necessary manpower and facilities (MoWCA, 2013b).

Status of Equity and Inclusion in Prenatal and Perinatal Services

Access to prenatal and perinatal healthcare in Bangladesh continues to show significant disparities, particularly for mothers in low-income, climate-vulnerable, and remote regions. Despite policies aimed at providing equitable services, many parents face practical barriers in utilizing available facilities. One mother visiting a community clinic in a coastal area described her experience, saying,

> Because of financial issues, I can not go to the private hospitals and come to this community clinic for an antenatal health checkup and ultrasound. But this clinic has only one doctor who does everything, including ultrasonography and deliveries single-handedly. That's why I have been waiting here for hours. If I were financially well off, I would have gone to the private hospitals where there are several medical officers and the patients do not need to wait much. [FGD 14, P3]

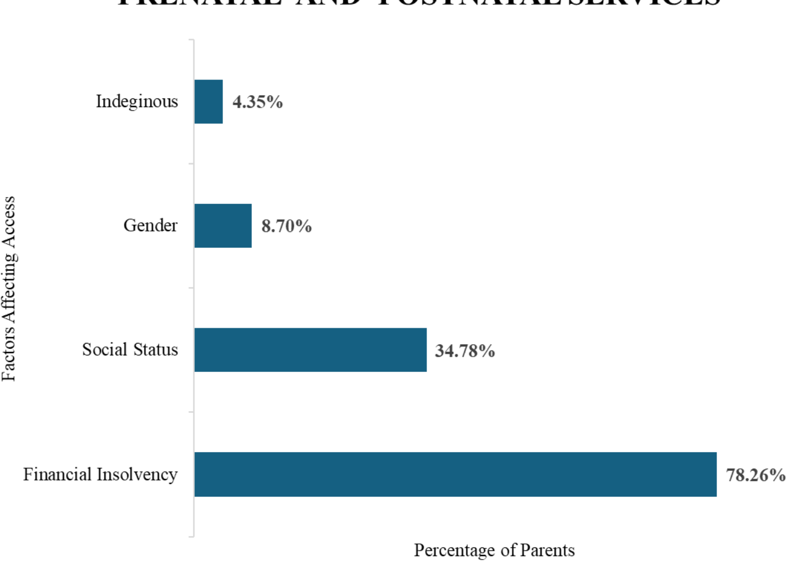
This account underscores how financial constraints and limited facility capacity create indirect discrimination, where mothers' access to quality care is shaped by their socioeconomic status. Mothers from disadvantaged areas often face long waiting times, reduced attention from overburdened providers, and a lack of choice between public and private services, which cumulatively undermine the quality of care they receive. While policymakers frequently highlight initiatives aimed at expanding access for low-income populations, these measures often fail to reach climate-vulnerable, remote, or resource-poor communities effectively. Key informants acknowledged that many families in these regions receive minimal targeted support and are unaware of the full extent of services available to them, which further perpetuates inequities. In

practice, this means that access to prenatal and perinatal care is strongly shaped by socioeconomic status, geographic location, and institutional capacity, resulting in systemic disparities that contradict the intentions of existing policies.

The findings from the parents' survey also align with the facts stated by the key informants.

- **Discrimination in service access:** Only 14.01% of respondents reported experiencing discrimination while accessing prenatal and postnatal services; among them, 78.26% identified financial insolvency and 34.78% cited social status as the main causes..

Figure 6: *Factors Affecting Discrimination in Prenatal and Postnatal Services*



Gender-based inequities also influence maternal care, particularly in resource-constrained settings. Although overall gender-based discrimination has decreased, disparities persist in some regions. A parent from the hill tracts noted that girls often receive less essential healthcare compared to boys, and identified this bias as a contributing factor to inadequate support for pregnant women in poor families.

Financial, geographical, and gender-based inequities remain key barriers to equitable maternal healthcare. Low-income families and those living in remote or climate-vulnerable areas often face long waiting times, insufficient healthcare personnel, and limited access to specialized services. Knowledge gaps prevent many families from fully utilizing available government programs, further exacerbating inequities. Gender bias, while reduced, continues to affect access to care in certain rural and hill tract communities. These disparities hinder the objective of universal and equitable prenatal and postnatal care as envisioned in national policies.

4.3.2 Exclusion of the Marginalized Communities and Persons with Disabilities

The policy provisions and strategic guidelines for prenatal and perinatal care services targeting marginalized communities, along with the status of these services for both marginalized individuals and people with disabilities, are discussed here:

> **Policy Provisions and Strategic Guidelines for Healthcare Services of the Marginalized Communities**
>
> CECCD Policy 2013 emphasizes mapping mothers and children who are at risk or belong to marginalized communities, such as indigenous populations and minority groups, and providing socio-economic support to bring them into mainstream services. It further recommends engaging union-level healthcare centers to ensure these families receive equal and continuous care (MoWCA, 2013a).
>
> Additionally, the operational and implementation plan of the CECCD Policy 2013 emphasizes launching special projects and programs for ethnic minorities, marginalized groups, and vulnerable mothers and children through the integrated planning of government and non-governmental organizations (MoWCA, 2013b).

Status of Prenatal and Perinatal Services for Marginalized Communities and Persons with Disabilities

Findings from the current study indicate that service providers generally did not differentiate between majority and minority groups in routine maternal and child care. Rather, in some hill tract areas, indigenous mothers even received additional support through home-visit services tailored to their circumstances. But the overall system is not facilitated enough to support the marginalized communities so that they can access quality services.

Gaps in inclusiveness appear prominently when considering mothers with disabilities. While national policies emphasize support for children with disabilities, there is little to no guidance on how mothers with disabilities should be supported during pregnancy, delivery, and postnatal recovery. Both ECCD providers and parents participating in the study reported having no information on how expectant or new mothers with disabilities are treated or facilitated during these crucial stages. This absence of structured services highlights a significant policy blind spot affecting a highly vulnerable group.

The lack of specific provisions for mothers with disabilities represents a major gap in ensuring universal access to quality maternal care. Current policy frameworks focus primarily on marginalized ethnic groups and children with disabilities, but overlook the tailored support needed for pregnant women with physical, sensory, or cognitive disabilities. Additionally, although indigenous communities in the hill tracts receive some targeted home-visit services, this level of attention is not uniformly available across other marginalized groups. The absence of systematic mapping and dedicated service strategies restricts the full implementation of the CECCD Policy's inclusiveness goals.

Highlights of Findings on the Status of Prenatal and Perinatal Services

- **Low coverage and continuity of ANC, PNC, and Neonatal ECCD Services**

Although ANC coverage has improved, continuity of care - particularly 4+ ANC visits and PNC uptake remains low. Mothers and children from rural and hard-to-reach areas (Haor, Char, coastal belts, and hill tracts) face persistent geographic disparities, limited service availability, and chronic staff shortages. Access to neonatal ECCD services is inconsistent within communities, reflecting uneven service reach and limited continuity from pregnancy through the neonatal period. There is a severe lack of NICUs and a supply of essential supplements. The suspension of key programmes like HPNSP further disrupted maternal care continuity. Many families continue relying on traditional providers due to limited trust in formal health facilities and financial barriers.

- **Lack of Pre-conception and Prenatal Awareness**

The study revealed several critical gaps in the provision, quality, and uptake of prenatal and perinatal care services in Bangladesh. Although national policies emphasize a life-cycle approach to maternal and child health, pre-conception and prenatal awareness remain largely absent, particularly among adolescents, youth, newly married couples, and broader community members. Community-level awareness efforts are also fragmented, limited to short-term project interventions rather than institutionalized mechanisms.

- **Influence of Family Dynamics on Maternal and Neonatal Health Practices**

Maternal and neonatal health decisions are heavily shaped by household dynamics, especially the influence of elderly family members in both the urban and rural areas. Misconceptions, superstitions, and low awareness among husbands or in-laws often obstruct mothers' efforts to follow medical advice for themselves and their children. This leads to resistance around supplements, vaccinations, and recommended clinical practices, despite mothers' willingness to adhere to professional guidelines. But in the urban, educated societies, fathers are found to be concerned about maternal and neonatal healthcare.

- **Negligence towards Maternal Mental Wellbeing**

Maternal mental health receives little attention in current service delivery. There are no structured systems for psychosocial support, counselling, or screening during pregnancy or the postnatal period across the country. Mothers frequently experience stress, emotional distress, or postpartum depression without access to professional help, and health workers lack the training and tools to identify or address these issues.

- **Insufficient Service Quality and Workforce Competency**

Public healthcare facilities face widespread trust deficits due to inconsistent quality, misdiagnosis, and inadequate clinical observation. Parents report dissatisfaction with the service provider's skills and overall service experience. Consequently, many families shift to private facilities from the government facilities despite financial strain, which deepens inequities in access to reliable maternal and newborn health care.

- **Lack of Facility Readiness and Inadequate Supply of Essential Supplements**

In the urban areas, parents reported inadequate NICU facilities for the children, which are nonexistent in the rural areas, despite the inarguable need for those wherever institutionalized delivery service is available. Free supply of micronutrients during ANC was also found to be missing.

- **Inequitable and Segregated Maternal and Child Healthcare Services**

Mothers and children with financial barriers and residing in remote areas face difficulties in receiving quality healthcare services due to an inadequate workforce and facilities. In some regions, gender bias creates insufficient support. Additionally, a lack of awareness about available services further worsens these inequities. Furthermore, there are no specific policy provisions or practical services in place to assist mothers with disabilities. While some marginalized groups in certain regions receive targeted healthcare services, this level of support is not available for all marginalized groups.

Major Recommendations

- **Strengthen Prenatal and Postnatal Service Coverage and Continuity**

Scale up HPNSP-type interventions nationally, ensuring routine ANC counselling, newborn care education, and continuous follow-up through community health workers. Prioritize home-visit models, especially in Haor, Char, hill tracts, and other underserved regions, to improve early risk identification and timely care-seeking.

- **Increase Awareness of Preconception and Prenatal Care**

Strengthen coordination among MoWCA, MoHFW, and MoE to harmonise curriculum content and health counseling. Integrate ECCD, reproductive health, and preconception information into secondary and higher-secondary textbooks and emphasize discussion in classrooms, expand existing school health programmes and maternal health service, and introduce pre-marriage counseling to ensure adolescents and newly married couples receive structured awareness.

- **Increase the Provision of Maternal Physical and Mental Health Counselling**

Redesign maternal health sessions to actively involve husbands, mothers-in-law, and influential household members. Train community health workers in culturally sensitive

counselling to address misconceptions, improve supplement uptake, and strengthen mothers' decision-making capacity through peer support groups and community women's circles. To address the mental health gap, health workers should be trained to screen for postpartum depression, provide basic psychosocial support, and ensure timely referrals to specialized facilities. Additionally, conduct community-level stigma-reduction campaigns to foster a supportive household environment for mothers' emotional well-being.

- **Improve Service Quality, Workforce Competency, and Facility Readiness**

  Enforcing quality assurance mechanisms and regulatory standards across both public and private facilities. Equipping community clinics and hospitals with essential medicines, supplements, diagnostic tools, and neonatal care facilities, along with the deployment of additional skilled health workers dedicated to prenatal and postnatal care services.

- **Improve the Provision of Services for Marginalized Communities and Persons with Disability**

  Expand the presence of skilled healthcare personnel, mobile clinics, home visits, and outreach services for mothers facing geographic and financial barriers. Arrange awareness campaigns to inform families about available maternal services and entitlements, helping them recognize and demand equitable care. Develop disability-inclusive maternal health guidelines and ensure facilities are accessible with appropriate assistive support. Design and implement structured training for health workers on cultural sensitivity, indigenous contexts, and disability awareness to provide respectful and responsive care to diverse groups.

Conclusion

Bangladesh has made notable progress in expanding prenatal and perinatal care through national programmes and policies, yet significant challenges remain in ensuring quality, equity, and accountability. Services are often limited to basic biomedical tasks, with gaps in counselling, follow-up, and developmental support. Regional disparities and shortages of skilled personnel continue to disadvantage vulnerable mothers and children. Strengthening system capacity, integrating holistic maternal-child care, and improving monitoring and grievance mechanisms are essential to translate policy commitments into meaningful outcomes for maternal and child health.

Chapter Five: Status of the ECCE Services

The first three years of life are the most critical for a child's physical, cognitive, and socio-emotional development. In Bangladesh, services for children aged 0–3 remain dominated by health-focused interventions such as immunization, maternal care, and nutrition programs, while developmental support, responsive caregiving, and early learning opportunities are limited. Despite national policies emphasizing a holistic ECCD approach, stimulation activities, parental coaching, and early learning guidance are not consistently integrated into routine service delivery. This section examines the current status of ECCE services for children aged 0–3, identifying strengths, gaps, and the urgent need for integrated, inclusive, and development-oriented interventions.

5.1 Access and Coverage of Services

This section examines the extent to which Early Childhood Care and Education (ECCE) services for children aged 0–3 are accessible and adequately covered across communities. It reviews policy commitments aimed at ensuring comprehensive early childhood support, focusing on health, nutrition, protection, responsive caregiving, and early learning, and assesses how these provisions translate into service delivery in practice. It also highlights key factors influencing service coverage, including the integration of ECCD within the health sector, availability of early stimulation opportunities, and social perceptions surrounding institutional childcare services such as daycare centers.

5.1.1 Service Coverage

The strategic guidelines and policy provisions for the ECCE service coverage and the status of service coverage are discussed here:

Policy Provisions and Strategic Guidelines on the ECCE Service Coverage for Children Aged 0 to 3

From birth to the first three years, a child requires access to services related to good health, adequate nutrition, responsive caregiving, safety and security, and early learning opportunities, according to the Nurturing Care for Early Childhood Development Framework by WHO (2018). Currently the children have access to birth certification, Essential Programme for Immunization (EPI), National Nutrition Services (NNS), and Integrated Management of Childhood Illness (IMCI) facilities in almost every corner of the country.

The CECCD Policy 2013 envisions a comprehensive Essential Service Package (ESP) for children aged 0–3 years, integrating healthcare, nutrition, protection, responsive caregiving, and early learning (MoWCA, 2013a).

Status of the ECCE Service Coverage for Children Aged 0 to 3

Ensuring timely and equitable access to ECCD services during the first three years of life is critical for laying the foundation for children's health, development, and well-being. Findings from the parents' survey reveal considerable gaps in service coverage for children aged 0–3 years.

- **Respondents' own children (0–3 years):** 55.03% of 169 children were reported to have access to necessary ECCD services.
- **Children in respondents' wider social networks (0–3 years):** Only 34.09% of 264 children (friends' and relatives' children) were reported to have similar access.

This clearly shows the unequal access to ECCD services within the community.

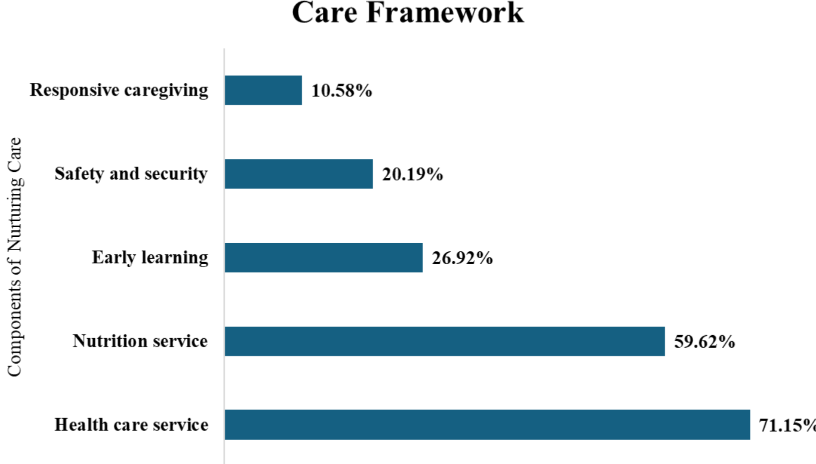
In practice, support for children aged 0-3 years is largely concentrated within the health sector, with limited emphasis on other developmental services. Children across Bangladesh, spanning diverse communities and geographical settings from urban areas to rural regions and hills to coastal belts, have access to essential services such as birth registration, immunization (EPI), nutrition services (NNS), childhood illness management (IMCI), and growth monitoring, along with scattered day-care facilities and breastfeeding corners. While these contribute to survival and basic well-being, they do not adequately encompass early learning or responsive caregiving components. Maternal and child health experts during the KIIs voiced it as,

> The scope of the services we have is too limited to be called ECCDE interventions. An ECCDE intervention should not be confined to health care services; it requires an integrated approach among the developmental areas of the children. [KII, P4]

Availability of Institutionalized ECCD Services (0–3 Years) according to Parents' Survey

In the parents' survey, 34.43% of respondents reported that institutionalized ECCD services are completely unavailable. Additionally, 40.98% indicated that these services have slight availability, while 17.21% noted moderate availability. Only 7.38% stated that ECCD services are mostly available in their area. Parent-reported data on access to the five key components of the nurturing care framework for children are presented in Figure 6.

Figure 7: *Access to the Five Components of the Nurturing Care Framework*



The parent-reported data on the five components of the Nurturing Care Framework reveal substantial gaps in service availability and utilization. Health and nutrition services were relatively better accessed, with 71.15% of parents reporting availability of healthcare facilities and 59.62% reporting access to nutrition-related ECCD services. However, early learning and safety and security were much less accessible, with only 26.92% of parents indicating availability of early learning opportunities and 20.19% reporting access to safety, protection, and psycho-social care services for their children. The most critical gap was observed in responsive caregiving, with merely 10.58% of parents reporting any support for engaging with and responding to their child's needs.

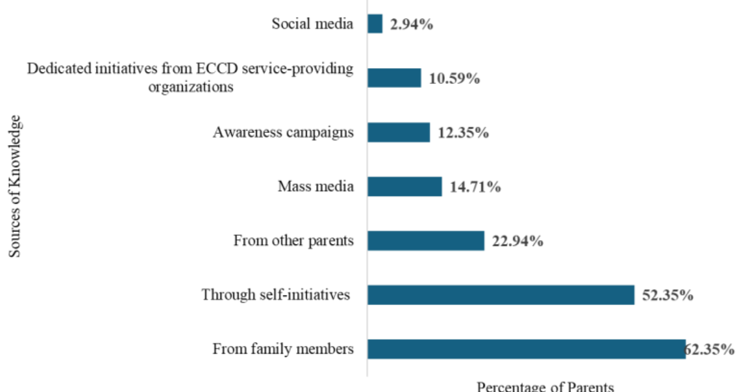
These findings suggest that the available ECCD services for children aged 0-3 primarily focus on survival-related services, such as health and nutrition. However, there is a severe lack of services aimed at promoting development and safety, such as early learning, psycho-social care, safety and protection, and responsive caregiving. This gap presents a challenge for the holistic development of children, highlighting a need for integrated interventions to strengthen holistic early childhood development.

In the previous decade, immunization awareness has increased significantly; however, consistent parental guidance on stimulation, play, and early learning is still rare. There is a clear absence of awareness-building activities related to stimulation, play, and early learning in their local community. The FGDs with the parents revealed that they did some kind of activities with their children at home, like playing, reciting rhymes, and trying to take the best care of their children as per their knowledge, but they never had any guidance regarding early learning from any service providers.

The parents' survey indicated that the majority of parents obtain knowledge about Early Childhood Care and Development (ECCD) from family members. Additionally, more than half of the parents

reported gaining knowledge through their own initiatives. Further details regarding other sources of parental knowledge can be found in the accompanying figure 7.

Figure 8: *Sources of Parental Knowledge on ECCD*



The NGOs opt for home visits in the rural areas, including the char, haors, coast, and poverty-stricken areas, to build awareness regarding ECCE. Along with that, awareness-building efforts such as yard meetings (uthan boithok) continue in rural and hill tracts, and all these activities are mostly health-focused.

The data from the survey of parents revealed the picture of parental knowledge on different aspects of nurturing care.

- **Parental knowledge:** The parents' survey showed most respondents are knowledgeable about nutrition (77.65%), health (64.71%), and child safety and security (55.29%), but awareness of early learning (15.29%) and responsive caregiving (28.82%) is limited.

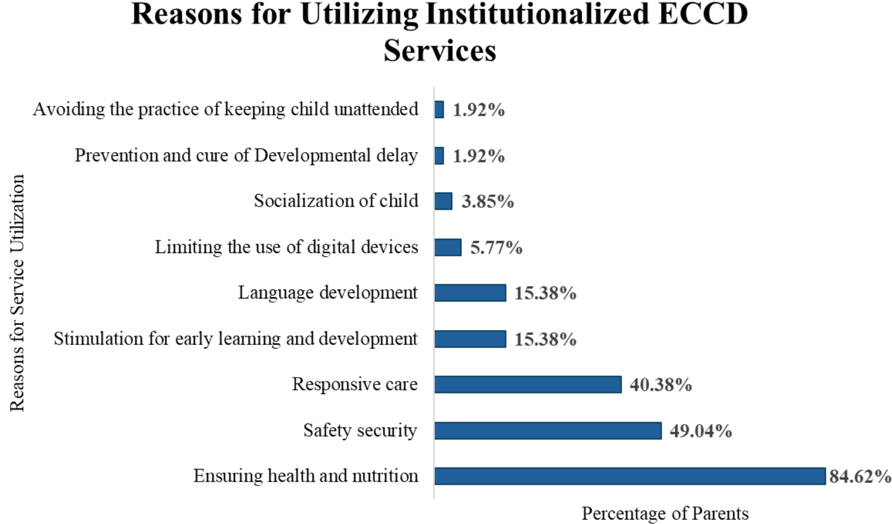
Thus, parents show strong enthusiasm in accessing healthcare services for their children, largely due to consistent communication from various service providers about the benefits of these provisions. Also in the coastal belts, the parents are found to value practical guidance and accessible health inputs in shaping a child's well-being.

The survey results indicate that a significant number of parents (61.18%) rely on formal ECCD services, with a strong emphasis on health-related services to support their children's physical well-being. The following outlines the various service providers that parents utilize:

- The primary sources of these services include community clinics (54.81%) and health and family welfare centers (44.23%).
- Parents also access these services from NGOs (26.92%), private organizations (15.38%), daycare centers (14.42%), and preschools (6.73%).

The main reason parents seek these services is to ensure their children's health and nutrition, with 84.62% citing this as their primary concern. (For more details on additional reasons, see Figure 8.)

Figure 9: *Reasons for Utilizing Institutionalized ECCD Services*



ECCE practitioners and experts similarly acknowledge this strong emphasis on child health within current service delivery. A healthcare professional has put it into words as,

> There was a time when we conducted home visits to counsel mothers about immunization. But now the UHFPOs are directly called by the parents if the designated staff for immunization is absent or late. Parents these days are very concerned about their children's physical health. [KII, P6]

The findings from the survey with parents also support this.

- The parents' survey showed that 97.65% of parents use vaccination and immunization services, and 60% take their children for regular health check-ups.

The findings from the parents' FGDs across all regions align with this perspective, as they expressed much of their concern regarding vaccination and the good health of their children.
Only the urban parents who are also financially well-off mentioned the importance of learning activities in this phase. An urban parent mentioned,

> What the children learn at an early stage stays with them. But unfortunately, neither do we know much about facilitating them, nor do we have anywhere to go. No one talks about what the dos and don'ts are with children or how to take care of them. We only know that we have to take them to the doctors if they are sick. [FGD 8, P4]

There lies a major mismatch between the policy's holistic ECCD vision and the narrow, health-focused services actually offered. Early learning, responsive caregiving, and structured parental education are not mainstreamed into routine service delivery. Community clinics and health centers remain underprepared to deliver integrated ECCE interventions due to a limited trained

workforce, competing priorities, and the absence of standardized modules for early stimulation. Parents themselves perceive that services for children under three are largely confined to medical support, indicating low visibility of developmental and psychosocial components.

In this regard, a child and maternal health researcher recommended scaling up the holistic cascade model of ICCDR,B, which was implemented only in a few areas but brought significantly positive outcomes through training supervisors and frontline health workers to coach mothers on responsive caregiving and early developmental practices.

5.1.2 Major Factors Affecting Access and Coverage of ECCD Services for Children Aged 0-3

The policy provisions and strategic guidelines for major factors influencing access and coverage in ECCD services for children aged 0-3, as well as the current status of these factors, are addressed here:

Integration of ECCD Services with the Health Sector for Children Aged 0-3

Policy Provisions and Strategic Guidelines on Integrated ECCD Services

During the first three years of a child's life, the child and the mother remain within the coverage of the health sector, and this is reflected in several national policy directions. The National Comprehensive ECCD Strategy, dedicated to children from 0 to 3 years, directs towards integrating ECCD services, including early learning stimulation, with existing healthcare and nutrition services. It also anticipates innovative and scalable options, such as linking primary health care centers with para centers and establishing workplace-based centers in RMG factories to improve access to ECCD services (MoHFW, 2022). These policy commitments highlight early childhood nutrition, developmental monitoring, caregiving practices, and parental support as central components.

Status of the Integrated ECCD Services for Children Aged 0-3

In recent times, various health-sector initiatives have already begun integrating ECCD services. From the key informants' statements, it has been revealed that under the 4th HPNSP, 16 upazilas are implementing activities where pregnant mothers receive awareness on four antenatal services, maternal and child nutrition, essential newborn care, skin-to-skin contact, and early breastfeeding. Mothers coming for child immunization are guided on early detection of developmental delays through active learning interventions. The IMCI corners at health centers also identify childhood illnesses and developmental delays and provide mothers with guidance on responsive caregiving and nurturing care.

Additionally, MoHFW has been piloting a structured play curriculum, 12 nurturing care practices, early developmental screening, and community engagement activities through the existing healthcare system. A key informant, directly associated with these initiatives, declared it as,

> At the grassroots level, the community health workers conduct home visits to disseminate necessary information about healthcare services. These piloting projects aim to tag ECCD with the existing practice, taking support from the existing workforce where the community health workers use ECCD flipcharts, and FWAs and HAs organise courtyard sessions with small groups of mothers to strengthen ECCD awareness in the project piloting zones, along with talking about health and nutrition. [KII, P16]

The implementation of integrated ECCD services through existing health and nutrition platforms remains limited. Despite sustained investments and focused efforts in health and nutrition, outcomes have not met expectations. MICS 2025 data indicate that 64.8% of children aged 6–23 months experience food poverty, underscoring persistent weaknesses in nutritional practices at the household level. Key informants noted that inadequate nutrition often begins during pregnancy, particularly in coastal and low-resource areas, suggesting that health and nutrition gains have not translated into broader ECCD outcomes. While integration of ECCD within healthcare services is widely viewed as the most resource-efficient approach, frontline service providers reported heavy workloads, resource shortages, and limited capacity, indicating that existing systems are not yet adequately prepared to effectively deliver integrated ECCD services.

Limited Stimulation and Early Learning Opportunities

Policy Provisions and Strategic Guidelines on Stimulations and Early Learning for Children Aged 0-3

The healthcare provisions for children aged 0 to 3 years have increased a lot in the past few decades. But there remains a major gap in ensuring their early learning opportunities or having dedicated services for providing early stimulation. There is a clear indication in the policies towards ensuring early learning opportunities through providing children with age-appropriate stimulation. The CECCD Policy 2013 emphasizes expanding the available services through promoting Essential Service Packages that include healthcare, nutrition, and WASH, along with early learning opportunities through the empowerment of families and communities. As most of the services are health, nutrition, and protection-oriented for this age group, the policy gives additional focus on using the existing infrastructures like breastfeeding corners, day care, child-friendly corners, and play corners for providing early learning stimulations (MoWCA, 2013a).

To increase awareness of ECCE among the maximum number of people, the CECCD Operational and Implementation Plan also recommends using mass media by producing television programs and publishing books for families and children across developmental stages (MoWCA, 2013b).

Status of Stimulations and Early Learning for Children Aged 0-3

In spite of the policy emphasis on early learning stimulations, according to the ECCE experts, it was revealed in the KIIs that the current social scenario does not support early learning much due to the lack of interaction with children. During KII, one of the child healthcare experts stated,

> In the previous decade, there was more access to early learning opportunities than in the present times, as children grew up in joint families, parents had more time for them, and there was less addiction towards devices. As a result, early learning stimulations were adequately provided at home, but now it needs institutionalized efforts to address early learning stimulation gaps. [KII, P6]

This reflects that, in practice, daily opportunities for early stimulation that used to occur naturally within the home environment have reduced significantly due to changing family structures and lifestyle patterns. The MICS Preliminary Report 2025 supports the concerns raised by experts, showing a significant decline in early stimulation and responsive caregiving for children aged 24 to 59 months. The percentage of children receiving four or more stimulation activities from any household adult decreased from 78% to 35.1% over the decade. Father involvement remains extremely low at only 2.6%, and mother engagement, although higher than fathers', also dropped to 27.2% (BBS & UNICEF, 2025).

When asked during FGDs, it was observed that the parents from all the other regions except the urban areas lacked an idea about the concept of early stimulation. Having a different perception, the urban parents, who are financially capable, identified the equal importance of early learning opportunities in this phase, whereas the others commented that learning should not start so early, as the concept of learning to them is all about reading and writing from textbooks. A mother from the char area mentioned,

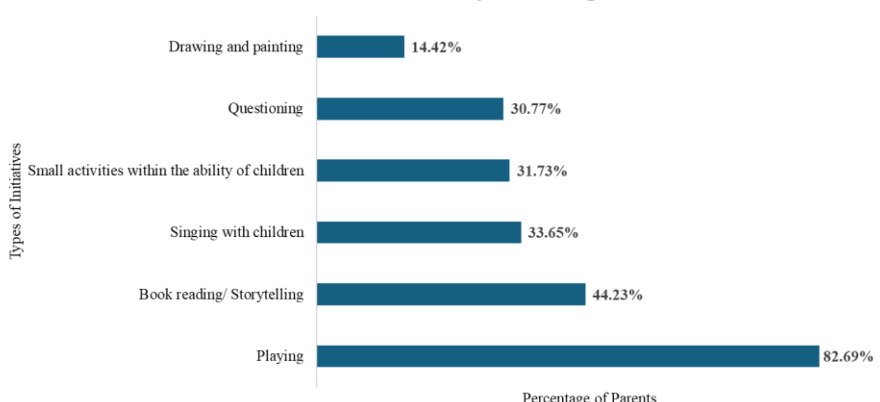
> My child is only 2.5 years old. I will send him to school when he grows up. I do not think learning activities should start before that. Children will learn on their own. [FGD 23, P5]

It indicates that any awareness regarding integrated ECCD has not reached the parents yet, and so, early learning experiences are hampered. The urban parents' awareness regarding early learning is highly shaped by social media content on parenting, which is not equally accessible to parents from rural areas.

The findings from the parents' survey also reveal the lack of parental knowledge about the early learning of the children.

- **Parental knowledge and engagement in early learning (0–3 years):** Only 15.29% of parents reported having adequate knowledge of early learning. Most engage their children through play (82.69%), while fewer use storytelling/book reading (44.23%), singing (33.65%), questioning (30.77%), small activities (31.73%), or creative activities like drawing (14.42%), as shown in Figure 9.

Figure 10: *Parental Initiatives for Early Learning at Home*



These findings suggest that while the foundation for learning is present through play, it lacks intentionality. Parental involvement with their children in other early learning activities is not satisfying, which may hamper their children's holistic development.

The findings from both qualitative and quantitative data present a clear policy–practice gap where national policies prioritize early learning and stimulation, but actual household-level practices are declining due to the rise of parents' additional engagement, nuclear families, and a lack of awareness initiatives for the families and communities. Other than some social media content, no trace of mass media initiatives was found for awareness building.

Cultural Stigma Towards Daycare Centers

Policy Provisions and Strategic Guidelines on Child Daycare Centers

National policies such as the CECCD Policy 2013 emphasize the importance of protection, responsive caregiving, and early learning for children, including those aged 0 to 3 years. The policy encourages the establishment and expansion of daycare centers, especially for working parents, and highlights the use of community-based and institutional supports to ensure that young children are not left unattended. These policy directions indicate that daycare services are considered an important mechanism for ensuring children's safety, stimulation, and developmental support.

To encourage quality daycare initiatives and formalize this sector, the Child Day Care Centre Act 2021 has also been passed. It aims to regulate and standardize childcare services, requiring registration, setting quality benchmarks for safety and development, and ensuring accessibility for working parents, with penalties for non-compliance.

Status of Accessing Daycare Centers for Children Aged 0-3

A lot of children aged 0 to 3 years remain unattended when their mothers or caregivers go outside for work or get busy with other household activities in both urban and rural Bangladesh. This compromises a child's early experiences and increases safety risks. Parents often hold negative perceptions about sending their children to daycare centers, linked to guilt and the fear of being judged as *"less responsible"* parents. However, mothers from urban areas who actually use daycare services acknowledge their value. One mother shared that despite being a housewife, she sends her middle child to a daycare for several hours because she cannot manage all three children equally. Over time, she observed improvements in her child's communication and learning. This reflects that daycares contribute to early learning stimulations beyond just shelter or supervision.

The mothers from the labor-intensive areas, especially the RMG workers, highly appreciate the establishment of daycare centers within their office compound in spite of the high expenses, as it takes a share of their domestic workload and ensures responsive caregiving and protection of their children. A mother working for an RMG factory described,

> The day care centre in our office is very responsive towards pregnant mothers and children. The mothers are given leave if needed. When we are at the office, they also feed the children twice a day, provide milk, calcium, and iron medicines, and diapers in the daycares. [FGD 1, P1]

In the labor-intensive areas where the RMG factories do not have their own daycares, home-based daycares have been established to support the working mothers, even though very few children are aged below 3 in those centers due to parents' negative perception towards daycares. Apart from the urban and labor-intensive communities, no other parents in the haors, char, coastal areas, hill tracts, poverty-stricken areas, and other rural areas were found to take support from any kind of centre-based services for their children aged below 3, as the service coverage is very minimal in those areas, and parents lack awareness. This aligns with the parents' survey findings. Only 14.42% of parents reported using daycare centre services for their children.

The key informants, who have years of experience in early childhood development and are aware of the activities of the daycare centers, also agreed on the cultural stigma towards sending their toddlers to daycare centers. A key informant said,

> When it comes to daycare in our country, everyone's reaction is like, 'Oh ho! Does the child go to a daycare? What a poor child! Parents might have no time for him. Thus, they completely ignore how a child benefits through the experience in day care centers. [KII, P15]

The ECCD service providers in the daycare centers also highlighted that most parents in the communities are indifferent about sending their children to daycare centers. Rather, they prefer to keep them in the supervision of nannies despite knowing they lack in childcare-giving skills, as the day care centers have not yet become successful in breaking the cultural stigma and becoming trustworthy to the parents. Because of this socio-cultural stigma and insecurity regarding the

service quality, children get deprived of their right to protection, responsive caregiving, and early learning opportunities.

Despite policy emphasis, the uptake of daycare services remains low due to strong socio-cultural stigma. Key informants with years of experience in early childhood development highlighted that parents often react negatively, assuming that daycare attendance reflects parental neglect rather than support. This stigma leads families to avoid daycares even when they could benefit, depriving children of their rights to protection, responsive caregiving, and structured early learning opportunities. As a result, there is a clear gap between policy intentions and actual household practice, with daycare remaining underutilized and misunderstood.

5.2 Quality of Services

This section examines the quality of ECCE services available for children aged 0–3 by assessing key dimensions of service delivery. It reviews the infrastructural readiness of service centers, workforce competency, and the actual quality of program implementation in daycare facilities. By comparing policy provisions with field evidence, the section highlights critical gaps affecting the quality of ECCE services.

5.2.1 Infrastructural Limitations to Quality Service Delivery

The discussion covers the policy provisions and the current status of infrastructural quality for ECCE service providers:

> **Policy Provisions and Strategic Guidelines on Infrastructural Quality of ECCE Service Providers**
>
> To ensure quality services, infrastructural development plays a major role. The Child Daycare Centre Act 2021 clearly outlines the minimum infrastructure, safety features, protection provisions, and space requirements that day care centers must maintain.
>
> Similarly, national policies and strategies guiding ECCD, such as the CECCD Policy 2013 and its operational and implementation plan, the National ECCD Strategy, emphasize establishing child-friendly, safe, and stimulating environments across health centers, community clinics, and ECCD facilities. These policies aim to create a conducive environment where children can receive quality care, early learning, and protection.

Status of Infrastructural Quality of ECCE Service Providers

In practice, the infrastructural readiness of service providers is far from adequate for children aged 0 to 3. A key informant in the health sector expressed,

> Even though we claim to serve children based on their needs, we do not have enough facilities. Even though we want it, there is a shortage of space for having an extra corner for the children or developing a play zone in the community health care centers. [KII, P16]

The day care sector reflects a similar scenario. Despite the existence of the Child Daycare Centre Act 2021, most daycare centers are not regulated according to it. A key informant pinpointed,

> There are a lot of daycare centers around us. But only a few practice it, because we have not been able to enforce that yet. There are just a few initiatives all around the country that have quality infrastructure, including adequate space, emergency exits, fire extinguishers, etc. [KII, P12]

Parents also shared concerns about the infrastructural quality of day care centers, and ECCD practitioners expressed an urgent need for a national quality standard so that every program dedicated to children aged 0-3 maintains a minimum level of quality.

There were mixed reactions about the infrastructural quality of home-based day care centers. One pioneer of centre-based day care centers remarked,

> I am strictly against the home-based day care centers, as most of them have just a few toys. There is no joyful environment. The rooms are dark and humid. It never helps a child's development. [KII, P17]

On the contrary, many key informants highly appreciated the home-based model as a low-cost approach that can ensure wider access to ECCE services for a large proportion of young children until we are infrastructurally ready to serve every child through community-based daycare centers.

The gap lies in the weak enforcement of existing policies and acts, the lack of infrastructural investment, and the absence of a national quality assurance mechanism. While laws exist, there is limited monitoring, insufficient resources in government and NGO centers, and no standardized checklist or certification system for day care centers. Health centers, too, face space shortages, a lack of child-friendly environments, the absence of play corners, and inadequate safety arrangements. Home-based centers remain unregulated, leading to significant disparities in quality. Overall, infrastructural readiness remains a major barrier preventing children from receiving the type of ECCD services envisioned in national strategies and policies.

5.2.2 Workforce Shortage and Skill Deficit

The policy provisions and strategic guidelines regarding workforce quality and competence, as well as the current status of the workforce quality and competence, are discussed below:

Policy Provisions and Strategic Guidelines on Workforce Quality and Competence

Along with infrastructural development, the CECCD Policy 2013 emphasizes capacity building of stakeholders for promoting early learning opportunities (MoWCA, 2013a).

The Child Day Care Centre Act 2021 also mandates that founders of child day care centers must have certain educational qualifications and training in relevant fields, along with employing a skilled workforce who will directly work with children.

> Similarly, the health sector's strategy for children under 3 years highlights strengthening the quality of nurturing care by updating ECCD training materials, building the capacity of service providers and caregivers, orienting managers across all levels, and introducing certification courses on child development (MoHFW, 2022).
>
> The Nurturing Care Framework also stresses continuous professional development for the workforce through pre-service and in-service training (WHO et al., 2018).

Status of Workforce Quality and Competence

The actual practice does not reflect the policy commitments. When ECCD service providers were asked about their qualifications, only a few had short-course certifications on ECCD. Every stakeholder, including ECCD service providers, parents, and key informants, agreed that there is a severe shortage of skilled workforce in ECCD. One practitioner with 15 years of experience running a private daycare and preschool stated,

> In these 15 years, I have never found someone well aware of ECCD while recruiting service providers for my daycare. [IDI, P8]

Key informants discussed understanding developmental milestones, child psychology, and early detection of abnormalities as essential skills for ECCD workers, but also acknowledged the shortage of these skills in the workforce. Another key informant highlighted the very limited opportunities for professional learning in ECCD, as only BRAC University and the Government College of Applied Life Science offer degrees in this field. Concerns were also raised about the degraded quality of caregiving in Bangladesh. Despite high demand globally, Bangladeshi caregivers cannot compete with countries like the Philippines or Vietnam due to a lack of skills and knowledge.

The parents expressed their expectation of getting ECCD-related guidelines from healthcare service providers in the rural regions. But there is a lack of commitment and insufficient relevant training resources for healthcare and community health workers. A health officer noted the absence of ECCD-specific curriculum and training modules as a major obstacle. A representative from MoHFW highlighted the importance of capacity building, saying,

> At present, we are training existing nurses and midwives to provide counseling across the 16 pilot upazilas. We believe that once the capacity is developed, daily a minimum of half-hour sessions with these healthcare service providers can produce a very good response in ECCD, as at least 80–100 children visit each upazila health center every day, accompanied by their parents. [KII, P6]

But other key informants are not convinced enough with the current quality of the healthcare providers on ECCD and emphasized preparing the workforce beforehand. One of the maternal and child healthcare providers mentioned,

> I've seen the nurses; whenever a child is born, they quickly take the child out to cut the umbilical cord. But that is wrong, that means less blood is going to the child, and the child will become anemic. So if the nurses, the doctors, the TBAs (traditional birth attendants) knew that this was wrong, they would have stopped doing it. So, ECCD needs to be in every medical and nursing curriculum. [KII, P4]

These findings clearly point to the lack of workforce competence and quality.
Although policies mandate qualified and trained ECCD personnel, the workforce remains largely untrained, unregulated, and insufficient in number. There is no standardized professional pathway for ECCD, limited institutional opportunities for obtaining degrees, a lack of ECCD-specific training modules for health workers, and minimal integration of health professionals into ECCD centers.
This reflects through parents' perspective and satisfaction with the quality of services.

- **Parental satisfaction with ECCE services (0–3 years):** According to the parents' survey, 53.85% reported moderate satisfaction, 25.00% slight satisfaction, 19.23% full satisfaction, and 1.92% were not satisfied at all, indicating a need for improvements in service quality.

The relatively low percentage of fully satisfied parents highlights the need for improvements in ECCE services to support the holistic development of children aged 0-3.

5.2.3 Observed Quality of Program Implementation in Daycare Centers

To observe the quality of program implementation in daycare centers, an observation tool was used where all the items were positively worded and rated on a 3-point scale. The higher scores indicated stronger agreement with the stated criteria. The observation focused on six common dimensions of program quality: physical facilities, inclusive practices, facilitators' or caregivers' attention to children's physical and mental well-being, learning experiences provided at the centers, availability of para-teachers or supporting teachers, and coordination with families.

The mean scores across these dimensions were 2.34 for physical facilities, 1.30 for inclusive practices, 2.52 for attention to children's wellbeing, 2.44 for learning experiences, 1.80 for availability of para-teachers, and 2.40 for coordination with families. Overall, the findings suggest a moderate level of program quality in most observed areas. The daycare centers were moderately clean, safe, had a child-friendly setup, and clean water and washroom facilities, along with having teachers and caregivers who are attentive towards children's physical and mental state and try to ensure a quality learning experience for the kids. But there is a huge gap in inclusive practice as most of the institutes lacked in physical facilities needed for the children with special needs, such as specialized equipment, ramps, walkers, and therapeutic facilities, and the educators and caregivers lacked in competence for dealing with children having special needs. That is why several daycare centers do not admit children with special needs. In most of the institutes, there was no para teacher or additional support to facilitate children other than the main teacher or caregiver. A quite high level of collaboration with the family members was noticed in most of the institutes providing daycare facilities. To sum up, while attention to children's wellbeing and

learning experiences demonstrated comparatively stronger implementation, inclusive practices and the availability of para-teachers showed relatively lower levels of presence, indicating areas where programme quality could be further strengthened.

5.3 Equity and Inclusion

This section examines equity and inclusion in ECCD services for children aged 0–3 by analyzing disparities across socioeconomic groups, geographic locations, and children with disabilities or developmental delays. It reviews existing policy commitments and compares them with the realities of service delivery. It also highlights persistent gaps that continue to limit equitable access to ECCD services for vulnerable populations.

5.3.1 Socioeconomic and Geographic Disparities

The discussion covers the policy provisions and strategic guidelines for equitable and inclusive ECCD services across various socioeconomic groups and geographic regions, alongside the current status of equity and inclusion in these services:

> **Policy Provisions and Strategic Guidelines on Ensuring Socioeconomic and Geographic Equity**
>
> According to the CECCD Policy 2013, all children between 0 and 3 years, regardless of their geographic or socioeconomic background, are to be brought under a protection zone and ensured access to the Essential Service Packages covering healthcare, nutrition, protection, and early learning opportunities. The policy also specifically advocates for establishing quality day care centers in factories so that children from low-income families can access secure facilities during early childhood (MoWCA, 2013a).
>
> The National Food and Nutrition Security Policy Plan of Action also highlights strengthening National Nutrition Services for children from poor and vulnerable backgrounds (MoF, 2022).

Status of Equity and Inclusion across Different Socioeconomic Groups and Geographic Regions

Service delivery on the ground shows clear disparities from policy. According to the parents, middle-class families are the worst sufferers because quality services are available only for the elites and the low-income groups. The upper-class families can afford nutritious food, skilled caregivers with high salaries, and quality day care centers, ensuring maximum protection for their children. Most of the parents were found to be reluctant to discuss the equity and inclusion issues. On the other hand, the low-income communities have targeted arrangements from both the government and NGOs. NGO-run initiatives often have trained caregivers, stronger management systems, and child-oriented programs. A service provider mentioned during the IDI,

> To be honest, we do not serve the middle class as much as we serve the underprivileged ones. The privileged people can afford and access anything for themselves and their children. But the middle-class people neither can spend like the wealthy parents nor get

> low-cost services from the NGOs. But among middle-class children, the trend of having working parents is much higher. [IDI, P2]

Key informants also acknowledged the insufficiency of services for the urban middle class and suggested expanding successful models developed earlier for economically disadvantaged groups to middle-class neighborhoods.

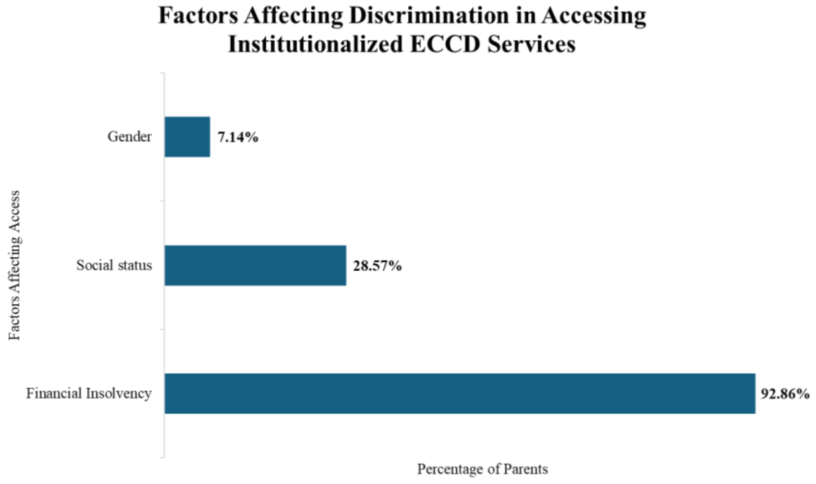
In terms of geography, the most disadvantaged are children from ethnic minority communities, disaster-prone populations, and children living in poverty-prone areas such as haors, tea gardens, char areas, coastal remote regions, and urban slums. A key informant noted,

> If you talk about the Para centers in the CHT, they provide service to children above 3. Most of the NGO initiatives in the urban slums, tea gardens, haors, or coast focus on pre-schooling of the 4+ children. There is a major gap in services for children below 3, even though these are the most important 1000 days of their lives. [KII, P11]

The parents' survey revealed some reasons behind discrimination in accessing services.

- **Discrimination in accessing ECCE services:** 13.46% of the parents reported experiencing discrimination. Among them, 92.86% cited financial hardship, 28.57% social status, and 7.14% child's gender as reasons, highlighting socio-economic barriers to inclusive ECCE access.

Figure 11: *Factors Affecting Discrimination in Accessing Institutionalized ECCD Services*



So, the primary gap lies in the unequal distribution of early childhood services across both socioeconomic and geographic lines. While policies emphasize universality, in practice the service landscape favors the elite and the poorest, leaving the urban middle class largely underserved. Furthermore, children under 3 in hard-to-reach regions, such as indigenous communities, climate-affected areas, coastal belts, tea gardens, and urban slums, have minimal access to ECCD interventions, particularly for children in their first 1000 days. NGO and government initiatives mostly target preschool-aged children, leaving a policy–practice disconnect for the 0–3 age group.

5.3.2 Persistent Gaps in Services for Children with Disabilities and Developmental Delays

The discussion covers the policy provisions and strategic guidelines for equitable and inclusive ECCD services for children with disabilities and developmental delays, alongside the current status of equity and inclusion in these services.

> **Policy Provisions and Strategic Guidelines on Addressing Disability and Developmental Delays**
>
> Every act and policy in Bangladesh, including the CECCD Policy 2013 and its operation and implementation plan and the Child Daycare Centre Act 2021, distinctly identifies the rights of children with disabilities. The Child Day Care Centre Act 2021 mandates that daycare centers must have necessary services and facilities to ensure inclusion of children with special needs.
>
> The Nurturing Care Framework (WHO et al., 2018) also highlights the need for dedicated ECD interventions for children with disabilities and developmental issues through early identification, timely referral services and capacity building of caregivers within families. These policy directions clearly emphasize equitable access, early intervention and disability-inclusive service delivery.

Status of Inclusive and Equitable ECCE Services for Children with Disabilities and Developmental Delays

In practice, early detection facilities are limited across the country, causing delays in identifying developmental issues and compromising recovery potential. During the KIIs, the child healthcare experts highlighted the underprepared system for ensuring equitable services for the children with disabilities or developmental delays. A representative from MoHFW mentioned,

> We need to focus significantly on the early identification of disabilities and developmental delays so that these children are not deprived. Screening is crucial. Inclusion means providing services according to each child's needs—one size does not fit all. We need to screen children to determine what specific services each one requires. Since we are at the primary stage, we are not yet able to fully identify children in need. Our facilities need to be ready, and ideally, each center should have a dedicated counselor, but currently, we do not have that capacity. [KII, P18]

The importance of screening and individualized services was acknowledged by the ECCD providers as well, since several children with disabilities and developmental delays are brought to centre-based service providers. ECCD providers also admitted that equitable services for children with disabilities are yet to be ensured, mainly due to the absence of trained human resources and inadequate infrastructure. Many service providers mentioned that even general infrastructural requirements are unmet, making it difficult to develop disability-friendly structures within current financial constraints. One of the service providers highlighted,

> We are empathetic towards children with disabilities. We try to address developmental delays, but dealing with disabilities needs extensive competence from the supplier side. Unfortunately, we lack both physical and human resources to serve all the children equitably. [IDI, P19]

Key informants advocating for disability rights further noted that no organization or project is exclusively working on early identification and early intervention, making it difficult to mainstream children with minor developmental issues. On the demand side, low parental awareness contributes to poor service utilization, as many parents hesitate to bring their 0–3-year-old children with special needs outside the household. The parents' survey, however, does not capture any data regarding disability related discrimination.

This absence likely indicates a data limitation rather than a lack of prevalence. This gap potentially reflects low institutional enrollment of children with disabilities, limited parental awareness of available support, or parents' reluctance to disclose that their child has a disability or requires extra support.

The policy–practice gap is evident in multiple dimensions. Despite strong policy commitments to inclusion, the country lacks functional early detection systems, trained personnel, disability-friendly infrastructure, and dedicated early intervention services. Parents' hesitancy and limited awareness further reduce demand for services, preventing ECCD centers from developing capacity for disability-inclusive care. District-level facilities exist, but upazila-level screening and referral mechanisms remain weak. As a result, many children remain unidentified until entering school, by which time recovery and intervention opportunities are significantly reduced. The gap is not only structural but also systemic and cultural, affecting children's equity, access, and developmental outcomes.

Highlights of Findings Regarding the Status of ECCE Services for Children Aged 0-3

- **Domination of Health-Focused Services and Limited Early Learning Opportunity**

  Although national policies emphasize a holistic Early Childhood Care and Development (ECCD) approach, including health, nutrition, protection, responsive caregiving, and early learning, the service coverage for children aged 0–3 remains overwhelmingly health-focused, especially for the parents actively seeking immunization services across the country. However, developmental and early learning guidance, parental coaching, and stimulation activities are not integrated into routine service delivery at the community level. Parents outside urban areas have little awareness about early learning needs. Nuclear families, parental workload, and reliance on digital devices have reduced natural stimulation at home for the children.

- **Unfavorable Outcome of the Integrated Health and ECCE Efforts**

Under the 4th HPNSP and MoHFW pilots, early stimulation messages, nurturing care practices, and developmental screening are being linked with ANC, EPI, and IMCI in 16 upazilas for piloting. But the frontline workers are overloaded, lack training, and are unprepared to consistently deliver ECCE along with health care services in every corner of the country, including these piloting areas. Structured dissemination of unified, repeatable messages on nurturing care, complementary feeding, and early stimulation is missing. Awareness efforts have not reached households effectively, especially in marginalized areas.

- **Low Utilization, Quality Gaps, and Limited Inclusiveness in Daycare Services**

  Despite policy backing, daycare services for children under three remain significantly underutilized due to persistent cultural stigma, with many parents perceiving daycare enrollment as neglect and preferring informal nannies with limited skills. Existing centers struggle with low enrollment while simultaneously facing infrastructural deficiencies, including the absence of child-friendly spaces, safe environments, and minimum standards mandated by the Child Daycare Centre Act 2021. Home-based daycares, though popular, remain largely unregulated, leading to uneven service quality. Across centers, NGOs, and related facilities, there is a substantial shortage of trained ECCD personnel, a limited understanding of child development and responsive caregiving, and inconsistent training opportunities. Moreover, inclusive practices are weak, as facilities and caregivers are inadequately prepared to accommodate children with disabilities, resulting in neglect of children with visual and mobility impairments and limited adaptation to diverse developmental needs.

- **Underprepared Early Screening and Disability-Inclusive Facilities**

  Early screening services are available only at district-level healthcare centers, with no strong referral system from the upazila or community levels. There is a significant lack of proper early detection tools and limited professional capacity for identifying developmental delays and disabilities. Moreover, the services that do exist are not effectively communicated to parents, resulting in many children not receiving the support they need.

- **Disparity in Service Accessibility for the Children from Hard-to-reach Areas and the Urban Middle Class**

  Early childhood services in Bangladesh are unevenly distributed, favoring the elite and the poorest while leaving the urban middle class largely underserved. Children under 3, especially in hard-to-reach areas such as indigenous communities, coastal regions, haors, tea gardens, and urban slums, have minimal access to essential ECCD interventions during their critical first 1000 days.

Major Recommendations

- **Scale Up Integrated ECCD Models and Strengthen Cross-Sector Coordination**

  Expand successful models such as the icddr,b's holistic cascade approach nationwide to ensure supervisors and frontline health workers receive structured training on responsive caregiving and early stimulation, and then disseminate it at the community level through parents and other family members. Strengthen coordination between MoWCA, MoHFW, MoE, and local government to streamline ECCD messages and align health, nutrition, and early learning interventions. Ensure consistent ECCD counseling across ANC visits, EPI sessions, IMCI corners, courtyard meetings, and home visits, so families receive unified messages. Train frontline health workers through refresher courses, ECCD flipcharts, and simplified dietary guidance.

- **Expand Early Learning and Stimulation Opportunities Through Community Platforms**

  Equip daycare centers, breastfeeding corners, and child-friendly spaces with age-appropriate play materials and simple stimulation guides. Integrate early play, storytelling, and responsive caregiving demonstrations into EPI sessions, courtyard meetings, and home visits. Revitalize mass media campaigns and engage local governments to promote stimulation practices among parents, including fathers.

- **Strengthen Trust, Quality, and Inclusiveness in Daycare Services**

  Implement nationwide awareness campaigns using community champions and parent testimonials to address cultural stigma and promote the developmental benefits of daycare. Ensure safe, transparent, and child-friendly environments through strict enforcement of the Child Daycare Centre Act 2021 and expansion of workplace-based daycare across sectors. Simultaneously, institutionalize inclusive service standards by ensuring physical accessibility, appropriate learning materials, flexible caregiving routines, and targeted training for caregivers on disability inclusion, psychosocial support, and gender-sensitive practices.

- **Improve Infrastructure and Strengthen ECCD Workforce Capacity Through National Quality Standards**

  Introduce a minimum quality standard and practical checklist for all centre-based and home-based childcare services, with regular monitoring and simple accreditation. Ensure play corners, breastfeeding spaces, and developmental screening stations within existing health facilities. Develop a national competency framework defining qualifications and core skills for ECCD personnel. Standardize training modules across health and daycare sectors and expand pre-service and in-service training through universities and TTCs. Introduce district-level short-course certifications and enforce workforce requirements.

- **Reduce Geographic and Socioeconomic Inequities**

  Introduce mobile ECCD services and outreach models for hard-to-reach, climate-vulnerable areas. Expand Para centers and NGO models to include children aged 0–3.

Establish affordable, quality ECCD centers for urban middle-income families through NGO initiatives and public–private partnerships.

- **Strengthen Early Screening and Disability-Inclusive ECCD Services**

  Establish newborn and early childhood screening (thyroid, hearing, developmental assessments) at upazila level and reinforce referral pathways to district facilities. Train ECCD workers and frontline staff on basic disability identification and responsive caregiving. Conduct stigma-reduction campaigns to encourage early intervention uptake.

Conclusion

The review of ECCE services for children aged 0–3 in Bangladesh shows strong health coverage but limited developmental and learning support. While immunization and maternal health services are widely accessed, early stimulation, responsive caregiving, and parental guidance remain largely absent from community-level delivery. Daycare services continue to be underutilized due to cultural stigma, poor infrastructure, and workforce shortages, while early screening and disability-inclusive facilities are inadequate and poorly communicated to parents. Geographic and socioeconomic disparities persist, leaving children in remote, climate-vulnerable areas and the urban middle class underserved during their most formative years. To ensure holistic development in the first 1,000 days, Bangladesh must scale up integrated ECCD models, expand early learning opportunities through community platforms, strengthen workforce capacity under national quality standards, and establish inclusive early screening systems. Sustained investment, cross-sector coordination, and stigma-reduction efforts are essential to transform ECCE services for 0–3-year-olds into a comprehensive, equitable framework that supports every child’s right to thrive from birth.

Chapter Six: Status of Services during Transition to Primary School

The transition to primary education for children aged 3–6 in Bangladesh is a critical stage that determines school readiness and long-term learning outcomes. Historically, services for this age group were sparse, with health-focused interventions dominating early childhood care and limited structured learning opportunities available. Recent government, NGO, and private initiatives have expanded coverage, particularly through one-year pre-primary programs for 5+ children and pilot two-year programs for 4+, yet participation among younger children aged 3–5 remains extremely low. This chapter examines the current status of services supporting the transition to primary education for children aged 3–6, highlighting achievements, systemic gaps, and the reforms needed to ensure equitable, high-quality early learning opportunities.

6.1 Access and Coverage of Services

This section examines the policy provisions and strategic guidelines related to access and coverage of ECCD services for children aged 3–6 in Bangladesh, along with the current status of service availability, participation, and utilization. It reviews policy commitments concerning service coverage, children's participation in ECCE below the age of five, and the expansion of universal pre-primary education to support school readiness. The section further explores how these policy directions are reflected in practice across different service providers and community contexts.

6.1.1 Service Coverage

The strategic guidelines and policy provisions regarding ECCD services for children aged 3 to 6, along with the status of service coverage, are discussed here:

Policy Provisions and Strategic Guidelines on the Coverage of Services during Transition to Primary School for the Children Aged 3-6

Before the formulation of the CECCD Policy 2013, the programs and services available for children between 3-6 were confined within limited access to National Nutrition Services based on the Operational Plan for NNS 2011, Universal Pre-primary Education based on the National Education Policy 2010, EPI program, and some non-governmental initiatives. Exclusively for early learning opportunities, there were para centers in the Chittagong Hill Tracts and religious institutes supported by the Ministry of Religious Affairs across the country (MoWCA, 2013b). All these initiatives remained highly concentrated, as the healthcare provisions were mostly targeted for children below 3 and early learning started after 5, leaving the 3–6 age group unattended.

The CECCD policy 2013 and its operational and implementation plan emphasized creating awareness among parents, caregivers, and local communities regarding ensuring accessibility to services related to children's health, nutrition, education, and protection in a way that no age group is disregarded. It also underlines the importance of regular health monitoring and opportunities for cultural activities for children aged 3 to 6 years (MoWCA, 2013a; MoWCA, 2013b).

Status of the Coverage of Services during Transition to Primary School for the Children Aged 3-6

The preschool years represent a critical window for structured early learning, school readiness, and socio-emotional development, making consistent access to ECCD services particularly important during this stage. However, evidence from the parents' survey highlights pronounced disparities in service coverage for children aged 3–6 years.

- **Respondents' own children (3–6 years):** 69.31% of 189 children were reported to have access to necessary ECCD services.
- **Children in respondents' wider social networks (3–6 years):** Only 31.58% of 285 children (friends' and relatives' children) were reported to have similar access.

This substantial difference indicates that a large proportion of children in the broader community remain underserved.

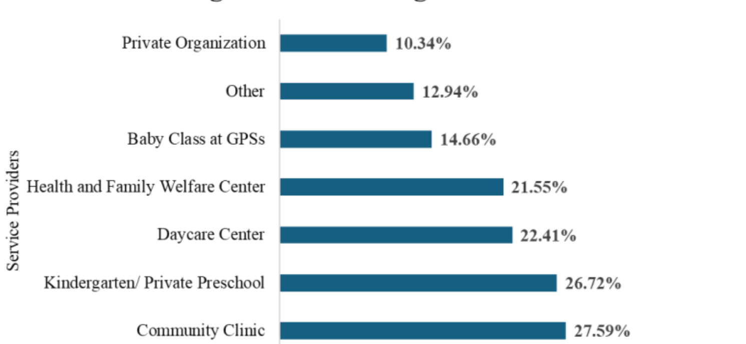
The services for the children aged 3 to 6 are also very much scattered and lack an integrated approach. This fragmented structure is reflected in parents' perceptions of service availability at the local level.

Local Service Availability:

- Nearly half of the respondents reported significant access barriers, with 23.17% stating services are not available at all and 25.61% perceiving them as only slightly available, indicating substantial gaps in service provision.
- A moderate level of availability was reported by 37.80% of parents, suggesting that while some services exist, they may not be sufficiently comprehensive or consistently accessible.
- Only a small minority of respondents (8.54%) indicated that services are mostly available in their area. In addition, a small proportion of parents (4.88%) reported having no knowledge regarding the availability of ECCD services in their locality, which points to possible information gaps and limited community awareness about existing services.

Despite the limited perceived availability of institutionalized ECCD services, where nearly half of parents reported services as unavailable or only slightly available, service utilization remains relatively high. Notably, 70.73% of parents reported using these services for their children aged 3 to 6, suggesting that parents often rely on whatever services are accessible, even when availability is limited or inconsistent. Parents' responses further indicate that ECCD services are delivered through a range of providers in their localities.

Figure 12: *Major ECCD Service Providers for Children Aged 3-6 according to Parents*



The survey result shows that no single ECCD service dominates overall coverage, with utilization spread across a variety of health- and education-oriented providers.

- **Predominance of Non-Governmental Services:** NGOs emerge as the leading provider of institutionalized ECCD services, utilized by 38.79% of participants.
- **Role of Primary Healthcare and Private Education:** Access through health-based and private educational facilities remains significant, with community clinics (27.59%), kindergarten/private preschools (26.72%), and health and family welfare centers (21.55%) serving as major service points.
- **Institutional and Community-Based Care:** Utilization is also distributed among daycare centers (22.41%), baby classes at government primary schools (14.66%), and private organizations (10.34%). Additionally, 12.94% of individuals access services through other sources, including madrassas, maktabs, and various religious or non-religious organizations.

As both health-oriented and education-oriented ECCD services are utilized at relatively low and fragmented levels (as shown in Figure 10), this suggests the absence of a comprehensive or integrated service model for this age group.

While the provider landscape is diverse, the actual utilization of these institutional services is shaped by specific parental priorities regarding child protection and developmental stimulation.

- **Primary Drivers for Service Utilization:** Parental engagement is largely motivated by the need for safety and security (68.97%), followed closely by concerns for health and nutrition (62.93%) and the desire for early learning stimulation (55.17%).

These findings suggest that parents prioritize basic protection, physical well-being, and early cognitive stimulation when engaging with institutionalized ECCD services. In line with these motivations, the availability of ECCD services appears to moderately align with parental priorities.

- **Perceived Availability of Services:** While early learning opportunities (58.62%) and safety/protection services (50.86%) are the most commonly reported available resources, access to healthcare facilities (43.10%) and responsive caregiving (41.38%) is notably lower.
- **Critical Gaps in Socio-Emotional Support:** A significant disparity exists in psycho-social care; despite parental interest in developing socialization (21.55%) and language skills (13.79%), only 6.90% of respondents reported the availability of psycho-social support.

This fragmented service coverage underscores the need for a more comprehensive and integrated ECCD service delivery model that balances physical care, cognitive stimulation, and socio-emotional development.

Having the view of establishing an integrated model dedicated towards children, the Government runs the Integrated Community-Based centre for Child Care, Protection, and Swim-Safe Facilities (ICBC) Project in rural areas, where children between 1 to 5 are kept within a centre-based facility when their parents or caregivers cannot attend to them. But it was found during this study that children coming to these centers are mostly above 3, and many key informants mentioned that the project is weakly implemented and has not been successful enough. A key informant stated,

> The government is running ICBC, but do you think it has reached the vision with what it had started? Can you see a single practice from ICBC that has been scaled up across the country? Then what is the point? [KII, P17]

The ECCD practitioners were also found not to be satisfied enough with ICBC's success and they identified a lack of parental awareness behind this. One of them mentioned,

> ICBC is not 100% successful, maybe 50%. The parents are often careless and unwilling to come to the centers. They prefer keeping the children unattended rather than putting in some extra effort to bring them to us. But they are not to be blamed as no initiative is taken to communicate about these centers and the further benefits in the future to them. [IDI, P20]

These perspectives highlight operational gaps, insufficient community outreach, and limited engagement with parents, all of which constrain ICBC's effectiveness in rural areas.

In contrast, urban areas exhibit a different ECCD landscape. There are both home-based and center-based daycares in labor-intensive zones, largely run by NGOs, alongside private daycares for the urban elites. For the healthcare of children above 3, only some immunization services are available, mainly booster doses or non-routine vaccines. Parents from rural and remote areas during FGDs reported lower coverage, long distances to clinics, and poor communication systems, making access challenging. Although a national-level child health program manager stated that IMCI corners exist in every upazila-level facility, parents are not adequately informed about these services.

Both parents and ECCD providers in the urban areas highlighted increasing developmental delays among urban children aged 3 to 6 due to nuclear families and screen addiction. Therefore, urban providers focus on play-based motor and sensory development, addressing speech and social communication issues, and counselling parents. But neither the parents from the rural and hard-to-reach geographic regions like haors, chars, coastal areas, or the hills, nor the ECCD practitioners were found to be much enlightened and concerned about these developmental issues.

The FGDs with parents and IDIs with service providers revealed that children's participation in cultural and co-curricular activities is very limited these days. Most children only participate in annual cultural functions at the centers after preparing for a few weeks without any regular structured play and cultural activities. Only one highly facilitated urban preschool was found to incorporate regular physical education, dance, music, storytelling, and other co-curricular engagements. Parents from that particular institution also reported school-supported visits to Shilpakala Academy. In contrast, in a government school, despite students' high demand, they could not have a music teacher due to a funding shortage. The situation is quite similar regarding health monitoring as well. Only the parents of the highly facilitated urban preschool reported regular visits from doctors through authorities' initiatives during the FGDs.

ECCD services for children aged 3 to 6 remain insufficiently coordinated across sectors, with limited multisectoral integration in practice. Parental awareness and communication regarding available child health services, including IMCI and routine follow-up care, remain weak and inconsistent. Cultural, play-based, and creative activities are not systematically embedded within ECCD center programming and are often confined to occasional or annual events, reflecting limited institutional prioritization and financing for such components. Geographic inequities persist, as ECCD service outreach in remote and rural areas remains limited, with weak referral linkages to nearby health facilities and insufficient mobile or outreach-based service delivery mechanisms.

6.1.2 Limited Participation of Children below 5 in ECCE Services

The policy provisions and strategic guidelines regarding the involvement of children under 5 in ECCE services, as well as the current status of their participation in these services, are discussed here:

> **Policy Provisions and Strategic Guidelines on ECCE Services for Children below 5**
>
> According to the National Education Policy 2010, children aged 4+ are considered eligible for pre-primary education, and it emphasizes preparing children for the transition to primary school as soon as they reach this age (MoPME, 2010). Government, non-government, and private initiatives also aim to provide early learning opportunities to children in this age group, recognizing the importance of foundational cognitive, social, and affective development.
>
> In the CECCD Policy 2013, infrastructural development for early learning of the children between 3 and 6 years and creating an inclusive zone combining health, education, and protection is spotlighted (MoWCA, 2013a).

Status of the Participation of Children below 5 in ECCE Services

In practice, children aged below 5 have very limited access to early childhood education. According to national data, only 16.6% of children in this age group are enrolled in ECCE programs (BBS & UNICEF, 2025), reflecting substantial gaps in early learning opportunities. Findings from FGDs with parents from diverse socio-economic backgrounds, along with IDIs with ECCD service providers, indicate that children living in urban slums or labor-intensive areas have comparatively better participation. This is largely facilitated through NGO-run programs that provide structured, play-based learning from an early age. One ECCD service provider working in slum communities noted,

> We start our programs through play, and then gradually the students reach nursery or pre-school. We try to serve the children from their foundational age and prepare them for preschool. But I would say not every child, in spite of coming from solvent families, is served properly in this period. The children here are sort of fortunate. [IDI, P3]

These findings highlight that while some children in urban, NGO-supported contexts receive early learning opportunities, the majority of children under five, especially those outside such programs, remain underserved. The limited availability of structured ECCE services for this age group points to a critical need for expanding access, ensuring that foundational learning and developmental support reach all children before the start of formal schooling.

Children in rural, poverty-stricken areas, chars, haors, or plain urban settings often only start ECCE programs after turning 5 or later. Some NGO-run initiatives claim to target children above 4. But according to the parents, as their services are completely academic, it limits the all-round ECCE experience and becomes overwhelming for the children. Many service providers claim to serve children above 2 in their learning centers. But during field visits, most children found are aged above 5 or 6. As the services are very much literacy-focused and disseminated in a strict academic approach rather than having a play-based approach, younger children and their parents tend to avoid the available services at least till the children turn 5. A few well-intended initiatives are there as well, but they lack the resources to serve a large portion of the children.

Also in urban areas, ECCD service providers primarily act as shelter homes for working parents' children, completely ignoring early learning, socioemotional, and cognitive development. Only a few high-quality and high-cost daycares emphasize play-based learning and competency development of the children, which are not accessible to all. The key informants also highlighted the gap in ECCE services for children from 3 to below 5. The two-year program for 4+ children is still in the piloting phase, leaving many children under 5 without access to early learning. One of them voiced it as,

> We are very clueless about the cohort from 3 to below 5. The health sector takes charge of the children below 3, and the education sector's initiatives start from 5 as the two years of pre-primary are not implemented yet. There is no policy indication in this regard as well. The children within this age only get some immunizations. The government should take initiatives to include children from 3 to below 5. Their participation in ECCE is not at all up to the expectation, which you can see in government data. [KII, P2]

This statement highlights a critical policy and implementation gap as children aged 3 to below 5 currently fall between the mandates of the health and education sectors, leaving them largely underserved in terms of structured early learning opportunities. While immunization services are provided, there is minimal attention to holistic development, including play-based learning, social skills, and cognitive growth. The lack of a formal framework or targeted program for this age group contributes to low participation in ECCE and underscores the need for a coordinated approach that bridges the gap between health and education initiatives.

In contrast, children below five living in humanitarian or crisis-affected contexts have seen somewhat better access to ECCE services through structured NGO initiatives in recent years. These programs, though limited in scale, demonstrate the potential of targeted interventions to reach underserved age groups and highlight the importance of expanding similar approaches nationally.

6.1.3 Universal Pre-Primary Education and School Readiness among Children between 3-6

The policy provisions and strategic guidelines for universal pre-primary education and school readiness for children aged 3 to 6, along with the status of universal pre-primary education and school readiness among these children, are discussed here:

Policy Provisions and Strategic Guidelines on Universal Pre-Primary Education and School Readiness among the Children Aged 3-6

Pre-primary education has the most extensive coverage among all the services available for children aged 3 to 6 years in Bangladesh because of the government interventions. The National Education Policy 2010 advocates for one year of pre-primary education for 5+ children, with plans to extend it to 4+ children (MoPME, 2010). Strategies in the policy also promote learning opportunities in religious institute-centric setups, combining basic literacy with moral and religious education.

The Consultation Committee Report for the reformation of primary and non-formal education emphasizes the urgency of implementing a two-year pre-primary program for 4+ children (MoPME, 2025). Currently, one year of pre-primary education is run in every government primary school, while the two-year program is in the piloting phase. Voluntary family participation and recruitment of para-teachers are encouraged to expand access despite resource and infrastructural limitations (MoPME, 2025).

The Operational and Implementation Plan of the CECCD Policy 2013 particularly focuses on promoting universal pre-primary education by government initiatives and also expanding pre-primary education for children between 3 to 6 through establishing community schools and using the infrastructure of primary schools if needed (MoWCA, 2013b).

Status of Universal Pre-Primary Education and School Readiness among the Children between 3-6

At present, pre-schooling opportunities for children between 3-5 are mostly provided by private and NGO-run schools, as the government initiative of two years of pre-primary is still in the piloting phase. In the GPSs, the one-year pre-schooling is highly appreciated. It was revealed in the FGDs with parents that, as the private and NGO initiatives are limited and often create a financial burden on the parents, sometimes the rural parents enroll their below-5 children in the one-year pre-primary program in the government primary schools to introduce them to the school environment and prepare them for formal education. The government primary schools are mandated to have a separate room for preschool. Even though GPSs are mandated to have a separate room for pre-schooling, in practice, this provision is not as ambitious or comprehensive as intended, and access remains limited in many areas. This gap in access underscores the importance of any available pre-primary program, as even a single year of preschool can have meaningful impacts on school readiness.

ECCD providers and child education experts noted that one year of pre-schooling significantly improved school readiness among the children. Data also support this claim ,as at least 79.6% of children just before Grade 1 either attend an early childhood education program or go to primary school, with 77.5% of Grade 1 students having attended ECCE before entering primary school (BBS & UNICEF, 2025). The education officers and PTI instructors also agreed upon the strengthening of universal pre-primary education as it benefits the learners in later life. One of them highlighted,

> If a child gets the right early learning experience at the pre-primary level, it makes his/her subsequent learning easier. The child becomes accustomed to learning, and the rate of dropout decreases. Therefore, if quality ECCD can be ensured, this directly or indirectly affects all levels of education. [IDI, P31]

These insights underline the significance of pre-primary education in establishing foundational learning habits, reducing future dropout rates, and supporting children's overall progression in school. The officer's observation emphasizes that early learning experiences not only prepare children academically but also socially and emotionally, forming a basis for lifelong learning.

Similarly, in the FGDs, parents across geographic regions strongly supported universal pre-primary education, regardless of whether it was provided by government or non-government actors, and advocated for starting it as early as possible, particularly emphasizing the two years of pre-primary in GPSs, citing both learning and childcare benefits. Mother of a child from the babyclass of a GPS noted,

> As I bring my children here, she plays with the other children and learns how to communicate. She is not shy at all while talking to others. Along with that, she knows the alphabets and numbers. Now I can easily admit her to Grade 1 next year. [FGD 19, P4]

This statement reflects parents' recognition of the multifaceted benefits of pre-primary programs, including socialization, early literacy and numeracy, and confidence-building. Parents from the Chittagong Hill Tracts also expressed appreciation for learning activities in para centers, noting that these initiatives help children achieve learning outcomes more easily when admitted to Grade

1. Along with pre-schooling, some private and NGO-run institutes were found offering additional learning in hygiene, life skills, and activity-based curricula that also positively contribute in school readiness of the children. But these services are not universal, and thus, several students lack preparation for primary schooling.

During the IDIs with the ECCD service providers to the children between 3-6 through government, private, and NGO initiatives, in the coast, char, haor, and poverty-stricken areas, a common dissatisfaction was noted regarding the resource shortage and limited facilities, which hinder the establishment of universal preprimary education and the school readiness among children. One of them mentioned,

> As we deal with young children, they have different needs. Such as the need for good food, play materials, a beautiful classroom, a playground, co-curricular activities, and so on. If all these needs are fulfilled, the children get ready for their formal education with proper socio-cognitive and physical development. But we can not provide adequately. It reduces the consistency and quality of their preschool experience. Children in rural, remote, or marginalized areas face additional barriers due to poor access and insufficient support in early learning from family members; as a result, transitioning to school comes as a challenge to them. [IDI, P5]

It highlights the importance of a well-resourced learning environment for holistic development, covering physical, cognitive, and socio-emotional growth. It also draws attention to the compounded disadvantage faced by children in marginalized areas, where both infrastructure and parental support for early learning are limited. The provider emphasizes that insufficient resources not only reduce the quality and consistency of preschool experiences but also make the transition to formal schooling more difficult for these children.

The parents' survey further confirms these constraints. The limited initiatives from family members for accelerating early learning at home and preparing the children for school have also been identified. Only 32.32% of parents reported having adequate knowledge regarding the early learning of their children between 3 to 6, which is reflected through their early learning initiatives at home.

- **Dominance of Play-Based Interaction:** The most frequent home-based initiative is playing with children (72.41%), followed by storytelling/book reading (48.28%) and engaging children in small, age-appropriate activities (48.28%).
- **Moderate Verbal Stimulation:** Approximately, only one-third of parents engage in interactive verbal practices, such as questioning children (33.62%) and singing together (32.76%).
- **Limited Structured and Creative Learning:** Engagement in tasks that support school readiness is notably lower, with only 24.14% of parents assisting with homework or involving children in creative activities like drawing and painting.

This finding suggests that parents' understanding of early learning is largely centered on play-based activities, while other practices that contribute to school readiness, such as providing age-

appropriate and creative tasks, using interactive methods, and guided learning, are comparatively less utilized.

The findings from both the quantitative and qualitative data clearly identify a significant policy-practice gap regarding universal preprimary education for a smooth transition to the primary stage. Even though universal preprimary education is highly appreciated and evidently beneficial for shaping the children's further learning experiences, we are far behind reaching what we envision due to resource scarcity and a lack of successful parental interventions. No universal community-based initiative for promoting pre-primary education, both in urban and rural areas, was found.

6.2 Quality of Services

This section explores the policy framework and guidelines designed to ensure quality ECCD services for children aged 3–6, covering pre-primary education, health, and socio-emotional development. It examines how these policies translate into practice, looking at service delivery, teacher competence, curriculum implementation, and program effectiveness across different regions, while highlighting key gaps and factors that influence the overall quality of early childhood services.

6.2.1 Mixed Evidence on the Service Quality for the Children Aged 3 to 6

The policy provisions regarding the quality of ECCD services for children aged 3 to 6 and the current status of this service quality are discussed here:

> **Policy Provisions and Strategic Guidelines on Ensuring Quality ECCD Services for Children Aged 3-6**
>
> All the relevant policies - such as the National Education Policy 2010 and the CECCD Policy 2013 aim to provide quality services to children. The National Education Policy 2010 commits to preparing children for the further stages of education through a strong pre-primary foundation (MoPME, 2010).
>
> The CECCD Policy 2013 prioritizes the maximum development of children aged 3 to 6 in terms of health, education, and socio-cultural experiences, emphasizing community involvement (MoWCA, 2013a). Together, these policies highlight the government's intention to ensure holistic development for every child within this age group.

Status of Service Quality for the Children Aged 3 to 6

In practice, the dedicated services towards children between 3 to 6 majorly involve pre-primary education. Even though, from the service providers' point of view, both the government and private organizations are working toward expanding pre-primary education and ensuring quality, the key informants expressed dissatisfaction regarding the quality of services and service outcomes. One key informant, directly involved with early childhood education, put it as,

> Globally, it has been observed that pre-primary education provides children with a very strong foundation. But if we look at our data, even in the NSA report, you will see that there is no significant difference between children who attend pre-primary and those who do not. This means pre-primary is not contributing as much as we expected. [KII, P15]

On the contrary, the parents from the geographically challenging areas, like haors, chars, coasts, and the hills, were found to be content with the service quality as their children were getting access to education with a minimum expense and getting prepared for formal education. NGO-run pre-primary programs in poverty-stricken and other rural areas were found to be providing comparatively better service and focusing on engaging in child-centered activities. Urban elite parents expressed satisfaction with the services of private daycare centers and preschools for the world-class practices they followed, which combined early learning with other skills development. One of the urban mothers shared her experience, saying,

> I have my full trust and confidence in this institute. The child is learning about the bad touch, good touch from now on. Her motor, language, and cognitive skills are developing. In fact, at this age, she already learns everything she needs for later life. [FGD 10, P4]

Together, these findings indicate a mixed picture of the service quality. While well-resourced urban and NGO-run programs demonstrate strong child-centered practices and early learning outcomes, overall service quality remains uneven, particularly in government programs and in remote areas. Access is often determined by geography, socio-economic status, and the availability of well-trained providers, suggesting that, despite expansion efforts, achieving universal, high-quality pre-primary education remains a major challenge.

Coming to healthcare services, in most plain urban and rural areas, parents expressed general satisfaction with clinic and hospital services, noting that their children received adequate attention from doctors. However, in the hill tracts, parents reported that the quality of healthcare facilities has been deteriorating, especially when compared to the relatively better educational opportunities available for young children. In hard-to-reach regions such as haor, char, and coastal areas, FGDs with parents highlighted limited availability of quality healthcare services, the high cost of basic medical care, and dependence on nearby cities for treatment. Mothers living in urban slums further added that the doctor’s visit fee for children is quite high, which is a major burden, often accompanied by the need to offer bribes for quicker access.

Parents’ satisfaction with institutionalized ECCD services was generally high.

- The majority of respondents expressed positive sentiments, with 54.31% reporting full satisfaction and 39.66% reporting moderate satisfaction.
- Only a small minority (6.03%) indicated that they were only slightly satisfied with the services received.

These satisfaction levels align closely with parents’ perceptions of service quality.

- **Perceived Service Quality:** Quality ratings mirrored satisfaction levels, with 45.73% of parents categorising services as "good" and 35.37% as "moderate."

- **Critical Quality Concerns:** Despite general satisfaction, 16.46% of respondents rated service quality as "bad," while only a negligible proportion (1.22%) perceived it as "very good."
- **Knowledge Gaps:** A marginal percentage (1.22%) of respondents reported not know the quality of the services utilized.

The correspondence between satisfaction and perceived quality suggests that parents who use ECCD services generally find them acceptable.

However, it is important to note that these evaluations may be influenced by limited exposure to alternative services or benchmarks for early childhood quality. Consequently, while parents report high satisfaction and generally positive quality perceptions, these ratings may reflect a generalized sense of adequacy rather than a detailed assessment against comprehensive early learning standards. The relatively low proportion of "very good" quality ratings highlights potential areas for improvement, particularly in holistic early learning, responsive caregiving, and developmentally appropriate practices.

Despite the strong policy intent to ensure holistic early childhood development, significant gaps remain in the quality and consistency of service delivery across geographic settings. While pre-primary education is central to services for children aged 3 to 6, its expected impact is not reflected in national learning data, indicating poor quality and limited effectiveness. Quality disparities are particularly prominent across different regions: geographically challenging areas express satisfaction mainly because any form of access feels valuable, not necessarily because services are truly high quality. Meanwhile, urban elite families benefit from world-class private services, creating a stark contrast with government and NGO-supported programs in rural and marginalized areas. In the health sector, uneven availability of quality healthcare, deteriorating facilities in the hill tracts, high costs in hard-to-reach areas, and systemic issues such as bribery in urban slums further highlight deep inequities. There is also a noticeable absence of data regarding the quality of health, life skill development, and cultural activities for 3-6-year-old children, making it difficult to assess overall service quality and identify targeted interventions.

6.2.2 Shortage of Skilled Workforce and Inconsistent Professional Development in Pre-Primary Education

The policy provisions and strategic guidelines on workforce competence and professional development in pre-primary education, along with the current status of workforce competence and professional development, are discussed below:

Policy Provisions and Strategic Guidelines on Skilled Workforce and Professional Development in Pre-Primary Education

The national policies emphasize ensuring a qualified and adequately trained workforce for pre-primary education, highlighting professional development and skill enhancement as essential components for delivering quality early learning. The CECCD Policy 2013 and National Education Policy 2010 envision pre-primary classrooms run by trained, child-friendly, and developmentally informed teachers capable of facilitating play-based learning. In the

Operational and Implementation Plan of CECCD Policy 2013, it is mentioned to have competent teachers for pre-primary and ensure continuous professional development for them.

Status of Workforce Competence and Professional Development in Pre-Primary Education

In reality, the quality of pre-primary education varies widely from institute to institute. In a number of government primary schools, the quality of pre-primary education is very disappointing. Parents, key informants, education officers, and PTI instructors repeatedly pointed to low workforce quality and weak commitment in GPSs. Key informants shared that mostly in the geographically backward areas, teachers are unqualified and irregular. One of them noted,

> The quality of early childhood and pre-primary education in Bangladesh is generally low, especially in hard-to-reach areas, as there is a lack of qualified teachers and the teachers barely attend classes. I, myself, have seen that they have a tendency to send any of their family members or neighbors to the school and sit aimlessly in the classrooms on their behalf. [KII, P10]

In contrast, practices in privately run and NGO schools are highly praised both by the parents and key informants compared to the government initiatives. Despite the high cost, many parents prefer private pre-schooling if they are capable of providing high quality of the teachers. But not every privately run preschool or kindergartens have qualified workforce, as many parents during the FGDs described their systems as *"show-offs,"* with unskilled teachers and no measures for capacity building. Parents and key informants are both more confident with the services of NGO teachers, who often receive better training and remain updated with evolving educational approaches, even though these NGO-led preschooling initiatives have lessened in the past few years as the government has taken over pre-primary education. Comparing the government and NGO-run initiatives, one of the key informants commented,

The govt. pre-primary teachers are not qualified enough. They receive training for a maximum of 10-15 days, which is barely enough. The NGOs could have been a great resource in implementing quality pre-primary education by providing an effective, affectionate, and experienced teachers pool who have the psychological readiness to deal with children if the government collaborated with them. [KII, P7]

While asked, the pre-primary level teachers in the government schools also agreed upon not being trained enough on the essential aspects of disseminating pre-primary education and ECCD, such as play-based pedagogy, child psychology, and early learning and development standards and there is no opportunity for in-the-job training. One of them mentioned,

I have been teaching for a while now, but, unfortunately, I have not received any particular training on ECCD. I know I need to be active and play with the children, but I do not know anything about the concepts of ECCD and how it's related to preprimary education. [IDI, P25]

There is a significant shortage of skilled teachers and inconsistent professional development across pre-primary settings. Government school teachers receive only brief training of 10–15 days, which is insufficient. Continuous professional development opportunities remain limited, contributing to low teaching quality. NGO schools have strong training systems, but these are not leveraged at scale. Private school teachers also lack structured capacity-development support, despite their willingness to participate. Overall, the system lacks standardized criteria for teacher qualifications, accountability, and ongoing professional development, creating uneven quality across government, NGO, and private providers.

6.2.3 Curriculum-Practice Disconnection in Preprimary Education

Strategic guidelines for implementing the curriculum and classroom practices in primary education, as well as the current status of these implementations, are discussed here:

Guidelines on Curriculum Implementation and Classroom Practices in Pre-Primary Education

The pre-primary education in Bangladesh targets children aged 4 to 6 years to develop their physical abilities, socio-emotional skills, ethics, language and communication, logic and arithmetic, creativity and aestheticism, knowledge of environment, atmosphere, science and technology, and overall well-being. The National Curriculum and Textbook Board (2025) provides a detailed curriculum that outlines learning areas, objectives, age-relevant teaching-learning activities, and assessment methods. The suggested activities include display, roleplay, storytelling, discussions, group and pair work, rhymes, singing, and play using child-friendly materials to ensure all-around development before transitioning to primary education.

For scaling up the pre-primary education for the children between 3-6, the Operational and Implementation Plan of CECCD Policy 2013, a strong direction is provided towards developing and implementing a quality curriculum, ensuring participation from a skilled workforce and usage of necessary learning materials (MoWCA, 213).

Status of Curriculum Implementation and Classroom Practices in Preprimary Education

Despite having a wonderful curriculum and well-planned strategies, the curriculum implementation remains weak. Experts identified this as a lack of competency on the practitioners' side. Teachers are expected to remain active throughout class time, but many are reluctant, causing the curriculum to remain largely unimplemented. From the practitioners' point of view, infrastructural and resource limitations worsen the situation. Pre-primary teachers hardly receive any support from para teachers, and the teacher–student ratio is much higher than standard.

Although government schools receive budgets for play-based materials, teachers lack the knowledge to select or use them properly. As a result, even with a curriculum that addresses all developmental areas, many children fail to reach the expected competencies outlined in the ELDS. Parents' expectations also contribute to the mismatch. While ECCD providers reported that parents demand reading, writing, and memorization, many parents actually prefer fewer exams and more communication, play, and hands-on activities. A parent explained,

> If my child's development is not delayed, he would know how to communicate, talk, and play with friends, which is appropriate to his age. If he is developmentally on track, I am confident that he will be able to learn on his own when it is needed. He does not need to bring medals home. So learning life skills should be the priority in pre-primary, not formal education. But most of the teachers teach in a way as if our children are grown-up adults. [FGD 9, P7]

The key informants also highlighted the issue of curriculum-practice disconnection in many preschools or in the baby classes of GPSs. One of the experts of primary curriculum mentioned,

> If you see the pre-primary books of NCTB you would see that it has everything properly planned. It integrates every learning experience a child requires at this age. For example, there is language and communication, mathematical skills, socio-emotional matters, physical and mental health, art, and aesthetics. All of this is guided by the curriculum. The current curriculum is competency-based. It will make you competent. The core competencies are set. But to implement this, the teachers need to be highly active. Unfortunately, the classroom practices do not reflect the curriculum at all. [KII, P8]

So it is evident that a major curriculum–practice disconnection exists due to inadequate teacher capacity, poor infrastructure, limited support staff, and the absence of continuous capacity building. Teachers' limited understanding of play-based pedagogy makes proper implementation difficult. The communication gap between parents and teachers also creates issues, as the parental expectations are not often voiced. Moreover, essential components such as personal wellbeing, healthy diet, communication of needs ,and personal safety are not consistently integrated in classroom practices, despite being strongly emphasized by key informants.

6.2.5 Observed Quality of Program Implementation by Pre-schooling Service Providers

The quality of program implementation in pre-schooling services was assessed using an observation tool with positively worded items rated on a 3-point scale, where higher scores indicated stronger agreement with quality criteria. The observation covered six dimensions: physical facilities, inclusion, attention to children's well-being, learning experiences, availability of para-teachers, and coordination with families.

The mean scores for these dimensions were: physical facilities 2.09, attention to children's wellbeing 2.10, inclusive practices 1.93, quality of learning experiences and activities 2.30, availability of para-teachers 1.60, and coordination with families 2.20. Physical facilities scored moderately overall, though WASH facilities, availability of clean water, and space for physical activities or sports were limited. Inclusion scored the lowest, reflecting limited structural accommodations for diverse learners, though children from minority groups were not treated differently, indicating inclusive attitudes. The quality of learning experiences demonstrated attempts at child-centered, play-based, and engaging activities. However, lesson planning was limited, innovative teaching–learning materials were seldom used, and practices were not fully implemented. On a positive note, teachers avoided corporal punishment and displayed empathy towards children during learning activities. Attention to children's well-being was moderately strong, reflecting teachers' attentiveness to physical and emotional needs. Availability of para-teachers was low, highlighting gaps in supporting staff for effective program delivery. Coordination with families was relatively strong, with parents often visiting centers to discuss children's progress and activities.

Overall, the findings suggest moderate program quality, with stronger performance in learning experiences, well-being and family coordination, and weaker performance in inclusion, staffing, and some aspects of physical infrastructure.

6.3 Equity and Inclusion

This section explores the policy frameworks and strategic guidelines aimed at promoting equitable access to ECCD services for children aged 3–6, with a focus on geographic, socioeconomic, and disability-related inclusion. It examines the extent to which these policies are translated into practice, highlighting the existing gaps in service provision, accessibility, and continuity for marginalized and vulnerable groups. The discussion also considers the social, institutional, and systemic factors that influence inclusive participation in early childhood programs.

6.3.1 Advancement towards Geographical and Socioeconomic Inclusion Amid Continuing Service Gaps

The policy provisions and strategic guidelines on ensuring geographical and socioeconomic inclusion in services for children aged 3 to 6, and the status of geographical and socioeconomic inclusion in these services, are discussed here:

Policy Provisions and Strategic Guidelines on Ensuring Geographical and Socioeconomic Inclusion in Services for Children Aged between 3-6

The CECCD Policy 2013 emphasizes increasing accessibility for children at risk, from disadvantaged backgrounds, hard-to-reach areas, and marginalized communities (MoWCA, 2013a). The operational and implementation plan of the CECCD Policy highlights establishing residential and satellite schools, providing social protection, stipends, mid-day meals, and cash transfers, along with creating awareness and empowering families. The policy also recognizes the right of indigenous children to study in their mother tongue and emphasizes publishing

textbooks accordingly (MoWCA, 2013b).

Status of Geographical and Socioeconomic Inclusion in Services for Children Aged 3-6

Government and NGO initiatives have improved access to pre-primary education for children in char, haor, and poverty-stricken areas. Parents appreciate the financial support, waivers, and provision of learning materials, school bags, and sometimes bicycles, which help ensure equitable participation. NGOs have scaled up early learning opportunities in urban slums, providing additional resources like educational materials, uniforms, books, etc. for quality learning. Government schools in both rural and urban areas serve children from various socio-economic backgrounds and provide extra socio-emotional support to underprivileged students. According to a head teacher of a government primary school, who has students in pre-primary classes,

> We have students from both privileged and underprivileged backgrounds. We treat the underprivileged ones with special care as they require socio-emotional support to a great extent. I individually talk to the students who have challenging lives, and our other teachers also take extra care of them. [IDI, P10]

In the geographically challenging locations, private initiatives like kindergartens have emerged for children between 3 to 6 years. But these institutes require comparatively higher expenditure from the family's side, as a result, the disparity remains. On a positive note, textbooks in mother tongues for the indigenous children by NCTB and 8,000 para centers under the SSS-CHT project in the hill tracts, have created access to early learning and pre-primary education even in extremely hard-to-reach areas.

Despite these positive practices, geographic challenges remain a major barrier. In char and haor areas, floods disrupt children's access to schools, causing detachment from learning experiences. Private pre-primary schools remain largely inaccessible to underprivileged children due to high fees. While indigenous children have access to mother tongue materials and para centers, continuity of services is affected when projects pause.

A similar finding has been found in the parents' survey as well, where 11.21% of the parents reported facing discrimination while accessing services for their children due to different reasons.

Figure 13 *Factors Affecting Discrimination in Accessing Institutionalized ECCD Services*

Factors Affecting Discrimination in Accessing Institutionalized ECCD Services

Factors Affecting Access

Gender 7.69%

Disability 15.38%

Social status 38.46%

Financial insolvency 92.31%

Percentage of Parents

The survey data indicate that economic issues are the primary barrier to accessing ECCD services.

- **Dominance of Economic Barriers:** Financial insolvency is the most pervasive constraint, reported by 92.31% of parents as a primary barrier to equitable access.
- **Influence of Social Positioning:** Beyond direct costs, 38.46% of respondents identified social status as a factor influencing their ability to access services.
- **Identity-Based Discrimination:** Reported barriers include disability-related discrimination (15.38%) and gender-based discrimination (7.69%).
- **Absence of Indigenous Discrimination:** Notably, no respondents reported facing discrimination based on Indigenous identity within the surveyed group.

Although the number of parents facing discrimination is limited, the graphical representation clearly illustrates the dominance of financial and social factors over other forms of discrimination in shaping unequal access to institutionalized ECCD services for children aged 3–6 years.

6.3.2 Gaps in Support Services for Children with Special Needs

Policy provisions and strategic guidelines concerning support services for children aged 3-6 with special needs, along with the current status of these services, are discussed here:

Policy Provisions and Strategic Guidelines on Support Services for Children with Special Needs within the age range of 3-6

The acts and policies in Bangladesh recognize the rights of people with disabilities. The CECCD Policy 2013 and the National Education Policy 2010 advocate ensuring equal access for children with disabilities. In CECCD Policy 2013, special attention is given to permanent infrastructural development and capacity building of the workforce engaged in providing services to children with special needs (MoWCA, 2013a). Bangladesh is also a signatory to major declarations on inclusive education.

The Persons with Disability Rights and Protection Act 2013 mandates the admission of eligible persons with disabilities in educational institutes, with legal consequences for denial.

> Collectively, these policies indicate a strong national commitment to promote inclusion and protect the rights of children with special needs.

Status of Support Services for Children with Special Needs

Real-life practices involving children with special needs vary across regions and service providers. In char and poverty-stricken areas, according to the parents, services are generally provided equally, but some parents are reluctant to send children to schools with disabled peers, and teachers face challenges providing extra attention in limited class time. The practitioners revealed that in rural areas, children with disabilities are sometimes hidden at home, even when they are eager to participate in learning.

In the IDIs with the ECCD providers, it was found that in the haor, char, coast, and extremely poverty-stricken areas ,there is some capacity to address many physical disabilities, and in the hill tracts, providers are compassionate and supportive toward children with physical impairments, even though the infrastructural facilities are rare. One of the service providers from the hill tracts explained,

> I, myself, often go to bring the children here. They may not always have access to wheelchairs, but their learning capacity is no less. [IDI, P18]

IDIs with the service providers in urban daycare centers targeting elite families admitted their attempts to address developmental and learning delays, but they lack structured approaches to inclusive education. In urban slums, low-cost programs and limited provider capacity further restrict equitable services. Observation of institutes confirmed that centre-based facilities are not infrastructurally ready to serve children with physical disabilities. The parents of special children also expressed similar concern during FGDs, as the inclusive practices are very minimal to leverage their children. One of the rural mothers voiced deep frustration about the unavailability of equitable services for children with special needs in the villages, saying,

> I am very much concerned about the future of my child, as he has special needs. There is no dedicated institution or arrangement available nearby to provide specialized education to the child. I am anxious and uncertain about what opportunities my child might have. I am afraid he might not even be able to get a basic education. [FGD 13, P2]

These findings reveal significant gaps in both policy implementation and practice. While individual providers demonstrate dedication and compassion, systemic challenges, including a lack of infrastructure, inadequate training, limited inclusive programming, and social barriers, hinder equitable access for children with special needs.

On the other hand, key informants expressed divergent views regarding the inclusion of children with special needs. Some informants were optimistic about the progress made so far, emphasizing gradual improvements in physical accessibility and learning support, as well as efforts to integrate children with mild disabilities into mainstream education. One key informant explained,

> Now ramps are being built for the physically disabled. We have provided Braille books for the blind. You can say that there are many more disabilities, but what are we doing for

> them? We try to bring those whose disabilities are not severe, those who are at a mild level, into the mainstream. For example, those who have ADHD but get a little better treatment or care, they come into the mainstream. So instead of saying we have established inclusion, I would say there is a sincere effort, and we will achieve it soon. [KII, P13]

However, other key informants viewed the current efforts toward equity and inclusion as minimal and inadequate. They highlighted weak institutional commitment and poor implementation of existing policies as the primary obstacles to achieving inclusivity. One informant noted:

> We would have established inclusivity for the children in primary schools by now if the education policy or the CECCD policy had been implemented. But we lack effort. We know that there are no infrastructural facilities for them, but we did nothing. [KII, P1]

Ensuring equitable services is found to be particularly more difficult for children with mental or intellectual disabilities compared to those with physical disabilities. Across rural and urban areas, ECCD providers are generally not trained in special education, and early identification systems are absent. Teachers often lack the competency to identify or assess children with learning disabilities, resulting in misidentification, exclusion, or neglect. Urban elite programs, while aware of the concept of inclusive education, have delayed implementing practices due to insufficient capacity. Systemically, there are no standardized diagnostic tools, limited teacher training, and minimal awareness at the school or community level. Consequently, policy aspirations for inclusive education do not translate into effective early identification, referrals, or tailored classroom support.

Highlights of Findings Regarding the Status of Services Supporting Transition to Primary Stage for Children Aged 3-6

- **Limited Access and Uneven Service Coverage for Children Aged 3-6**

  Services for children aged 3–6 were historically sparse, with health-focused programs mostly for children under 3 and limited early learning options for 3–6 year olds. Current government, NGO, and private initiatives exist but are weakly implemented. There is a lack of integrated service provisions dedicated to the educational, health, and psycho-social development of the children. Rural areas face low coverage due to distance, poor communication, and lack of awareness, while urban children experience developmental delays due to nuclear families and screen addiction. Cultural and co-curricular activities are minimal across most settings.

- **Very Low Participation in ECCE for Ages 3–5**

  The number of children aged 3–5 enrolled in ECCE programs is very low. Labor-intensive areas and refugee camps and urban privileged populations benefit from NGO initiatives and private services, respectively, but rural, remote, poverty-stricken areas and urban slums mostly remain underserved. The schoolification of early learning initiatives and scarcity of

structured, play-based learning before age 5 limits children's participation and increases inequities in school readiness.

- **Strong Demand for Universal Pre-primary Education Amid Implementation Constraints**

  Universal pre-primary education is widely perceived as essential for improving school readiness and easing children's transition to primary school, with strong appreciation from parents and education stakeholders. There is a strong indication for initiating earlier entry to preschool. Even limited exposure to pre-primary learning shows clear benefits for children's cognitive, social, and learning preparedness. However, resource shortages, uneven coverage, and limited early learning and school readiness-promoting activities at home and minimum facilities, particularly in rural and marginalized areas, constrain consistent and universal provision.

- **Uneven Service Quality and Workforce Capacity Driven by Providers and Geographic Locations**

  The quality of ECCD services for children aged 3–6 varies widely across settings. While NGO-run centers often demonstrate more child-centered practices and engaging learning environments, government provision, particularly in hard-to-reach areas, remains inconsistent. To the parents in many marginalized regions like the coastal belt, haor, and hill tracts, perceived service quality is shaped by access rather than actual standards, masking underlying quality gaps. There is a widespread shortage of trained pre-primary teachers, especially in government schools, where training is short-term and irregular. In contrast, NGO practitioners are generally better trained and more prepared to implement child-centered approaches, yet their expertise is not systematically integrated into the public pre-primary system.

- **Limitations in Translating the Well-Designed Pre-Primary Curriculum into Practice**

  Although a well-structured, comprehensive, and competency-based pre-primary curriculum exists, classroom practices frequently face limitations in reflecting its intent. Teachers' limited understanding of play-based pedagogy, high teacher–child ratios, inadequate infrastructure, and weak mentoring mechanisms contribute to a persistent gap between curriculum design and practice.

- **Moderate Learning Quality with Limited Inclusive and Supportive Practices among Preschooling Service Providers**

  While many provide moderately engaging learning experiences and show attentiveness to children's wellbeing, gaps remain in inclusive practices, availability of para-teachers, and certain physical facilities such as WASH, play areas, and accommodations for children with special needs, indicating that structural and process-level quality is inconsistent even within the same setting.

- **Progress in Regional and Socioeconomic Inclusion**

  Government and NGO initiatives have improved access to pre-primary education through financial support, learning materials, stipends, and social-emotional care, especially in char, haor, urban slums, and hill tract areas. Private kindergartens and para centers provide additional options, though high fees and project interruptions sustain disparities. Geographic challenges, such as floods and remote locations, continue to limit consistent participation.

- **Lack of Early Identification of Special Needs and Inclusive Support**

  Limited teacher capacity, lack of early identification tools, insufficient infrastructural readiness, and minimal parental awareness prevent children with physical, intellectual, or mental disabilities from receiving appropriate support.

Major Recommendations

- **Strengthen Multisectoral ECCD Services for Ages 3–6**

  ECCD services should be reinforced through coordinated efforts. Clear implementation guidelines, adequate staffing, and regular monitoring are essential to operationalize the CECCD Policy 2013 effectively. Communication with parents about health services like IMCI and routine follow-ups must be improved, and cultural and play-based activities should become regular components rather than annual events, with dedicated funding for instructors. Outreach and mobile services are critical for remote and rural areas to reduce geographic barriers.

- **Expand Early Childhood Education Participation for Ages 3–5**

  Community learning centers should be established across urban and rural areas, adopting play-based and competency-focused curricula starting from age 3. Government, NGO, and private initiatives must coordinate to expand coverage, particularly in underserved regions such as chars, haors, and poverty-stricken communities. The two-year pre-primary program should be scaled nationwide to improve coverage and quality. Investments in infrastructure, age-appropriate learning environments, teacher training, para-teacher recruitment, and structured community participation are essential.

- **Establish a Standardized Service Quality Assurance Framework**

  A uniform quality assurance framework for early childhood services should be applied across all providers and regions, including hard-to-reach areas. Regular monitoring of pre-primary education, targeted investments in healthcare, mobile clinics, and reforms to

address financial and governance challenges are recommended to reduce inequities and improve school readiness.

- **Strengthen Support Staff Facility and Physical Infrastructure in Early Learning centers**

  Enhance structural support by providing accessible facilities, safe play areas and accommodations for children with diverse needs. Increase the availability of trained para-teachers and build teachers' capacity in responsive, child-centered pedagogy. Strengthen collaboration with parents and community stakeholders to support consistent implementation, and embed indicators for inclusion, staff adequacy, and facility standards into regular monitoring.

- **Develop and Professionalize the Pre-Primary Teaching Workforce**

  A structured professional development pathway with competency-based training, refresher courses, and monitoring mechanisms should be established. Collaboration of the government with NGOs can leverage their experienced teacher pools, and private ECCD providers should be included in national training initiatives. A national accreditation or licensing system for pre-primary teachers, with in-service training and supervision, will enhance consistency and restore parental confidence.

- **Bridge Curriculum-Practice Gaps in Pre-Primary Education**

  Teacher capacity development, classroom support, and alignment between policy and practice should be prioritized. Improving teacher-student ratios, providing guidance on educational toy usage, and parental awareness programs will ensure effective implementation of play-based pedagogy and curriculum objectives.

- **Enhance Equity and Inclusion for Marginalized Children**

  Alternative delivery methods, such as mobile learning or temporary community centers should be developed for children in flood-prone or geographically isolated areas. Sustained financial and material support, and strengthened NGO-government collaboration, are critical to ensure continuity of services for underprivileged groups.

- **Establish Early Identification and Inclusive Support for Children with Special Needs**

  Structured early identification systems, standardized assessment tools, and mandatory teacher training on disability and inclusion are required. Parental awareness programs and NGO-government collaborations should be strengthened to reduce stigma and ensure consistent support, especially in remote and disaster-prone areas.

Conclusion

In this chapter, services for children aged 3–6 underscore both progress and persistent challenges in ensuring a smooth transition to primary education. While government expansion of pre-primary programs has improved enrolment and school readiness, inequities remain stark, with rural, remote, and marginalized children facing the greatest barriers. Weak teacher capacity, poor infrastructure, high student-teacher ratios, and fragmented service delivery continue to undermine the effectiveness of play-based curricula. Children with disabilities remain excluded due to insufficient early identification and inclusive support systems. To address these gaps, Bangladesh must strengthen multisectoral ECCD services, expand participation from age 3, scale up nationwide two-year pre-primary programs, professionalize the teaching workforce, and establish standardized quality assurance frameworks. Sustained investment, government–NGO collaboration, and parental engagement are essential to ensure that every child enters primary school prepared, confident, and equipped for lifelong learning.

Chapter Seven: Status of Services in the Early Primary Education Stage

Early primary education for children aged 6-8 represents a foundational stage for consolidating school readiness, developing core literacy and numeracy skills, and supporting children's overall well-being. In Bangladesh, this stage is supported through government, NGO, and private initiatives. While early primary education services are widely available in principle, children's experiences vary significantly depending on geographic location, socio-economic conditions, and institutional capacity. This chapter examines the current status of early primary education services for children aged 6-8, focusing on access and coverage, quality of service delivery, and equity and inclusion to understand how policy commitments translate into practice and where further strengthening is required.

7.1 Access and Coverage of Services

This section examines the policy provisions and strategic directions concerning access to and coverage of early primary education services for children aged 6-8, alongside the current status of service reach and utilization. It reviews national commitments to universal, compulsory, and quality primary education, as articulated in key policy frameworks, and assesses how these commitments are translated into practice across different regions and service providers. The section further explores disparities in service availability, parental awareness, and utilization patterns, highlighting systemic and contextual factors that shape equitable access during the early primary years.

7.1.1 Service Coverage

The guidelines and policy provisions on early primary education service coverage and the status of service coverage are discussed here:

Policy Provisions & Strategic Guidelines on Coverage of Early Primary Education for Children Aged 6 to 8

According to the National Education Policy of 2010, primary education must be universal, compulsory, free of cost, and of consistent quality for all (MoE, 2010).

The CECCD Policy 2013 provides a guideline for enhancing access and services for children aged 6 to 8. This guideline includes strategic initiatives focused on improving early primary education, ensuring the provision of supportive infrastructure, and promoting quality learning environments. Additionally, the policy emphasizes the importance of incorporating age-appropriate creative and cultural activities within primary school settings (MoWCA, 2013a).

The operational and implementation plan of the CECCD policy from 2013 focuses on ensuring students' nutrition, protection, health, and hygiene through various interventions apart from disseminating education. It emphasizes creating second-chance education opportunities for children who have dropped out of the system and ensuring student retention in schools by implementing measures tailored to the specific contexts and local needs (MoWCA, 2013b).

Status of Service Coverage for the Early Primary Education Stage

Government agencies, NGOs, and private organizations are working toward the goal of making early primary education enrollment universal. Key informants of several organizations emphasized that mostly early primary education service is available for children aged 6 to 8 through public and private initiatives. Similarly, ECCD program managers stated that pre-primary and primary education services are accessible in all regions, through the initiatives of both government and non-governmental organizations. However, parents in the hill tracts and rural areas stated that there is a lack of institutions available for providing early primary education. Moreover, in char areas, people are more dependent on NGO schools than government schools.

To create safer learning environments, the government has made several infrastructural improvements, such as providing access to clean drinking water and constructing safe, hygienic washblocks in government primary schools. However, in many of these schools, the maintenance of the washblocks is insufficient, leading to hygiene issues.

In some regions, besides providing early primary education, the schools take the initiative to build awareness among parents. Parents from rural and poverty areas stated that they get to know about teaching their children at home, the necessary foods for their children, maintaining good health, and the importance of deworming medicine and vaccinations during meetings with teachers. However, there is no clear system for the routine monitoring of health, growth, and nutrition for children aged 6 to 8 years. In the primary schools of the hilly regions, teachers conduct neighborhood-centric courtyard meetings (uthan boithok), providing guidance on child care, vaccinations, and nutritious food with the purpose of providing a better, healthier life for children. A teacher from a government primary school in a hilly region stated,

> Early primary education demand has increased compared to previous years. Parents are more aware now and are eager to enroll their children in school. Now, by coming to school, they are receiving health and wellness education. Parents are learning how to teach their children with an open mind, when to start their schooling, which nutritious foods will promote better growth, and how to properly care for them at school. [IDI, P17]

An upazila primary education officer shared,

> There are government information offices in the main upazila or district, and they organize mother gatherings with marginalized mothers. In those gatherings, they discuss multidimensional issues such as child marriage, nutritious food, and child development, and address the awareness gaps related to these issues. [IDI, P30]

These findings suggest that awareness-building programs for parents positively influence children's development. These localized initiatives have improved parental engagement and increased school enrollment. However, these programs are currently limited to specific regions, leading to inadequate awareness efforts nationwide. The absence of established institutional, school-based, and community-level mechanisms hinders the lasting dissemination of prenatal awareness messages.

Besides these initiatives, the government and NGOs have implemented various initiatives to support at-risk or disadvantaged children and enhance child safety. One such program is the Reaching Out of School Children (ROSC) Project, which aims to deliver formal primary education to out-of-school children using a non-formal approach. Additionally, the Department of Social Services operates various programs that focus on educating street children, as well as providing healthcare, shelter, and safe employment opportunities. There are also orphanages, baby homes, and other facilities that provide social security for at-risk children. A key informant highlighted the "Swim-Safe" initiative, which is part of the Integrated Community Based centre (ICBC) project led by the government, which provides survival swimming training to children aged 6 to 10 years.

The transition from early childhood programs to formal primary education is a critical phase that requires continued developmental support to sustain learning and well-being. Findings from the parents' survey suggest that access to ECCD-related services during the early primary years remains limited and uneven.

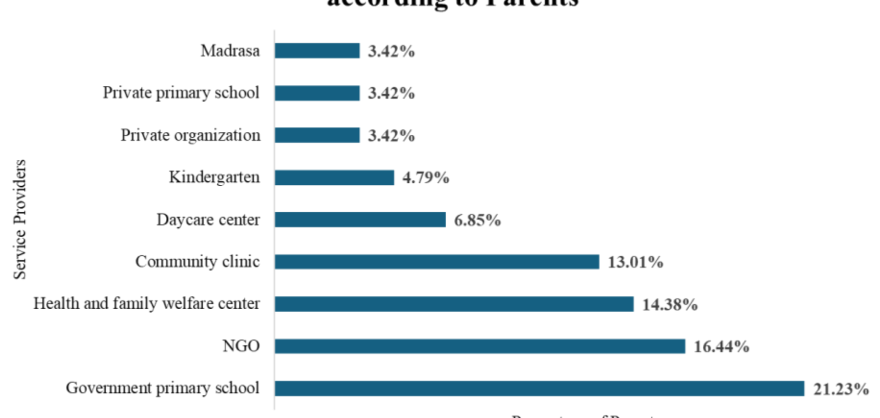
- **Respondents' own children (6–8 years):** 51.85% of 162 children were reported to have access to necessary ECCD services.
- **Children in respondents' wider social networks (6–8 years):** Only 22.43% of 262 children (friends' and relatives' children) were reported to have similar access.

In spite of the national policy provisions, such disparity in numbers indicates a crucial issue in service reach. These inequities are further explained by the localized availability of services, which fails to provide comprehensive national coverage and creates the following regional disparities:

- Nearly half of the respondents reported substantial gaps in service provision, with 22.60% stating services are not available at all and 23.29% perceiving them as only slightly available in their locality.
- A moderate level of availability was reported by 37.21% of parents, suggesting that while some services exist, they may not be sufficiently comprehensive or consistently accessible to the broader population.
- Only a small minority of respondents (15.07%) indicated that services are mostly available. Furthermore, a minor proportion of parents (2.74%) reported having no knowledge regarding the availability of ECCD services, pointing to possible information gaps and limited community awareness about existing resources.

As nearly half of parents reported services as unavailable or only slightly available in their localities, service utilization remains constrained by these systemic supply-side barriers. Consequently, only 58.90% of parents reported utilizing institutionalized services for their children aged 6 to 8. Their responses further indicate that ECCD services are delivered through a range of providers in their localities, as illustrated in the accompanying Figure 16.

Figure 14 *Major ECCD Service Providers for Children Aged 6-8 according to Parents*



The survey results reveal that among children aged 6 to 8, the utilization of ECCD services increasingly relies on formal state infrastructure, but no single provider has yet achieved complete dominance.

- **Predominance of Government Primary Schools:** As children transition into formal education, Government Primary Schools (GPS) emerge as the leading provider for this age group, utilized by 21.23% of respondents.
- **Sustained Role of NGOs and Public Health Facilities:** NGOs remain a significant secondary provider at 16.44%, followed closely by essential public health infrastructure, including Health and Family Welfare centers (14.38%) and Community Clinics (13.01%).
- **Decreased Reliance on Specialized and Private Settings:** Utilization drops notably for more specialized or private environments, with daycare centers and kindergartens serving only 6.85% and 4.79% of children, respectively.
- **Minority and Alternative Service Points:** A small, equal proportion of participants (3.42%) utilize Madrasas, private primary schools, and other private organizations, indicating a fragmented but present reliance on religious and independent providers.

While the provider landscape remains diverse, the actual utilization of institutional services is shaped by specific parental priorities regarding child protection and developmental stimulation. The following data outlines the drivers and service availability for children aged 6 to 8 years:

- **Primary Drivers for Service Utilization:** For this age group, parental engagement is primarily motivated by the need for safety and security (43.84%), followed by a focus on early learning and development stimulation (36.30%) and the requirement for responsive care (29.45%).

These findings suggest that parents prioritize basic protection, physical well-being, and early cognitive stimulation when engaging with institutionalized ECCD services. In line with these motivations, the availability of ECCD services appears to moderately align with parental priorities.

- **Perceived Availability of Services:** Service availability shows moderate alignment with these priorities, with early learning opportunities (28.77%) being the most accessible, followed by safety and protection (21.92%) and healthcare facilities (21.92%).
- **Deficiencies in Nutritional Support:** A notable gap exists in essential physical care, with only 16.44% of parents reporting that the fulfillment of nutritional needs is an available service component for this age group.
- **Critical Gaps in Socio-Emotional Support:** A significant imbalance persists between parental interests and actual service provision. While families expressed a clear interest in socialization (15.07%) and language development (10.27%), only 6.85% reported access to formal psychosocial care.

This fragmented service coverage underscores the need for a more comprehensive and integrated ECCD service delivery model that balances physical care, cognitive stimulation, and socio-emotional development.

Early primary education services for children aged 6 to 8 are offered by government, non-governmental organizations (NGOs), and private initiatives, but their coverage is uneven and fragmented across different regions. In hill tracts, chars, and some rural areas, access to government primary schools is limited, increasing reliance on NGO-run institutions. While basic infrastructure like washblocks and drinking water points has been established in many schools, weak maintenance and poor hygiene management hinder their effectiveness. Additionally, there is no systematic mechanism for regularly monitoring children's health, growth, and nutrition at this early stage. Although parental awareness initiatives exist in certain areas, they are not consistently implemented nationwide. Support programs for disadvantaged and out-of-school children are available in some locales, but a lack of coordination among these initiatives and uneven coverage ultimately reduces continuity of care, learning support, and holistic child development.

7.1.2 Major Factors Affecting Access and Coverage of Early Primary Education Services

The policy provisions and strategic guidelines for major factors influencing access and coverage in ECCD services for children aged 6-8, as well as the current status of these factors, are addressed here:

Strategic Guidelines on Educational Retention, Child Labor Prevention, and Public Awareness

In the Operational and Implementation Plan of the CECCD Policy 2013, emphasis is placed on ensuring educational retention through context-specific measures, including second-chance education opportunities for children who have dropped out of the system. The policy also highlights the importance of creating awareness among families and local communities to prevent child labor and support children's continued participation in education. In addition, the policy underscores the need to generate widespread public awareness by maximizing the use of Information and Communication Technology (ICT) platforms such as community radio, television, telephone services, local media, and social media (MoWCA, 2013b).

Lack of Awareness

The literacy rate among most parents in the hilly, haor, and char regions is relatively low. As a result, they are often unaware of their children's fundamental rights. A PTI instructor from a hilly region notes that parents tend to be satisfied with the services they currently receive for their children, as they do not have a clear understanding of their children's actual needs. This lack of parental awareness poses a challenge for children in accessing educational services. An ECCD practitioner in the char area remarked,

> There is a noticeable gap in parental awareness regarding their children's education and health. Here, children often remain at home and do not start school until they are seven years old. [IDI, P24]

These findings indicate that in geographically disadvantaged areas, low parental literacy creates a state of uninformed satisfaction, where parents accept limited services due to a lack of awareness regarding standard developmental milestones. This lack of knowledge causes a significant mismatch between a child's age and their educational grade, resulting in delayed school entry.

There is also a shortage of institutions focused on raising awareness among parents about Early Childhood Development (ECD). Additionally, initiatives aimed at promoting awareness of ECCD for parents are limited to specific regions. The survey of parents revealed a strong reliance on informal and self-driven channels rather than institutional or field-based communication:

- **Predominance of Informal and Intergenerational Channels:** A significant majority of parents rely on self-initiated efforts (63.01%) and family members (62.33%) for ECCD information. This suggests that in the absence of structured guidance, parents fall back on traditional knowledge systems and personal initiative.
- **Importance of Peer-to-Peer Networks:** Over a quarter of parents (27.40%) consider other parents a primary source of insights. This indicates a lack of formal institutional support, leading parents to trust the experiences of other parents.
- **Underperformance of Institutional and Campaign Outreach:** Formal awareness efforts show a disproportionately low impact. Only 17.12% of parents learn from ECCD organizations, and a mere 15.07% are reached by awareness campaigns, suggesting that the current institutional awareness-building initiatives may not be effectively reaching their intended audience.
- **Underutilization of Digital and Mass Media:** Despite increasing connectivity, mass media (13.01%) and social media (11.64%) remain secondary information sources. This indicates that a majority of parents may lack consistent digital access, or there may be a deficiency of ECCD-related content within these media channels.
- **Critical Gap in Frontline Community Engagement:** Most notably, only 1.37% of parents reported learning from field workers. This represents a near-total absence of frontline engagement, revealing a major systemic failure in service delivery for the 6-to-8-year age group.

These findings suggest a significant systemic disconnect between formal ECCD initiatives and parental awareness. The limited accessibility of formal information channels likely necessitates parents to rely on informal sources, such as family and peer networks, for developmental guidance.

While parents' survey results indicate limited use of social media, interviews with urban parents revealed a greater reliance on social media for information regarding early childhood care and development. In this context, a PTI instructor from an urban area mentioned,

> In the post-COVID era, the global influence of social media has increased awareness about ECD. However, there are no formal social or state-run institutions addressing this issue. Much of the information available on mobile phones includes misinformation, which parents may rely on, even though it may not be accurate. To support children's development effectively, we must first raise awareness among parents and provide them with proper counseling. Today, issues such as boredom, anxiety, and autism are increasingly prevalent among children, presenting significant challenges for us. [IDI, P28]

These findings suggest that while digital awareness is rising in urban areas, the lack of formal counseling and regulated information may lead to inaccurate caregiving practices. This gap in verified guidance is particularly critical for parents of children with special needs or those facing complex developmental challenges like anxiety.

Lack of available formal institutionalized counseling creates a great hazard for parents of special needs children. In this regard, a parent from a rural poverty-stricken area stated,

> A parent of an 8-year-old child who is struggling with memory issues, facing difficulties in teaching her child due to a lack of guidance and training on early childhood care and development (ECCD). [FGD 22. P1]

This finding indicates a lack of specialized support availability for special-needs children in rural and impoverished regions. Consequently, children with special needs in these areas are at high risk of being excluded from early primary education, further widening the gap in educational equity.

Financial Constraints

Parents from both rural and urban underprivileged areas have expressed their financial challenges in accessing education services. Due to a lack of funds, they have difficulty buying notebooks, pens, school uniforms, and bags for their children. Although they can barely afford these expenses at this stage, they are worried about what they will do when the expenses increase further in the future, when they move up to higher classes. A parent from a rural area stated,

> In the city, parents prioritize their child's education above all else, even if they have to go hungry. But in the village, if there is even a slight financial struggle, schooling is the first thing to be dropped. [FGD 12, P3]

These findings suggest that for some families living in extreme poverty, education is viewed not as a basic necessity but as a luxury. This situation is particularly common in rural areas, where

there is a lack of awareness about the long-term benefits of education. As a result, education often becomes the first expense that families choose to cut. This mindset significantly increases the risk of early school dropout, as families prioritize their immediate economic survival. Moreover, the additional costs associated with early primary education create a substantial financial burden for parents with limited means. This pressure leads to anxiety about future expenses, as parents worry about the rising costs in higher grades. As a result, there is a constant threat of educational interruptions.

Child Labor

Although policies focus on raising community awareness to eliminate child labor, the practice continues due to deep-seated socio-economic factors. Several reasons may contribute to this issue, such as the fact that child labor often serves as a survival mechanism for children who are orphaned, financial pressures that compel children to support their families, and a general lack of awareness among parents and the community. These challenges prevent children from accessing early primary education. In this context, a teacher from a government primary school in an urban area stated,

> Here, the parents are helpless. Some children have no parents, and for those who have, their economic condition is very frail. Most of these children are involved in child labor. They work in garages, sell water or flowers at the station, or work in various shops in the local market. There are no social initiatives for them. [IDI, P10]

These findings indicate that child labor continues to be a survival strategy for the most vulnerable children, including orphans and those from economically disadvantaged families. Limited targeted social initiatives make it difficult for these children to enroll in school since they must work to meet basic needs. In addition to raising awareness, urgent financial and social interventions are necessary to address this issue and alleviate the economic pressures that drive children out of the classroom and into the labor market.

Despite policy emphasis on student retention, second-chance education, and child labor prevention, access to early primary education for children aged 6 to 8 continues to be constrained by low parental awareness, financial hardship, and the persistence of child labor. In hilly, haor, char, rural, and urban underprivileged areas, many parents lack adequate understanding of children’s educational and developmental needs, which delays school enrollment and limits continued participation. Formal and reliable platforms for parent awareness and counseling on ECCD are limited, while misinformation increasingly shapes parental decisions. Financial constraints further restrict families’ ability to meet basic schooling costs, making education vulnerable during economic stress. Furthermore, child labor remains a major barrier for the most disadvantaged children, especially those without parental care or social protection and those from economically disadvantaged families, diminishing their opportunities to attend and remain in school.

7.2 Quality of Services

This section examines the policy framework and strategic guidelines intended to ensure quality early primary education and related ECCD services for children aged 6–8. It analyzes how national commitments to child-friendly learning environments, smooth transition mechanisms, trained teachers, inclusive practices, and quality monitoring are reflected in actual service delivery. The section further reviews variations in teaching practices, teacher capacity, infrastructure, learning materials, and program implementation across government, NGO, and private providers, highlighting key gaps and contextual factors that shape the overall quality of services during the early primary years.

7.2.1 Mixed Evidence on the Service Quality for the Children Aged 6 to 8

The policy provisions regarding the quality of ECCD services for children aged 6 to 8 and the current status of this service quality are discussed here:

Policy Provisions & Strategic Guidelines on Ensuring Quality ECCD Services for the Children Aged 6-8

The operational and implementation plan of the CECCD Policy 2013 emphasized a smooth transition for children from home to pre-primary and then to primary education. For this smooth transition, the guideline recommends the formulation of a strategy paper and action plan, which will include making homes and educational institutions child-friendly and establishing deep connections between families and schools, as well as parents and teachers. It focuses on strengthening and organizing activities related to early childhood learning and development and school readiness to integrate them with primary education. It also encourages the establishment of child-centric classrooms with adequate child-friendly instructional materials, introducing inclusive, technology-oriented, and child-appropriate teaching and learning activities, reducing the teacher-to-student ratio, and implementing a quality monitoring system so that every student gets a quality early learning experience (MoWCA, 2013b).

The National Education Policy of 2010 emphasizes the importance of fostering children's creative thinking and skills through active learning methods. It advocates for providing opportunities for individual or group-based tasks. Additionally, the policy encourages and supports research aimed at innovating, testing, and implementing effective teaching methods (MoE, 2010).

Status of Service Quality for the Children Aged 6 to 8

In early primary education, government primary schools adhere to the NCTB curriculum and the teacher's guide as national standards to ensure quality. In contrast, schools run by NGOs also use NCTB textbooks, but many do not follow the national curriculum or the teacher's guide. Instead, they implement their own teaching methods, which are mostly play-based and child-centered, guided by their own institutional guidelines.

The underprivileged parents in urban areas express satisfaction with the quality of education provided by government primary schools. They appreciate the positive behavior of teachers and

the exam-oriented teaching methods. However, the urban elite parents have a different perspective. They have observed that teachers do not conduct parent-teacher meetings to discuss where a child may be struggling or to provide advice on what parents can focus on at home. In addition, some parents in rural areas are dissatisfied with the education quality at government primary schools, leading them to enroll their children in NGO schools. A mother from a rural area commented,

> The quality of education at the NGO school is so good that even a Grade 5 student from a government primary school can't keep up with a Grade 1 student from this school. They can't compete in terms of their studies, nor is their handwriting nearly as good. [FGD 11, P1]

These scenarios indicate that the available services are inadequate to meet demand and are unsatisfactory in quality.

The Consultation Committee Report on reforming primary and non-formal education identified significant learning challenges among early primary students, who often lack basic reading, writing, and mathematical skills. This clearly points to a decline in the quality of primary education in Bangladesh. To address this issue, the committee recommended ensuring a seamless transition from pre-primary to primary education, maintaining the play-based pre-primary curriculum at least until grade 3 to guarantee quality education for children (MoPME, 2025).

Due to the lack of quality education in most government primary schools and the availability of various types of education systems, parents feel confused about which path to choose for the transition from pre-primary to primary education. A parent expressed his concern, stating,

> There are various types of education systems at the primary level in Bangladesh. For instance, there are Ebtedayi Madrasas, Hefzkhana, private primary schools that follow international curricula, and government schools that follow the NCTB curriculum. These are all distinct systems. Because of this multi-faceted education system, so many doors are open to us that we end up confused about which path to choose. [FGD 9, P1]

In the case of health care services, people take services from hospitals and community clinics. However, in hard-to-reach areas, the availability of these services is insufficient. In this regard, an ECCD practitioner from the hill-tract region stated,

> It would be beneficial if the number of area-based community clinics could be increased. For example, instead of having one community clinic serving several unions or wards, if one were established in every ward, the quality of service would improve significantly. [IDI, P17]

Overall, the qualitative data indicate that the service quality for children aged 6 to 8 varies significantly among government, NGO, and private primary schools. Additionally, health care services available in hard-to-reach areas are inadequate, revealing mixed evidence based on socio-economic and geographic factors.

Despite this mixed evidence, parents' satisfaction with institutionalized services for children aged 6–8 years was notably high.

- The majority of respondents expressed positive sentiments, with 52.33% of parents reporting full satisfaction and 37.21% reporting moderate satisfaction.
- Only a small minority (10.47%) indicated that they were only slightly satisfied with the services received.
- Importantly, none of the surveyed parents reported complete dissatisfaction, suggesting an overall positive perception of service delivery at the institutional level.

Parents' assessments of service quality were generally favorable, though slightly more varied than their satisfaction levels.

- **Perceived Service Quality:** Nearly half of the respondents (43.15%) rated the quality of services as "good," and 13.70% considered them "very good." Additionally, 29.45% described the quality as "moderate," indicating that a substantial share of parents perceive room for improvement.
- **Critical Quality Concerns:** Despite the predominance of positive ratings, 10.96% of parents evaluated the quality of services as "poor," reflecting the presence of perceived shortcomings within institutional provisions. Furthermore, 2.74% of respondents reported having no idea about the quality of services, pointing to a minor but notable knowledge gap among service users.

A comparison of satisfaction and quality ratings reveals a notable divergence. Although 10.96% of parents rated service quality as poor, none reported complete dissatisfaction, and a majority indicated full satisfaction. This suggests that parental satisfaction may be influenced not only by objective service quality but also by expectations, accessibility, affordability, or limited exposure to alternative benchmarks.

This data suggests that, generally, parents are satisfied with the services available for their children. Although some parents acknowledge the poor quality of services, they still express satisfaction, possibly because they have no better alternatives or are simply appreciative of any support they receive.

Although the CECCD Policy 2013 emphasizes child-friendly learning environments, smooth transitions, and quality monitoring for children aged 6 to 8, these provisions are not consistently reflected in practice. Service quality varies widely across government, NGO, and private primary schools, resulting in uneven learning experiences for children. While national curriculum standards exist, their implementation is inconsistent, particularly regarding teaching methods, play-based learning, and teacher-parent engagement. Many schools lack structured mechanisms for monitoring learning progress, providing feedback to parents, or supporting children who are struggling. The coexistence of multiple education streams without clear guidance further creates confusion for parents during the transition to primary education. In addition, access to quality health services remains limited in hard-to-reach areas, affecting children's overall well-being and readiness to learn.

7.2.2 Teacher Capacity and Professional Development

The policy provisions and strategic guidelines on teacher capacity and professional development in early primary education, along with the current status of teacher capacity and professional development, are discussed below:

Policy Provisions & Strategic Guidelines on Teacher Capacity and Professional Development in Early Primary Education

The CECCD policy 2013 puts significance on teachers' training along with capacity building of the entire workforce dedicated to ensuring quality early learning from local to national level, with the help of the local government (MoWCA, 2013a).

The consultation committee calls for quality teacher recruitment, pre-service training, continuous professional development of the teachers, and strong monitoring and supervision (MoPME, 2025).

The National Education Policy of 2010 states that effective measures will be implemented for teacher training. This includes the development of in-service training opportunities and, when appropriate and possible, training abroad. Additionally, efforts will be made to enhance the efficiency and capacity of domestic training institutions (MoE, 2010).

Status of Teacher Capacity and Professional Development in Early Primary Education

In reality, there is a lack of adequately skilled manpower to ensure quality ECCD services. At the time of recruiting a teacher, their knowledge is given priority. However, not only teachers' knowledge but also their pedagogical skills and understanding of child psychology are major concerns when working in this profession. Their behavior with children can have a large impact on their emotions, motivation, and success. In this regard, a parent stated,

> Primary school teachers have no understanding of child psychology. They don't realize how their words might affect a child. Teachers need sensitization when it comes to teaching children; they must know how to behave with them. Once a child is emotionally damaged, it is incredibly tough to recover. The government should have a policy that every school must follow. All primary teachers should undergo one or two months of mandatory training. Without a certificate, they shouldn't be allowed to handle children. [FGD 6, P3]

This finding suggests that to ensure high-quality ECCD services, the recruitment of teachers should prioritize both academic qualifications and formal training in pedagogy, child psychology, and emotional sensitivity. A teacher's behavior toward a child can have a lasting impact on the child's development.

NGOs and some private institutions, both in urban and rural areas, have gained the trust of parents due to the quality of their teachers. In contrast, most government primary schools in these regions struggle to earn that trust because their teachers often lack accountability and empathy. A parent from an urban area expressed his dissatisfaction, stating,

> In government primary schools, teachers are not concerned about students' learning. They show no interest in identifying the specific problems of their students. They seem to feel that now, as government employees, they no longer have any accountability. [FGD 9, P6]

This finding suggests that teachers' accountability and behavior towards students are crucial for providing quality service, as they help address the specific learning needs of students.

For professional development, training is mandatory. However, the amount of training available for government primary school teachers is not sufficient, and many essential topics are not included in the training. ECCD practitioners noted that, besides subject-based training, training on child psychology, parent counseling, child health, and development should be included in the training program. Moreover, some NGO schools operating in rural areas also face challenges in providing quality education due to a lack of trained and adequate teachers. In this regard, an ECCD practitioner from a rural area stated,

> We don't really have a dedicated art teacher. Every class actually requires two teachers; it's difficult for one person to handle everything on their own. I understand that from my own experience. Since we lack both trained teachers and a sufficient number of staff, it becomes very difficult to maintain the quality of these activities. [FGD 7, P2]

Overall, these findings indicate that to ensure quality and build stakeholder trust, a shift is needed toward teacher recruitment and training models that prioritize psychological understanding, adequate staffing, and professional accountability.

Although the CECCD Policy 2013 and recent consultation recommendations emphasize qualified recruitment, continuous professional development, and strong supervision, teacher capacity in early primary education remains uneven. Teacher recruitment largely prioritizes subject knowledge, while pedagogical skills, understanding of child psychology, and child-sensitive behavior receive limited emphasis. Mandatory training opportunities for government primary school teachers are insufficient in duration and scope, and key ECCD-related areas such as child development, classroom interaction, and parent engagement are inadequately covered. Accountability and supportive supervision mechanisms are also perceived as weak, affecting parents' trust in government schools. In both government and NGO settings, shortages of trained teachers and support staff further limit the consistent delivery of quality, child-centered learning experiences.

7.2.3 Infrastructure and Learning Materials

The policy guidelines and provisions regarding infrastructure and learning materials in early primary education, as well as the current status of these materials, are discussed here:

Policy Provisions & Strategic Guidelines on Infrastructure and Learning Materials in Early Primary Education

> The operational and implementation plan of the CECCD Policy 2013 emphasizes establishing child-friendly and attractive schools and classrooms, along with child-centered, joyful, inclusive, and technology-driven teaching-learning activities and materials (MoWCA, 2013b).

Status of Infrastructure and Learning Materials in Early Primary Education

The government has provided some infrastructural support to primary schools, including access to clean drinking water and hygienic wash facilities. However, schools struggle with budgeting for classroom organization, often lacking the resources to create child-friendly and attractive learning environments. Instead of using their allocated budgets effectively, many schools purchase unnecessary materials that do not contribute to children's cognitive development or the achievement of essential learning outcomes. Additionally, inadequate classroom space and insufficient playground facilities are common issues faced by most government primary schools.

The situation in NGO schools is even more concerning. Parents from rural, particularly haor areas expressed the need for washrooms and drinking water for their children. In rural areas, some NGO schools run their activity in houses made with fences, which need to be repaired every year. In this regard, a mother voiced,

> If the school building were constructed to a high standard, it wouldn't fall into disrepair year after year. Here, the floors are uneven, which makes it hard for children to develop good handwriting. Because there are no toilets, the children are forced to relieve themselves right behind the school building. The condition of the school room discourages them and kills their interest in coming here. The children even say, ‘I won't go to that broken school anymore. [FGD 6, P1]

This data shows that the school's environment influences both children's learning and development, as well as their motivation to attend school.

Besides infrastructural facilities, the quality and availability of learning materials are important. Though the government supplies free NCTB books in all primary schools, NGO schools in rural areas face a struggle to collect books for their students. Moreover, the quality of the NCTB books is not good enough to attract early primary students. In this regard, A key informant said,

> I had many suggestions for the NCTB and NGOs a long time ago, but no one listened to me. I pointed out that ‘this textbook is the main barrier to achieving our Early Childhood Development (ECD) targets for quality education.’ Students are required to read a textbook that is unattractive, lacks color, and is printed on poor-quality paper. However, when they see other, more appealing books around them, we don’t allow them to use those. Instead, we insist, ‘You must read this one.’ That is the problem. [KII, P3]

In the early primary stage, learning materials need to be appealing to foster intrinsic motivation among students. However, the current NCTB textbooks, characterized by poor paper quality and unappealing visuals, act as a barrier to engagement

Although the CECCD Policy 2013 emphasizes child-friendly infrastructure and engaging learning materials, these provisions are only partially realized in early primary education. Many government primary schools face limitations in creating attractive and child-centered classroom environments due to weak planning, low budgets, and ineffective use of allocated resources. Inadequate classroom space and limited playground facilities further constrain joyful and inclusive learning. Infrastructure conditions in many NGO-run schools, particularly in rural and haor areas, are more fragile, with insufficient access to safe buildings, toilets, and drinking water. While NCTB textbooks are widely distributed in government schools, NGO schools often face difficulties accessing these materials, and the design and quality of the textbooks are not always engaging for children aged 6 to 8, limiting their effectiveness in supporting early learning.

7.2.4 Observed Quality of Program Implementation in Early Primary Education Providers

The quality of program implementation in early primary education was assessed using an observation tool with positively worded items rated on a 3-point scale, where higher scores indicated stronger agreement with the stated quality criteria. Observations focused on six dimensions of program quality: physical facilities, inclusion, attention of teachers to children's physical and mental well-being, learning experiences, availability of para-teachers or supporting staff, and coordination with families. The mean scores across these dimensions for early primary education were: physical facilities 2.35, attention to students' mental and physical well-being 1.83, inclusive practices 1.13, quality of learning activities and learning experiences 1.86, availability of para-teachers 1.50, and coordination with families 1.75.

Physical facilities were moderately adequate overall, with proper seating arrangements, but outdoor play opportunities were limited, and WASH facilities were insufficient. Attention to well-being was relatively low, reflecting empathetic teachers but limited resources to support children's physical and nutritional needs, as there were no canteen services or provision of nutritious meals, and access to medical support was minimal. Inclusive practices scored the lowest here as well, highlighting a lack of ramps, braille books, supportive equipment, and teachers trained in inclusive or special education practices, indicating that children with diverse needs face substantial barriers to participation. Learning activities were primarily traditional and teacher-centered, with minimal play-based learning, limited instructional materials, few toys, and sparse classroom decoration, constraining opportunities for child-centered engagement. Availability of para-teachers was low, indicating insufficient supporting staff to assist teachers in managing classrooms and implementing effective learning practices. Coordination with families was moderate, as parents sometimes met with teachers to discuss children's progress, but systematic engagement and feedback mechanisms were limited. Overall, the findings suggest moderate to low program quality, with relatively stronger physical facilities but substantial gaps in inclusion, learning experiences, teacher support, and resources for well-being.

7.3 Equity and Inclusion

This section examines the policy frameworks and strategic commitments aimed at ensuring equitable and inclusive early primary education for children aged 6–8. It explores how provisions addressing geographic, socioeconomic, gender, and disability-related disparities are translated into

practice, highlighting persistent barriers such as poverty, remoteness, limited financial support, and inadequate specialized services. The discussion also considers institutional and systemic gaps that affect meaningful inclusion and equal participation in early primary education.

7.3.1 Geographical, Financial, and Gender Disparities in Accessing Equitable Early Primary Education

The discussion covers the policy provisions and strategic guidelines for equitable and inclusive early primary education services across various socioeconomic groups and geographic regions, alongside the current status of equity and inclusion in these services:

Policy Provisions and Strategic Guidelines for Equitable and Inclusive Early Primary Education

The CECCD Policy 2013 and its operational and implementation plan emphasize establishing residential schools and satellite schools, ensuring social protection, providing stipends and mid-day meals, and even transferring cash for coming to schools, along with creating awareness and empowering their families. It also recognizes the right of indigenous children to study in their mother tongue and the need for publishing books accordingly (MoWCA, 2013a; MoWCA, 2013b).

The National Education Policy of 2010 emphasizes the importance of providing inclusive primary education for ethnic minorities. It aims to achieve this by introducing mother-tongue-based learning, hiring indigenous teachers, and involving local communities in curriculum development. To improve access to education in remote, hilly, and disaster-prone areas, such as haors and chars, initiatives will be implemented. These include establishing new schools, providing residential facilities for students and teachers, and allowing flexible school calendars based on recommendations from the local community (MoE, 2010).

Status of Geographical, Socio-economic, and Gender-based Barriers

In reality, geographical location and socio-economic status are creating challenges to receiving early primary education in many areas of Bangladesh. Communication problems and transportation are the major barriers in the hill tracts and the haor areas. During floods in the haor areas, children face struggles to come to school. People from remote areas in hill tracts receive fewer services due to transportation difficulties.

Economic status is a common barrier in many regions of Bangladesh. An ECCD practitioner in the haor area mentioned that most of the women work outside. For this reason, girls cannot go to school as they have to take care of the family. In some families, boys have to go to work instead of going to school. Parents from an urban slum area expressed their dissatisfaction with the support system. In this regard, a parent stated,

> We were told about the stipend. I heard there was supposed to be a guardian meeting regarding this stipend money. Because of that, they took my phone number and all my

> information. However, nothing ever came of it after that. There was a flood somewhere, and I heard that the stipend money was given there. [FGD 2, P2]

The "stipend gap" and concerns about financial aid management weaken parental trust. This leaves families in need without the support they need to focus on education instead of immediate survival.

The government, NGOs, private institutions, and, in some areas, community people are taking necessary initiatives to ensure equal access in early primary education. For instance, the government has made the NCTB books available in the languages of small ethnic groups to ensure all ethnic minority groups can receive knowledge in their mother tongue. Additionally, a UEO in a hill tract area mentioned that there are two primary school hostels. These hostels generally accommodate students who otherwise wouldn't be able to attend school due to distance. All the children in these hostels stay together under the supervision of a designated person. The military provides them with food supplies and bedding. One parent cooks for all these hostel children, while the other parents provide support for the arrangement. Moreover, in an urban slum area, a government school parent expressed her satisfaction and said that she is never pressured regarding the fees. She can manage to pay them at her own pace.

In most of the regions, there is no gender disparity. Parents from both urban and rural areas stated that there are no gender-based disparities in clinics or schools. In this regard, an ECCD practitioner from a char area said,

> In our institution, both boys and girls participate equally and receive equal opportunities and facilities. If two notebooks or two pens are distributed, everyone receives them; in other words, there is no discrimination based on gender. The institution regularly organizes meetings with students and parents to discuss gender equality and anti-discriminatory behavior. However, some families in the area still display bias between sons and daughters. Specifically, there is a tendency to keep girls at home to do household chores. [IDI, P23]

This finding indicates that while educational and health institutions have successfully achieved gender-neutral service delivery and equal distribution of resources, deep-seated socio-cultural biases persist within families.

In the parents' survey, 11.63% of parents reported facing discrimination in accessing early primary education for various reasons.

Figure 15: *Factors Affecting Discrimination in Accessing Institutionalized ECCD Services*

Factors Affecting Discrimination in Accessing Institutionalized ECCD Services

Factors Affecting Access

Gender 9.09%

Social status 36.36%

Financial insolvency 70.00%

Percentage of Parents

The survey data indicate that economic issues are the primary barrier to accessing ECCD services.

- **Primary Economic Constraints:** Among parents reporting discrimination, 70% cited financial difficulties as the primary reason for limited access.
- **Impact of Social Status:** 36.36% of respondents indicated that their social status contributed to the disparity in service accessibility.
- **Gender-Based Barriers:** 9.09% of parents reported that their child's gender created a barrier to accessing early primary education.
- **Identity and Ability:** Notably, no parents in this age bracket reported facing discrimination based on disability or indigenous identity.

Although the number of parents facing discrimination is limited, the graphical representation clearly illustrates the dominance of financial and social factors over other forms of discrimination in shaping unequal access to institutionalized ECCD services for children aged 6-8 years.

Although the CECCD Policy 2013 outlines strong provisions for equitable and inclusive early primary education, geographical and socio-economic barriers continue to limit access in practice. Children in hill tracts and haor areas face persistent challenges due to poor transportation, seasonal flooding, and long distances to schools. Financial support mechanisms such as stipends and social protection measures are not consistently accessible or clearly communicated to all eligible families, leading to uncertainty and unmet expectations. While mother-tongue education and residential schooling initiatives exist for indigenous and remote communities, their coverage remains limited. Gender disparities are generally low at the institutional level, but household-level responsibilities and economic pressures still affect school participation for some boys and girls.

7.3.2 Gaps in Support Services for Children with Special Needs

Policy provisions and strategic guidelines concerning support services for children aged 6-8 with special needs, along with the current status of these services, are discussed here:

Policy Provisions and Strategic Guidelines on Support Services for Children with Special Needs within the age range of 6-8

In the CECCD policy 2013, special attention is given to permanent infrastructural facility building and capacity development of the workforce engaged in providing service to children with special needs (MoWCA, 2013a).

The operational and implementation plan of the CECCD Policy 2013 provides guidelines for targeted support for children with disabilities, such as specialized residential schools, inclusion under social safety nets, provision of stipends, cash transfers, and mid-day meals. This strategic guideline emphasizes early identification of special needs and ensures the delivery of necessary services following the identification of risks or special needs (MoWCA, 2013b).

The National Education Policy of 2010 emphasizes the importance of inclusive education. To achieve this, schools will be equipped with facilities that are friendly to students with disabilities, including accessible toilets and improved mobility support. Additionally, specialized Braille textbooks will also be provided specifically for visually impaired students to enhance their learning experience (MoE, 2010).

Status of Support Services for Children with Special Needs

In reality, the government tries to implement the policy by taking different initiatives like supplying Braille books, constructing ramps in schools, and making efforts to bring children with mild disabilities into mainstream education. In the haor area, one parent shared that money is given for the treatment of disabled children every three months, maybe by government or NGO initiative. Despite taking such initiatives, ECCD practitioners emphasize that the infrastructure is still insufficient.

Besides infrastructural challenges, the teachers aren't trained for teaching special children. A PTI instructor stated that there is a lack of specialized manpower to teach special children, such as those with visual or hearing impairments. In addition, during teacher recruitment, individuals with specialized skills for teaching children with disabilities, such as proficiency in Braille and sign language, are not selected. Similarly, a government primary school head teacher from an urban slum area stated,

> We have children with physical and mental disabilities coming to us. While those with physical disabilities can still access some services, we lack the necessary infrastructural facilities for them. On the other hand, those with mental or intellectual disabilities cannot access any services at all. They require specialized teachers who are experts in special education, as well as dedicated classrooms. We have none of these. Simply seating them on the front bench is not enough; we need teachers who are actually trained to teach them. [IDI, P1]

Lack of specialized manpower creates a challenge for early identification of disability and taking necessary actions for that. In this regard, a key informant stated,

> We don't have early identification of disabilities or learning disabilities. There is a very minor assessment that teachers do in the case of school enrollment. They don't even know what a disability is. Teachers call someone with an extra finger or an operation a disabled person. We are far, far behind. From an equity perspective, investment is not equitable. [KII, P12]

The absence of trained experts and early identification tools means intellectual disabilities are largely ignored, and physical disabilities are poorly managed. Consequently, inclusion remains superficial, relying on "front-bench seating" rather than the equitable investment and specialized pedagogy required for early primary success.

Although the CECCD Policy 2013 outlines comprehensive provisions for children with special needs, including infrastructure development, early identification, and targeted support, implementation remains limited. Existing initiatives, such as ramps, Braille books, and financial assistance, reach only a small proportion of children and are insufficient to ensure inclusive early primary education. Schools largely lack trained and specialized teachers to support children with physical, sensory, intellectual, or learning disabilities. Recruitment and training systems do not adequately prioritize special education competencies, such as Braille or sign language skills. Mechanisms for early identification and assessment of disabilities are weak, resulting in delayed or missed support and limited service referrals. As a result, many children with special needs, particularly those with intellectual or learning disabilities, remain underserved within mainstream education settings.

Highlights of Findings Regarding the Status of Services for Children Aged 6-8

- **Widespread Access to Early Primary Education with Notable Geographic and Service Disparities**

  Early primary education for children aged 6-8 is broadly available across Bangladesh through government, NGO, and private initiatives. Parental awareness regarding schooling, child health, nutrition, and care has increased, supported by school-based meetings, courtyard sessions, and government-led mother gatherings, particularly in rural and marginalized communities. Some schools, especially in hilly and rural regions, actively engage parents in child development, hygiene, and health practices. Targeted initiatives such as ROSC, Swim-Safe, and social services for street and at-risk children contribute to inclusive education and child protection. However, access gaps persist in geographically hard-to-reach areas, infrastructure maintenance remains weak, and routine health, growth, and nutrition monitoring for this age group is largely absent. The fragmented use of institutions and services further indicates the lack of an integrated ECCD service model for children aged 6-8.

- **Parental Awareness, Poverty, and Child Labor as Key Barriers**
  Low literacy levels among parents in remote and disadvantaged areas limit awareness of children's rights, education, and health needs, often resulting in delayed school entry. There is a lack of structured institutions or services providing accurate guidance and counselling on ECCD, while reliance on informal digital sources has increased. Financial hardship affects families' ability to cover basic educational expenses, making schooling less sustainable for poor households. Child labor remains a significant barrier for the most disadvantaged children, particularly those without parental care or social protection, further restricting access to early primary education and increasing the risk of dropout.

- **Variation in Education Quality and Transition Experiences**

  Government primary schools generally follow the NCTB curriculum, while NGO schools often apply more flexible, play-based, and child-centered approaches. Parental perceptions of quality differ by socio-economic context: underprivileged parents tend to be satisfied with government schools, while urban elite and some rural parents express concerns about limited feedback, exam-focused teaching, and overall learning outcomes. Evidence from national consultations indicates that many early primary students struggle with basic literacy and numeracy skills, pointing to quality challenges across the system. Parents also report confusion due to the presence of multiple parallel education systems at the primary level. In terms of health services, children rely on hospitals and community clinics, but coverage and quality remain insufficient in remote and hilly areas.

- **Gaps in Pedagogical Skills, Training, and Accountability**

  There is a general shortage of adequately trained teachers with a strong understanding of child psychology and inclusive and child-friendly pedagogy in early primary education. Parents and ECCD practitioners emphasize that teachers' behavior and interaction styles significantly influence children's emotional well-being and learning motivation. Learning activities remain largely teacher-centered and traditional, with minimal play-based approaches, limited instructional materials, and few toys or classroom enhancements. NGO and some private schools are often perceived as providing higher-quality teaching due to better-trained and more accountable teachers. Government primary school teachers receive mandatory training, but its frequency, duration, and content are considered insufficient, particularly regarding ECCD-specific competencies. Both government and NGO schools, especially in rural areas, face challenges due to limited staffing and a lack of specialized teachers for creative and co-curricular activities.

- **Infrastructure Gaps and Limited Use of Child-Friendly Learning Materials**

  Government primary schools have received basic infrastructural support, such as water and wash facilities, but maintaining child-friendly, safe, and attractive learning environments remains a challenge. Government schools often lack adequate classroom space and playgrounds, while NGO schools in rural and haor areas operate in temporary or poorly maintained structures without essential facilities. These conditions negatively affect children's comfort, motivation, and attendance. Although free textbooks are provided nationally, their visual quality and child appeal are limited, and access to books is

inconsistent in NGO schools. Learning materials that support joyful, play-based, and developmentally appropriate learning are insufficient across settings.

- **Geography and Poverty as Major Factors Contributing to Inequity**

  Geographical isolation and difficult terrain make it hard for students in hill tracts and haor regions to attend school, especially during the monsoon and flood seasons. Economic hardship influences household decisions, with children sometimes withdrawn from school to support domestic work or income-generating activities. Support initiatives such as stipends, hostels, and fee flexibility are valued by families where available, but inconsistent implementation reduces their overall impact. Mother-tongue textbooks and residential schooling have improved access for indigenous children in some areas. Overall, gender equality is largely maintained within schools, though some families continue to assign household responsibilities to girls, affecting regular attendance.

- **Limited Infrastructure, Skills, and Early Identification to Support Students with Special Needs**

  Some progress has been made through the provision of assistive infrastructure and materials, such as ramps and Braille books, and through limited financial support for treatment and care. However, overall infrastructure remains inadequate, especially beyond physical accessibility. Teachers generally lack training in special education, and schools do not have specialized classrooms or personnel to support children with diverse needs. Early identification and assessment practices are minimal, with a limited understanding of disability among teachers, affecting timely intervention. Children with intellectual, developmental, or learning disabilities face the greatest exclusion due to the absence of specialized support services.

Major Recommendations

- **Strengthen Equitable and Context-Sensitive Access to Early Primary Education**

  Early primary education services for children aged 6-8 should be expanded and strengthened in underserved areas such as hill tracts, chars, haor regions, and remote rural locations. This is necessary because geographic barriers, seasonal disruptions, and limited government presence continue to restrict regular attendance. Expanding satellite schools, hostels, flexible schooling arrangements, and aligning NGO-supported schools with national standards will help ensure equitable access, continuity, and consistent learning experiences.

- **Integrate Health, Nutrition, and Hygiene Support within Early Primary Schools**

Primary schools should function as entry points for basic health, nutrition, and hygiene monitoring for children aged 6-8 through coordination with local health services. This is important because, despite existing awareness activities, the absence of routine monitoring delays early identification of health and growth concerns. Simple check-ups, hygiene maintenance, and referral mechanisms can strengthen children's well-being and learning readiness.

- **Ensure Child-Friendly, Inclusive, and Well-Maintained Learning Environments**

  Minimum standards should be ensured for safe, child-friendly, and inclusive school infrastructure, including functional toilets, clean drinking water, basic play spaces, and accessible classrooms. This is essential because poor physical environments reduce children's comfort, motivation, participation, and regular attendance. Improved planning, better budget utilization, and increased allocation for child-friendly infrastructure and learning materials, along with improved design and quality of NCTB textbooks, are critical to support holistic early learning.

- **Strengthen Teacher Capacity, Staffing, and Inclusive Classroom Support**

  Regular and structured professional development should be strengthened for early primary teachers, with emphasis on child psychology, child-friendly pedagogy, inclusive education, classroom behavior, and parent engagement. This is necessary because teachers' daily interactions directly influence children's learning outcomes, emotional well-being, and inclusion of children with special needs. Addressing teacher shortages, strengthening supervision and mentoring, and developing a basic pool of trained special educators will improve classroom quality and service delivery.

- **Strengthen Parental Awareness, Guidance, and School-Family Linkages**

  Targeted and context-specific parental awareness initiatives should be strengthened to support families' understanding of children's education, development, and well-being. This is essential because limited guidance affects enrollment, attendance, and learning support at home. Improving the quality of existing platforms, such as teacher-parent meetings, courtyard sessions, and community forums, along with expanding trusted ICT-based channels (community radio, television, mobile messaging, and social media), can provide accurate information and reduce reliance on misinformation.

- **Reduce Financial and Social Barriers to Participation, Including Child Labor Risks**

  Education-linked social protection measures should be strengthened to reduce financial barriers that limit children's participation in early primary education. This is important because poverty and household vulnerability contribute to irregular attendance and child labor. Strengthening stipends, material support, second-chance education, and linkages with social services can improve retention and reintegration of at-risk and out-of-school children.

- **Improve Early Identification and Coordinated Support for Children with Special Needs**

  Simple and practical mechanisms should be introduced at school entry and in early grades to identify disabilities and learning difficulties. This is necessary because delayed identification limits timely intervention and meaningful participation. Strengthening referral linkages between schools, health services, and social protection programs will support inclusive education and equitable learning outcomes.

Conclusion

This chapter highlights that early primary education services for children aged 6-8 in Bangladesh have expanded, yet challenges persist in ensuring consistent access, quality learning experiences, and equitable inclusion. Geographic barriers, financial constraints, uneven teacher capacity, inadequate infrastructure, and limited support for children with special needs continue to affect participation and learning outcomes, particularly among disadvantaged groups. Variations in service quality across education streams and weak coordination further contribute to parental confusion and uneven transitions. Addressing these challenges will require focused investments in teacher professional development, child-friendly infrastructure, inclusive support services, and context-responsive access strategies, alongside stronger coordination among stakeholders to ensure that all children benefit from a supportive and inclusive early primary education experience.

Chapter Eight: Financing, Monitoring, Research and Evaluation, Coordination and Collaboration in ECCD

This chapter examines Early Childhood Care and Development (ECCD) in Bangladesh, with a particular focus on financing, resource allocation, collaboration and coordination, monitoring, evaluation, and research ecosystems. Drawing on policy review, key informant insights, practitioner perspectives, and parental experiences, the chapter explores the extent to which existing systems translate policy commitments into functional implementation.

8.1 Finance and Resource Allocation

The policy provisions and strategic guidelines regarding financing and resource allocation in ECCD services, along with the status of financing for ECCD sustainability, are discussed here:

Policy Provisions and Strategic Guidelines Regarding Financing and Resource Allocation in ECCD

The CECCD Policy 2013 provides the foundation for integrating ECCD across ministries, where MoWCA would lead the entire fund collection for the successful implementation of the policy. In 2024, the MoWCA, with support from UNICEF Bangladesh and advocacy from the BEN, initiated the formulation of a Costed Action Plan. This process engaged all relevant ministries to review ECCD initiatives, assess implementation status, and examine budget allocations.

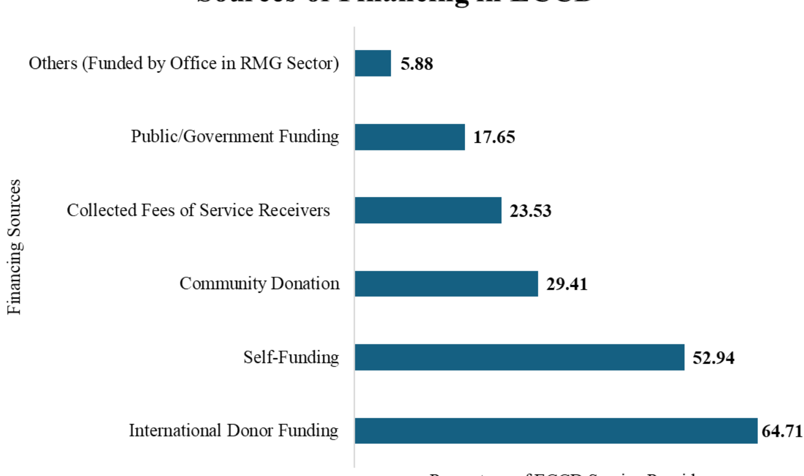
The Operational and Implementation Plan of CECCD Policy 2013 emphasizes having an adequate and sustainable ECCD budget that incorporates the funds allocated to various ministries and departments within the government and development sectors. It calls for collaboration among government, non-government, and private sectors to mobilize resources, while ensuring ECCD is prioritized in the Annual Development Plan. (MoWCA, 2013b).

Along with that, the National Education Policy 2010 also highlights the need for adequate financing and resource allocation to improve infrastructure, expand services, and ensure equity in ECCD and education, alongside increasing community participation and financial support mechanisms to reduce the burden on families (MoE, 2010).

8.1.1 Status of Public, Donor, and Private Financing for ECCD Sustainability

The current state of financing in ECCD is quite critical, as in the practitioners' survey, 35.29% of the ECCD service providers claimed having a very limited budget for running their programs, and none of the organizations are found to have fully sufficient financial resources. These organizations rely on a variety of funding sources to deliver services. In some cases, these organizations are funded through multiple donors.

Figure 16 *Sources of Financing in ECCD*



Among the ECCD service providers, international donor funding is the most common source of financial support.

- **External Funding Dominance:** International donor funding serves as the primary financial driver for 64.71% of ECCD organizations.
- **Organizational Self-Sufficiency:** More than half of the providers (52.94%) depend on their own internal resources to finance their operations.
- **Community and User Contributions:** Financial sustainability is further supported by community donations (29.41%) and service fees collected directly from parents (23.53%).
- **Limited Public Investment:** The reliance on government or public funding is relatively low, with only 17.65% of organizations reporting it as a source of funding.
- **Limited Workplace Support:** A small percentage of interventions (5.88%) receive support from mothers' workplaces, primarily within the Ready-Made Garment (RMG) sector.

However, the findings from the Key Informant Interviews (KIIs) indicate a significant shift in the global and national financing landscape, with Early Childhood Care and Development (ECCD) increasingly deprioritized within broader development funding agendas. International donor funds are gradually decreasing. Over-reliance on donor funding has emerged as a critical concern, as donor-supported initiatives are often time-bound and vulnerable to abrupt withdrawal, posing serious risks to program continuity and long-term sustainability. As highlighted by one key informant,

> NGO-led or funded programs may show a path by piloting for 2 or 3 years, but the sustainability can only be ensured through government financing. [KII, P7]

Despite the existence of the CECCD Policy and its operational and implementation plan, the absence of a dedicated and institutionalized government financing strategy and the needful actions for ECCD continue to undermine sustainability. Public financing for ECCD remains fragmented across multiple ministries and programs, with no assured long-term budgetary commitment. Consequently, ECCD implementation remains highly susceptible to external funding fluctuations, limiting the ability to scale successful interventions or ensure equitable service delivery across regions. In contrast, donor-funded ECCD initiatives are generally characterized by stronger financial governance, including systematic reporting requirements, independent monitoring, and clear accountability mechanisms. These frameworks help ensure transparency, efficient resource utilization, and alignment between financial inputs and program outcomes. However, while such projects often demonstrate effective models of service delivery, their impact is low due to the lack of transition into government-financed systems. Similar concerns arise in relation to self-funded ECCD initiatives, where the absence of formal monitoring and accountability mechanisms often results in compromised service quality and inconsistent standards. As noted by one key informant,

> The donor-supported projects generally uphold stronger accountability standards compared to government and self-funded initiatives. We are all aware of the mismanagement of government funds. But the donors typically require systematic reporting and establish independent monitoring mechanisms, which contribute to greater transparency in the financing processes. Some programs are run on self-funds, and in those, quality has been compromised. There is no monitoring mechanism there. Even if there is some service, these are to be considered as special cases, not as common practice. [KII, P9]

In a nutshell, it highlights critical gaps in ECCD financing sustainability, particularly the scarcity of predictable public financing and the absence of robust monitoring and accountability systems within government and self-funded programs. While donor-supported initiatives continue to play an important catalytic role by piloting innovative models, the lack of government-led financing and institutional ownership prevents these initiatives from being scaled or sustained. This fragmented financing landscape raises serious concerns regarding the long-term sustainability, quality, and equity of ECCD services, underscoring the urgent need for a coherent public financing and accountability framework to support ECCD in Bangladesh.

8.1.2 Status of Budgeting and Resource Allocation for ECCD

National budget allocations for health, nutrition, and education are intended to cover Early Childhood Care and Development (ECCD) services; however, there is no clear disaggregation of funds specifically earmarked for ECCD. Although the policy environment emphasizes a multisectoral approach to ECCD financing, budgetary provisions for ECCD remain embedded within broader sectoral budgets, limiting transparency and traceability. ECCD practitioners across organizations consistently reported shortages in budget allocations that constrain their ability to adequately meet children's needs, despite making maximum efforts to maintain service quality. Budget inconsistency and lack of transparency also emerged as recurring concerns during key informant interviews. While substantial portions of the national budget are allocated to health, nutrition, and education, the absence of a clear breakdown makes it difficult to determine the proportion actually directed toward ECCD services. As one key informant explained,

> In the government-level financing, there is some allocation for health. Now, it is not known how much of the health allocation is allocated for early child development. Similarly, if we talk about education in this way, we know that 0.77% of GDP is allocated for education. But how much of that is actually for primary education? There is still no separate budget for ECCD. [KII, P10]

The study further revealed significant challenges across budgeting practices in public, donor-funded, and privately run ECCD initiatives. ECCD practitioners working in Government Primary Schools (GPSs) and government education officials highlighted limitations in public budgeting for young children, particularly affecting the provision of healthcare and hygiene facilities, nutritious food, safety and security, and age-appropriate recreational opportunities. One practitioner reflected on these constraints by stating,

> I want to do a lot of things for the children. But there is a severe budget constraint. I wish I could provide some food, as I know the children are starving when they come here. The number of fans in the rooms is not enough. I have developed the washrooms as much as possible, but there is still a lot of room for improvement. They often demand playzones, singing and dancing facilities, which I cannot arrange due to the shortage in budget. [IDI, P10]

These concerns were corroborated by government education officers involved in budget planning and utilization. They acknowledged that insufficient financing directly limits the quality of ECCD experiences for children and expressed a strong willingness to improve infrastructure, services, and learning environments if budget allocations were increased.

Over the past five years, several donor-funded and privately run ECCD initiatives were found to have been discontinued due to persistent budget constraints. Among those still operational, some NGO/INGO-led and private initiatives rely on their parent organizations or donors for budgeting, fund management, and allocation, while others depend on local microcredit organizations or community collaboration to sustain activities during funding shortages. Several ECCD providers reported having little to no involvement in budget planning or management, as financial decisions are handled centrally. Since many local initiatives do not prepare need-based budgets and instead receive pre-planned allocations that are often inadequate, several ECCD programs struggle to sustain operations over time.

In addition to budgetary constraints, weaknesses in budget transparency continue to pose challenges within the ECCD sector. Although government mechanisms exist to promote financial accountability, such as auditing systems, mistrust regarding the transparency of government budget allocation and utilization persists. Both key informants and ECCD practitioners emphasized the importance of community participation in budgeting processes to enhance transparency and accountability. As one key informant noted,

> For the local level, after sitting with the union parishad, parents, local leaders, and other stakeholders to know the demands, a draft budget and resource allocation planning on ECCD based on these consultations should be prepared so that they remain accountable regarding the budget transparency. Also, regarding the national level budgeting, the

> government should disclose to the public how much they are allocating to the health care sector and child development sector. [KII, P2]

Despite policy recognition of ECCD as a multisectoral priority, critical gaps persist in budgeting and resource allocation mechanisms. The absence of a separate, clearly defined ECCD budget line at the national level limits transparency, accountability, and effective tracking of expenditures. Budget allocations remain largely input-based rather than need-based, failing to reflect local context, service demand, or quality requirements. Limited involvement of local-level ECCD providers in budget planning further weakens responsiveness and efficiency.

8.1.3 Status of Household Expenditure and Parental Perspectives

Parents reported during the study that the average expenditure associated with childbirth and subsequent care ranges between 5,000 and 8,000 taka, with additional medical costs during delivery or child illness posing significant financial challenges. Monthly child-rearing expenses were estimated at 5,000 to 7,000 taka, with higher costs for children aged 0–3 years compared to those aged 3–6 years. Even though across all areas, parents highlighted that educational costs exceed household income, the parental perspective on household expenditure for their children differed based on the socioeconomic background and geographic location of the parents. Well-off parents from the urban regions articulated positive perceptions of existing services, highlighting that activities such as educational trips, fairs, science exhibitions, fruit festivals, cooking classes, art exhibitions, and cultural competitions offered substantial value. One mother said,

> The service we are getting is okay. We don't feel bad spending money on the service we are getting, it's value for money. [FGD 9, P6]

Another parent added,

> There are educational trips, fairs, science fairs, fruit festivals, cooking classes, art exhibitions, and cultural competitions. In that sense, I would say the cost is low. The cost can be said to be minimal. We are grateful to them. [FGD 9, P2]

The findings suggest that household expenditure on childcare and early education places a considerable financial burden on families, particularly in lower-income and rural contexts. However, parents from well-off urban backgrounds perceive the costs as reasonable or worthwhile, valuing the variety of educational and enrichment activities provided, which they see as enhancing their children's learning and development.

In contrast, parents in economically disadvantaged areas face significant financial challenges in supporting their children's early learning and care, often struggling to meet even basic needs. They expressed the need for school uniforms, learning materials, stipends, and access to free education, health, and nutrition services. Mothers from coastal belts suggested regular monthly financial support, while mothers from other poverty-affected regions reported some satisfaction with existing services, noting that managing expenses largely remains the family's responsibility. Across rural areas, parents emphasized the importance of nutrition training, accessible health services at village and union levels, and the need for higher-quality schools to ensure better education outcomes. In haor regions, NGO-run schools help reduce the financial burden by

providing books, notebooks, and pens, although stipends are not universally available as in government schools.

Several ECCD practitioners noted that the financial burden often discourages parental participation, particularly when parents lack awareness of the long-term benefits of early childhood development. One practitioner explained,

> Most of the parents carry the cost themselves, but they do not always understand why this investment matters. Without proper awareness of the benefits of ECCD, they tend to see it only as an additional financial burden rather than an investment in their child's future. [IDI, P4]

The findings from the parents' survey also reveal a similar result regarding the financial barriers they face while accessing ECCD services.

- Nearly 80% of parents report difficulty in affording services, with 39.12% stating it is very difficult and 38.14% finding it difficult.
- Only a combined 22.74% of respondents found services accessible from a financial standpoint, with 21.03% reporting it as easy and a negligible 1.71% considering it very easy.

These findings indicate that financial constraints remain a major barrier to equitable access to early childhood services from the household perspective.

The main gap found in this study is that while a few parents perceive services as affordable and valuable, economically disadvantaged families face significant barriers to participation. The lack of understanding among the parents regarding the benefits of ECCD also limits their enthusiasm. Government stipends and NGO support are unevenly distributed, and there is no consistent mechanism for financial assistance, nutrition training, or accessible health services across regions for those who are in need.

8.2 Monitoring, Evaluation, and Research

Policy provisions and strategic guidelines regarding the monitoring, evaluation, and research ecosystems in ECCD are discussed here:

Policy Provisions and Strategic Guidelines Regarding Monitoring, Evaluation, and Research Ecosystems in ECCD

The CECCD Policy 2013 by MoWCA emphasizes the importance of systematic, research-oriented data collection, monitoring, and evaluation to enhance ECCD service quality and scale up interventions. It underlines the need for independent research, data-driven decision-making, and a comprehensive ECCD database to support policy implementation while ensuring transparency, accountability, and service quality in ECCD. The policy also encourages the development of monitoring and evaluation toolkits to ensure transparency and accountability (MoWCA, 2013a). National ECCD frameworks emphasize participatory monitoring, parental engagement, and evidence-based decision-making to ensure quality service delivery. Institutions

are expected to maintain child records, facilitate parental feedback, and integrate monitoring into routine practice.

The MoPME Primary Education Reformation Committee (2025) also recommends proper monitoring mechanisms with active participation from headmasters, education officers, and URC instructors to enhance quality at the pre-primary and primary levels through strengthening teacher capacity, improving child development outcomes, and ensuring accountability to communities.

Similarly, the Child Day Care Centre Act 2021 mandates that daycare centers maintain complete records of every child enrolled.

The CECCD Policy 2013 also underscores research on nutrition for children aged 0–3 years and the use of toolkits to track development for children aged 0–8 years against the Early Learning and Development Standards (ELDS). It advocates for maintaining records of children's development with indicators for monitoring and continuous follow-up of health and development programs (MoWCA, 2013a).

Again, the Health Sector's Integrated Strategy (MoHFW, 2022) highlights the importance of monitoring and supervision, recommending regulatory frameworks for both public and private sectors, supported by logic models, checklists, and other monitoring tools. The Nurturing Care Framework (WHO et al., 2018) encourages the use of global indicators, including those outlined in the SDGs, for monitoring ECCD. It emphasizes regular data collection and dissemination through scorecards and dashboards to improve transparency, accountability, effectiveness, and service quality.

8.2.1 Status of Record Keeping in ECCD across Regions

Record-keeping for ECCD services shows significant gaps across regions. Parents reported that apart from birth certificates, no systematic data is maintained, and in some areas, children's information has not been collected for years. A mother from the haor areas said,

> No one has come in the last two years to collect any kind of information about our children. [FGD 4, P1]

According to the ECCD service providers, vaccination cards and birth certificates are the main forms of data collected, primarily to track immunizations. Some initiatives, such as the "Little Doctor Campaign" and annual surveys, record children's height and weight, but these are rarely analyzed in detail for planning. In fact, 26.6% of children's valid birthweight data were missing, indicating weak monitoring systems (BBS & UNICEF, 2025).

However, the types of information collected and the extent of record-keeping vary widely across regions, reflecting inconsistent practices and capacities among providers. In most of the rural areas, only birth records are kept, while in the urban labor-intensive areas, vaccination cards are used

mainly as proof for workplace leave. NGOs in the coastal belts record height and weight proactively, while both government and privately run schools in rural and urban areas maintain basic documents for vaccinations and stipends, but systematic updates on growth or development are lacking. In char areas, information is collected occasionally without linking it to services. Some positive examples exist, like in some urban areas, the centre-based daycares closely monitor children's progress. Parents highly expressed the need for more comprehensive data collection. A parent from the plain rural areas noted,

> Several important information, like children's height, weight, health status, etc. are collected abroad, so it would be so much better if it were collected here too. [FGD 13, P5]

These findings reveal fragmented and inconsistent record-keeping across ECCD services, which hampers evidence-based planning, monitoring of child outcomes, and targeted support. There is a clear disconnect between policy intent and practice. While national policies advocate for comprehensive child data collection and systematic monitoring, implementation is fragmented, irregular, and often limited to administrative records. There is very limited use of monitoring and evaluation tools like checklists, logic models ,and data presentation tools like dashboards or scorecards. Growth indicators such as weight and height are inconsistently recorded, parental feedback is rarely integrated, and monitoring activities are either absent or conducted only once annually. This lack of systematic oversight undermines accountability, weakens service improvement, and reduces the utility of data for evidence-based decision making.

8.2.2 Status of Monitoring and Evaluation Practices and Quality Assurance in ECCD

The study found that monitoring and quality assurance practices in ECCD are uneven and largely inconsistent across regions and service providers. ECCD practitioners described a mix of monitoring actors, including NGO officials, education offices, data agencies, school managing committees, and guardians. In most institutions, monitoring takes the form of periodic observation, reporting, and audits. Head teachers, Upazila Primary Education Officers, and Assistant Upazila Primary Education Officers generally conduct monitoring in education-focused ECCD services, while NGOs use internal supervision systems. PTI instructors also take part in monitoring and evaluation of the designated GPSs. But due to the limited workforce, this monitoring remains largely administrative, with limited attention to teaching quality or child development outcomes.

Within the education sector, public institutions primarily emphasize supervision and guidance rather than structured evaluation. A PTI instructor explained the lack of a formal evaluation system for teachers, stating,

> We do not evaluate, but rather work as supervisors or helpers. To be honest, there is no evaluation system for teachers. We guide them, inspect them, and try to help them with their development in various areas of children's growth. The education officers are too overwhelmed with their responsibilities to monitor for quality enhancement. We need to work on the evaluation method of our teachers. Teachers do very little work on the life skill development of children; they only share information. They do not work to improve the morals and values of children. Therefore, teachers need to be made skilled through

> evaluation and assessment so that they can ensure learning according to the age of the child. Teachers with a good mentality need to be developed. [IDI, P29]

This statement highlights the limitations of current supervision systems, which focus more on administrative compliance than on the holistic development of children. The instructor underscores that without structured teacher evaluation, areas such as life skills, values, and age-appropriate learning remain underdeveloped, weakening overall service quality. In poverty-stricken areas, some evaluation occurs through demonstration classes during URC training sessions, while NGO-run ECCD programs use structured checklists from early childhood development manuals. NGO and private initiatives generally conduct monitoring through inspections by senior officials from head offices, focusing mainly on administrative compliance and financial accountability. Although these systems are more structured than those in many public institutions, they remain fragmented and rarely feed into systematic professional development or service improvement. The absence of a comprehensive teacher evaluation framework weakens quality assurance, particularly regarding life skills, values, and holistic child development.

Monitoring challenges are equally pronounced in the health sector. Key informants highlighted service gaps and instances of misconduct linked to weak monitoring and limited evaluation of frontline health workers. A child and mother health researcher noted,

> We can't go to every community clinic and observe the ECCD-related sessions and healthcare services, as the number of researchers is very few. Now that adequate monitoring is not happening, there remain gaps in services. I have heard about a case of misconduct where the health assistant dedicated to immunization did not provide a single vaccine but took the list of the children. It would not have happened if there were a proper monitoring mechanism. A digitalized monitoring system will be highly effective. [KII, P4]

Public health monitoring largely relies on routine reporting and occasional supervision, with limited field-level verification. NGO-supported health initiatives tend to apply stronger accountability measures, but coverage remains uneven, and monitoring is often project-specific rather than system-wide. Across both sectors, stakeholders emphasized that monitoring is largely compliance-driven and insufficiently linked to service quality or child outcomes. One key informant stressed the need for an integrated approach, stating,

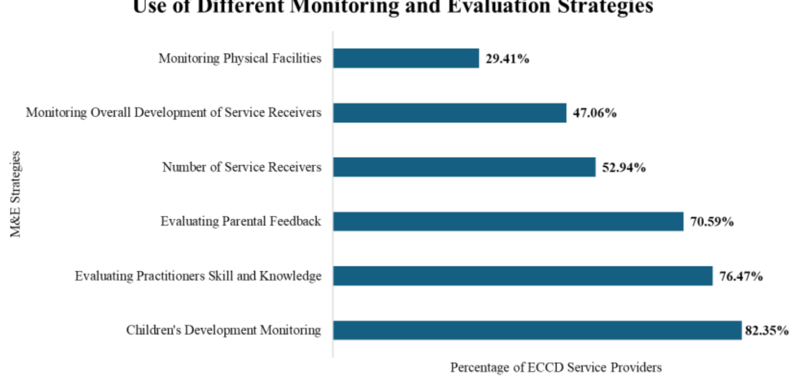
> In my view, unless there is a single, comprehensive plan with clearly defined monitoring and evaluation components, the entire effort will remain sporadic. Conducting isolated surveys or studies, even with strong policy implications, will not lead to significant programmatic changes in overall ECD outcomes. Without integrating M&E into a well-structured plan, meaningful impact is simply not possible. [KII, P7]

It was revealed during FGDs with parents that parental engagement in monitoring and feedback varies widely by institution type and location. Privately-run and NGO-run schools in the urban areas more frequently encourage parental input through meetings and are more responsive towards the complaints, while government schools and ECCD initiatives for the backward populations hold meetings infrequently and report low attendance along with limited awareness of complaint procedures and weak documentation of parental concerns. On the contrary, the key informants

highlight the importance of community involvement along with enforcing a national-level integrated monitoring or central reporting system.

In the survey conducted with the ECCD service providers, 94.12% of them reported being regularly monitored and evaluated employing different strategies.

Figure 17 *Use of Different Monitoring and Evaluation Strategies*



- **Focus on Children and Staff:** The most prevalent practices include monitoring the development of children receiving services (82.35%) and evaluating the skills and knowledge of ECCD practitioners (76.47%).
- **Stakeholder Engagement:** Evaluating parental feedback is a widely implemented strategy, reported by 70.59% of organizations.
- **Operational Tracking**: Monitoring the number of service receivers is moderately common at 52.94%, while nearly half of the organizations (47.06%) monitor the overall development of those receiving services.
- **Infrastructure Oversight:** Assessment of physical facilities is conducted less frequently, with only 29.41% of organizations reporting this practice.

These findings suggest that organizations prioritize child development and staff competence in their M&E efforts, with less focus on infrastructure monitoring.

Overall, a clear gap persists between policy intentions and actual monitoring practices. While ECCD frameworks emphasize participatory, child-centered monitoring, existing systems remain fragmented, administratively focused, and weakly connected to quality improvement. The lack of systematic evaluation, meaningful parental engagement, and integrated monitoring mechanisms limits accountability and constrains progress toward improved ECCD service quality. Limited human resources, fragmented approaches, and weak community participation further undermine accountability. Without centralized oversight, monitoring remains ineffective and fails to ensure equitable service delivery.

8.2.3 Status of Evidence-Based Research and Data in ECCD

Key informants with long-standing engagement in the ECCD sector consistently reported that evidence-based research and data-driven practices in Bangladesh remain limited. Only a small

number of organizations actively conduct ECCD research or systematically generate data, while government agencies show limited reliance on locally generated evidence for decision-making. As a result, promising ECCD initiatives are often not scaled nationally due to insufficient contextual data to support expansion. Reflecting on the limited mainstreaming of evidence-informed programs, one key informant stated,

> Despite center-based practices in 16 districts under the ICBC project, it is still not mainstream. To meaningfully highlight child development, you must have access to holistic, regular (monthly or quarterly) data and information through regular tracking so that research-based initiatives can be scaled up. [KII, P13]

ECCD practitioners across institutions also echoed concerns regarding the overall scarcity of research and reliable data on early childhood development. They emphasized the need for a structured data ecosystem, proposing the establishment of an integrated ECD data hub spanning from the union to national levels. Such a system would enable the systematic storage of child information from birth registration onward, improving data availability for research, monitoring, and program planning.

The lack of locally generated evidence was also highlighted by representatives from the government health sector, who noted that reliance on international data weakens advocacy and planning efforts. One key informant explained,

> We often rely on international evidence to advocate for ECCD, but the lack of strong local evidence makes it harder to build credibility and secure support. Generating context-specific, long-term evidence would help guide investment decisions, identify effective interventions, and support more realistic planning and scaling of ECD programs. [KII, P6]

This statement underscores that without robust local data, ECCD advocacy and program planning remain dependent on external evidence, which may not fully reflect the realities of Bangladesh. While a few research institutions, including ICDDR'B, BRAC IED, and CIPRB, conduct small-scale ECCD studies, often with support from BEN, the overall volume and scope of research remain insufficient for longitudinal tracking or advanced analysis. Government agencies and UNICEF maintain selected datasets, but these are fragmented and inadequate for comprehensive planning.

Stakeholders highlighted the need to expand research into priority areas such as parental situation analysis, parenting counseling, prenatal and postnatal health and development tracking, and the effects of technology use and screen time on early childhood development. Informants further emphasized that heavy reliance on evidence from other country contexts often overlooks critical local factors affecting child development in Bangladesh. Issues such as disability prevalence, climate vulnerability, geographic isolation, arsenic contamination, and salinity in coastal regions were identified as under-researched areas requiring systematic investigation. The importance of inclusive ECCD research, system mapping, and studies on the link between climate change and child development was repeatedly stressed as essential for contextualized planning.

Research on ECCD is widely recognized as essential for strengthening monitoring and evaluation systems and for building an evidence-based implementation ecosystem. It supports needs

assessments, ensures contextual relevance, and helps assess the effectiveness of ongoing initiatives. Robust data enable systematic evaluation of project performance, outcomes, and value for money, informing timely course correction and scaling decisions. In this regard, an ECCD researcher emphasized,

> Without baseline, midline, and endline research, projects are essentially operating in the dark. Clear indicators are necessary to measure whether interventions are working; otherwise, resources continue to be spent on activities that have no proven impact. [KII, P12]

Despite growing recognition of the importance of evidence-based planning, major gaps persist in ECCD research and data systems. These include the absence of a coordinated national research agenda, limited integration between research and monitoring and evaluation systems, weak longitudinal data collection, and restricted access to existing datasets. The lack of a centralized data platform and insufficient focus on local contextual factors further constrain evidence-based decision-making. Without strengthening the research ecosystem and aligning it with monitoring and evaluation frameworks, ECCD initiatives risk remaining fragmented, inefficient, and insufficiently responsive to the needs of children and families across diverse contexts in Bangladesh.

8.3 Collaboration and Coordination

This discussion addresses the coordination landscape of ECCD services in Bangladesh, focusing on policy-level guidelines, the interplay among government, non-government, and private stakeholders, and the operational alignment of services across different regions and sectors.

Policy Provisions and Strategic Guidelines Regarding Collaboration and Coordination in ECCD

The CECCD Policy 2013 envisioned strong collaboration by engaging ministries, agencies, NGOs, private sectors, ECCD networks, development partners, and research institutes from formulation to implementation. It emphasized the establishment of ECCD committees at national, district, and upazila levels, alongside ECCD cells and a Directorate of Child Affairs, to ensure coordination and clear role distribution among stakeholders toward achieving common goals. It advocates for strengthening referral systems across programs and services and highlights the need for a collaborative action plan to scale up quality primary education nationwide. Policy documents emphasize joint responsibility and coordinated service delivery to ensure nurturing care and holistic child development. (MoWCA, 2013a).

The National Strategy for Ensuring ECCD Services for children below 3 recognizes the importance of engaging families and the community altogether in practicing nurturing care, besides strengthening the inter-ministerial collaboration and public-private partnerships (MoH&FW, 2022).

The Nurturing Care Framework advocates for the same through a whole-of-government and whole-of-society approach by bringing together the government, non-government and private

> sector, donor organizations, media, civil society, and academia, besides family and local community, to confirm ECD for every child (WHO et al., 2018).

8.3.1 Status of Inter-Ministerial, NGO, and Private Sector Coordination

Key informants in this study highlighted weak inter-ministerial coordination, inactive ECCD committees, and bureaucratic hurdles as major barriers to quality ECCD services. They particularly mentioned the lack of inter-ministerial coordination, not adopting an ecosystem approach, and the inactivity of the National ECCD Coordination Committee and National ECCD Technical Committee as one of the core reasons behind our low-quality standard ECCD services and advocated for establishing a separate Directorate of Child Affairs for facilitating collaboration and coordination among the stakeholders and getting rid of bureaucratic problems.

An inter-ministerial power imbalance is also an important factor, and due to this, MoWCA often fails to collaborate with the more influential ministries. To balance it out, one key informant working in the health sector recommends the Prime Minister's Office take the lead, saying,

> When one ministry is tasked with leading, many of the action points require compliance from principal secretaries across several line ministries. As a line ministry, how can MoWCA directly instruct the Prime Minister's Office or ensure compliance from other ministries? Therefore, elevating the committee to a higher administrative authority is essential. This would be a major next step for strengthening overall ECD coordination and effective ECD programming in the country. [KII, P15]

Along with that, the frequent change or transfer of government officials disrupts the coordination mechanism, as those who come for short durations often do not have the necessary commitment to drive the policy forward.

While the Department of Primary Education has taken positive steps by aligning its curriculum with national ECCD policy frameworks, strengthened coordination is required to bridge the gap between healthcare interventions and early childhood development. Another key informant highlighted the lack of alignment between initiatives. She/he explained that while, with the support of UNICEF, the Ministry of Health was developing a strategy for children under three, at the same time, the Ministry of Primary and Mass Education (MoPME) was running an ICBC project for children under five. However, the coordination between these two initiatives and what services would be provided in both areas remains a gap.

There is currently no well-coordinated ecosystem among institutions providing ECCD services. This is evident in the absence of a uniform national curriculum for parenting and pre-primary education, with approaches varying from institution to institution. Establishing such an ecosystem would enhance coherence and consistency in service delivery. One proposal to achieve this is the introduction of 10–15 national indicators supported by a robust monitoring framework, ensuring that all institutions work toward common goals and are held accountable. Given the

multidisciplinary nature of ECCD, it has also been suggested that responsibility for coordination be directly assigned to the prime minister's office to secure high-level oversight and integration.

On the other hand, NGOs, despite their proven role in expanding ECCD access, are not formally recognized in policy frameworks and often operate independently due to a lack of government engagement. Private sector involvement is minimal, with few incentives for childcare facilities. While some NGOs and development partners implement successful interventions, these efforts are not integrated into a national system. Key informants stressed the need for government and NGO partnerships and incentives for private childcare facilities. As one of the key informants stated,

> The government perceives that it has sufficient funding and therefore does not require NGO involvement. Despite repeated recommendations emphasizing that experienced NGOs are essential for maintaining pre-primary education quality, the government did not show any interest. Hence, the NGOs are now largely operating independently according to their own approaches. Also, the government can incentivize private sector organizations to provide child care facilities for female employees, fostering a collaborative approach to expanding early childhood care services along with implementing provisions like “cost of doing business” for ensuring private investment in ECCD. [KII, P7]

This finding highlights a significant gap in governance. The exclusion of NGOs from national policy frameworks results in fragmented and independent operations that do not utilize established expertise effectively. Additionally, the absence of incentives for private sector involvement hinders a cohesive and collaborative approach to expanding and sustaining high-quality ECCD services.

The disconnect lies in the inactive coordination structures and the power imbalance between ministries. Despite policy provisions for multi-level committees and collaborative mechanisms, ECCD services remain fragmented, with MoWCA unable to enforce compliance or sustain long-term coordination. The absence of an ecosystem approach and reliance on bureaucratic processes, lack of a uniform curriculum, inactive coordination mechanisms, and poor alignment between ministries weaken accountability and hinder the development of a coherent national ECCD program. Government–NGO partnerships are underutilized, and private sector contributions are not incentivized. The absence of a coordinated framework results in fragmented implementation, undermining the quality and equity of ECCD services. Without strong recognition of NGOs’ contributions and alignment across ministries, ECCD remains piecemeal rather than systemic.

8.3.2 Status of Coordination in Different Regions and Sectors

Evidence from the field shows mixed levels of coordination. In some regions, effective collaboration exists; for example, vaccination information is shared through Para Kendro, resulting in successful vaccination programs through joint efforts of health and education departments. An Upazila Assistant Primary Education Officer from a coastal district highlighted that collaboration with the health directorate had resulted in a 90% success rate in vaccination programs. He further

noted that healthcare services for children were being delivered collectively through the involvement of multiple departments.

Some degree of coordination exists in education services across remote and disadvantaged areas such as poverty-stricken, char, haor, and urban regions. In poverty-stricken areas, NGOs collaborate with underdeveloped primary schools by providing learning materials and instructional support through Education Support Organizers. In urban settings, schools coordinate educational activities and maintain communication with parents, while referral systems help connect families with hospitals and schools for necessary services. Urban preschools show limited coordination, though some partner with university departments or related institutions to organize parent seminars on child development issues such as speech delays. Practitioners in poverty-stricken and haor areas also noted coordination between education and health services, particularly vaccination programs, facilitated by both government and NGO initiatives. In some cases, Deputy Commissioners (DCs), Additional Deputy Commissioners (ADCs), and Upazila Nirbahi Officers (UNOs) are invited to participate in NGO-led activities, strengthening collaboration. In hilly regions, program personnel reported contacting government and social welfare organizations to provide educational services for children with special needs. Similarly, a practitioner from a primary school in an urban area explained that, after children from disadvantaged communities complete primary education, they attempt to engage local secondary school administrations to arrange learning materials and free education opportunities.

Despite these practices, coordination remains limited and inconsistent. In hilly areas, coordination is minimal. A Primary Teacher Training Institute (PTI) instructor reported that they only follow the prescribed curriculum to train teachers and are not engaged in coordinating services. In urban regions, coordination between government and non-government institutions is weak, leaving parents to manage services themselves. NGOs attempting to collaborate with government primary schools often face negative attitudes and disagreements, particularly around differences in service provision, such as stipends and exclusion from Upazila Education Office meetings. In rural and char areas, services are delivered in a scattered manner, with limited communication between institutions. Overall, while some coordination exists, it is fragmented and lacks continuity across regions. However, NGOs have expressed interest in partnering with government and international organizations to establish minimum quality standards for childcare, signaling a willingness to strengthen coordination and improve service delivery.

Meetings organized by the Family Planning Department also involve health volunteers and union supervisors, ensuring follow-up and accountability. However, in other areas of services, such as developmental services and referrals, provision remains inconsistent. Program personnel often attempt to meet needs beyond their scope or make ad-hoc referrals, but systematic collaboration is absent.

Parents in most regions lack awareness of collaboration mechanisms and are engaged only marginally through meetings, often limited to receiving information rather than contributing to decisions. Positive examples exist in poverty-stricken schools supported by NGOs, where coordinated efforts have improved services, and in hilly regions where health and education sectors collaborate effectively on vaccination campaigns. Similarly, in poverty-stricken areas, community clinics disseminate vaccination information through neighborhood centers. However, in

marginalized areas such as the char region, parents report no opportunities to participate and no evidence of coordination among service providers.

Key informants emphasized the need for a national ecosystem to align services and map needs across regions. A key informant said,

> Some may be working on education, some may be working on health. Some overlap. If such an ecosystem could be established where there would be a national structure, a mapping of who has what needs, what needs are in which areas, and if we work accordingly, we would be able to understand the progress. [KII, P5]

This finding indicates the urgent need for a centralized national ecosystem to harmonize fragmented health and education services through strategic regional mapping. Such an approach would eliminate service overlaps and enable a data-driven assessment of progress by aligning interventions with the specific, localized needs of various communities.

The disconnect lies in the uneven and inconsistent coordination across regions and sectors. While policy envisions strong collaboration, practices vary widely; some areas demonstrate effective joint action, while others lack communication altogether. Referral systems are weak, developmental services are fragmented, minimal parental involvement beyond meetings, and partnerships remain sporadic. This inconsistency undermines the sustainability and equity of ECCD service delivery.

Highlights of Findings on Financing, Monitoring, Evaluation, and Research Ecosystem, and Collaboration and Coordination in ECCD

- **Over-Reliance on Donor Funding and Limited Government Financing**

  ECCD financing in Bangladesh is heavily dependent on time-bound donor contributions, while public funding remains limited and unpredictable. Self-funded initiatives operate inconsistently, often compromising service quality. The absence of sustained, institutionalized government financing restricts the scalability and long-term sustainability of effective ECCD programs.

- **Lack of Disaggregated Budgets and Inefficient Resource Allocation**

  ECCD services are embedded within broader health, nutrition, and education budgets without a clear breakdown, making it difficult to track funds. Budget allocations are largely input-driven rather than need-based, limiting service quality and responsiveness to local needs. Weak transparency and minimal local-level involvement in budgeting further reduce accountability and effective use of resources.

- **High Household Expenditure and Limited Parental Awareness**

Household expenses for ECCD place a significant burden on parents, restricting access and participation, especially to the economically disadvantaged families. While wealthier parents perceive services as valuable, poorer households struggle to meet basic costs and rely on external support. Limited parental understanding of ECCD benefits further weakens investment in early childhood development, reinforcing inequities in access and outcomes.

- **Fragmented and Weak Child Data and Record-Keeping Systems**

  Across regions, ECCD record-keeping remains irregular, minimal, and largely administrative. Data collection is mostly limited to birth registration and vaccination records, with little systematic tracking of children's growth, development, or well-being. Modern M&E and data dissemination tools are barely used. Practices vary widely by geography and service provider, and collected information is rarely analyzed or used for planning. This fragmentation limits accountability and reduces the usefulness of data for improving ECCD services.

- **Inconsistent and Compliance-Driven Monitoring and Evaluation Practices**

  Monitoring and evaluation in ECCD are uneven, fragmented, and primarily focused on administrative compliance rather than service quality or child outcomes. Even though ECCD organizations claim to focus on children's development and staff competence, less attention is given to infrastructure and overall service reach. Limited human resources and the absence of structured evaluation frameworks restrict meaningful assessment of ECCD practices and holistic child development. Parental engagement in monitoring is weak and inconsistent, while the lack of integrated oversight prevents feedback from translating into system-level improvements.

- **Underdeveloped Evidence-Based Research and Data Ecosystem**

  Evidence-based ECCD research and data generation remain limited, with only a few institutions producing small-scale studies. The absence of coordinated research agendas, longitudinal data, and centralized data platforms constrains the scaling of effective initiatives. Heavy reliance on non-contextual evidence further weakens decision-making, leaving critical local factors insufficiently explored and limiting data-driven planning, investment, and program adaptation.

- **Policy-Level Coordination Structures Exist but Are Largely Non-Functional**

  Although national policies envision strong inter-ministerial and multi-stakeholder collaboration through formal ECCD committees and coordination mechanisms, these structures remain mostly inactive. Weak leadership authority, bureaucratic processes, frequent staff turnover, and inter-ministerial power imbalances, particularly limiting MoWCA's role, have resulted in fragmented planning, poor accountability, and ineffective coordination across sectors.

- **Absence of an Integrated ECCD Ecosystem Leads to Fragmented Service Delivery**

ECCD services operate without a unified national ecosystem linking health, education, parenting support, and developmental services. Parallel initiatives targeting different age groups lack alignment, referral systems are weak, and the absence of a uniform curriculum, shared indicators, and a common monitoring framework contributes to inconsistent quality and uneven service coverage nationwide.

- **Coordination Is Uneven Across Regions and Remains Largely Issue-Specific**

  Field evidence shows isolated examples of effective coordination, most notably in vaccination and basic education services, particularly in some poverty-stricken, haor, and urban areas. However, coordination remains inconsistent across regions, limited in scope, and highly dependent on individual leadership rather than institutionalized systems, with hilly, char, and urban areas often experiencing fragmented or minimal collaboration.

- **NGO, Private Sector, and Community Engagement Are Underutilized**

  Despite NGOs' demonstrated capacity to expand ECCD access and improve service quality, their contributions are not systematically integrated into national coordination frameworks. Private sector involvement remains minimal due to a lack of incentives, and parental participation is largely limited to information-sharing rather than decision-making. This underutilization of non-state actors further weakens system coherence and sustainability.

Major Recommendations

- **Institutionalize Sustainable Public Financing for ECCD**

  A dedicated and predictable public financing mechanism for ECCD should be institutionalized to reduce dependence on time-bound donor funding and ensure long-term sustainability. This requires consolidating ECCD-related allocations and costed action plan across ministries under a coordinated financing framework and progressively increasing government budget commitments. Strengthening public ownership is essential to scale effective models, ensure equitable coverage across regions, and safeguard continuity beyond project cycles.

- **Introduce Disaggregated, Need-Based Budgeting with Enhanced Transparency**

  ECCD budgeting should be clearly disaggregated within national and sectoral budgets and linked to need-based planning rather than uniform input allocations. Transparent budget disclosure, combined with participatory planning involving local institutions and communities, can improve accountability and trust in resource use. Aligning budget allocation with service demand, quality standards, and regional disparities will enable more efficient and equitable resource utilization.

- **Reduce Household Financial Burden through Targeted Support and Parental Awareness**

  Targeted financial support mechanisms should be strengthened to reduce the burden of ECCD costs on economically disadvantaged families, particularly in high-poverty and vulnerable regions. At the same time, parental awareness initiatives should be expanded to improve understanding of ECCD as a long-term investment rather than a short-term expense. Combining financial assistance with awareness-building can increase participation, promote equity, and improve early childhood outcomes.

- **Establish an Integrated and Functional Child Data and Record-Keeping Practice**

  The government should establish a nationally standardized child data management system that ensures consistent collection of key indicators, including birth registration, vaccination, nutrition, weight, height, and developmental milestones across all regions. Local governments, schools, and daycare centers must be mandated to maintain updated records, supported by standardizing simple data tools across sectors, linking existing records maintained by education, health, and social services, regular audits, and participatory monitoring frameworks. NGOs and community-based organizations should be integrated to harmonize practices in underserved areas, while ECCD personnel receive training in systematic data collection and utilization.

- **Institutionalize a Consistent and Participatory Monitoring and Evaluation System**

  The government should establish a digitalized, integrated monitoring and evaluation system for ECCD, enabling real-time tracking of services across institutions by introducing structured observation tools, clear performance indicators, and regular feedback mechanisms. Monitoring must extend beyond administrative oversight to include quality assurance and coverage of services, physical facilities, infrastructure, child health, and developmental outcomes. Local governments, school committees, parents, NGOs, and other stakeholders should be formally engaged in participatory monitoring, fostering accountability and community ownership.

- **Strengthen National ECCD Evidence and Research Ecosystem**

  A national ECCD research and data hub from local to national level should be established, and ECCD research should be systematically integrated into planning and monitoring processes to ensure programs are informed by local evidence rather than external assumptions. This can be operationalized by defining national research priorities, improving access to administrative and survey data, and encouraging collaboration between government agencies, research institutions, and implementing organizations. Investing in longitudinal and implementation-focused research would support timely course correction, efficient resource allocation, and the scaling of effective models. Strengthening this ecosystem is essential to move from policy aspiration to data-driven action.

- **Elevating ECCD Oversight for Integrated National Coordination**

ECCD oversight should be elevated to a higher administrative authority, ideally the Prime Minister's Office, to ensure inter-ministerial compliance and balanced power dynamics. A separate Directorate of Child Affairs must be established to facilitate collaboration, reduce bureaucratic hurdles, and strengthen accountability. ECCD committees at all levels should be reactivated with clear mandates, while mechanisms must be introduced to minimize disruption caused by frequent official transfers. By institutionalizing high-level oversight and revitalizing coordination structures, Bangladesh can transform fragmented efforts into a coherent, accountable, and sustainable ECCD system.

- **Institutionalizing Multisectoral Partnerships for ECCD Coordination**

  The government should establish a formal multisectoral ECCD coordination framework that integrates ministries, NGOs, and private sector actors under shared accountability. Experienced NGOs must be recognized as essential partners, with government funding mechanisms supporting their implementation capacity. Private sector organizations should be incentivized to provide childcare facilities, linking ECCD to workforce participation and economic growth. Referral systems across health, education, and nutrition services should be strengthened to ensure continuity of care.

- **Strengthening Regional Coordination and Institutionalizing Parental Engagement in ECCD**

  The government should establish structured coordination mechanisms across all regions, ensuring that health, education, and social service providers collaborate consistently. Mobile service delivery, community-based learning spaces, and enhanced outreach through clinics and schools can help reduce persistent regional inequities. Local governments should be empowered to convene regular multi-stakeholder meetings, integrating NGOs, universities, and community organizations into ECCD service delivery. Parents must be formally integrated into ECCD governance through decision-making committees, participatory monitoring, and feedback systems, moving beyond passive involvement in meetings.

Conclusion

This chapter demonstrates that despite strong policy commitments, ECCD implementation in Bangladesh remains constrained by fragmented financing, weak coordination, inadequate monitoring systems, and an underdeveloped research ecosystem. Over-reliance on donor funding, lack of disaggregated and need-based budgeting, and uneven household capacity continue to undermine the equity, quality, and sustainability of ECCD services. The findings further reveal a persistent gap between policy intent and practice, reflected in inconsistent monitoring, limited use of evidence, and weak inter-ministerial and cross-sectoral collaboration. Addressing these

structural and systemic weaknesses through integrated financing, robust data systems, strengthened coordination, and institutionalized accountability is essential to transform ECCD from fragmented initiatives into a coherent, sustainable, and child-centered national system.

Chapter Nine: Discussion and Major Recommendations

This chapter synthesizes the empirical findings of this study to critically examine the status of Early Childhood Care and Development (ECCD) services in Bangladesh across the full developmental continuum, from prenatal and perinatal care to early primary education (6–8 years). Drawing on survey data, IDIs, FGDs, KIIs, and observations, the chapter situates field evidence within national policy frameworks such as the Comprehensive Early Childhood Care and Development Policy 2013 and the National Education Policy 2010, while engaging with relevant regional and global literature for comparative insight. It examines access, quality, equity, financing, monitoring, and multisectoral coordination to assess whether Bangladesh has effectively operationalized a holistic, life-cycle approach to child development. By comparing policy commitments with implementation realities, the chapter identifies systemic gaps and structural constraints. It further evaluates the broader ECCD ecosystem's functionality, including governance, institutional coordination, and stakeholder engagement. The discussion ultimately lays the foundation for strategic, evidence-based recommendations to strengthen an integrated, inclusive national ECCD system.

9.1 Prenatal and Perinatal Care Services

This section presents the current status of Early Childhood Care and Development (ECCD) services in Bangladesh during the prenatal and perinatal stages, drawing on surveys, IDIs, FGDs, KIIs, and observations, and situating findings within existing policies, reports and literature.

9.1.1 Access and Coverage of Prenatal and Perinatal Care Services

National policies, including the National Children Policy 2011 and CECCD Policy 2013, emphasize maternal and neonatal health as foundational for early childhood development. Services include maternal nutrition, antenatal care (ANC), breastfeeding counselling, immunisation, and essential newborn care, delivered primarily through community clinics, outreach programs, and maternal health initiatives. Policies also highlight preconception awareness, family involvement, and maternal mental wellbeing as components of nurturing care. However, evidence of systematic integration of mental health and responsive caregiving support in routine maternal services is limited.

Bangladesh has developed a strong policy foundation supporting early child development from the prenatal stage. Inclusion of maternal nutrition, ANC, breastfeeding promotion, and parenting support reflects recognition of the role of maternal health and caregiving environments in child development. These policy commitments align with global frameworks like the nurturing care approach, which emphasizes integrated health, nutrition, safety, responsive caregiving, and early learning from pregnancy onward (WHO et al., 2018). Community-based platforms offer high potential to reach rural populations with maternal and newborn services. Sectoral programs have strengthened awareness on maternal nutrition, early breastfeeding, and newborn care.

National data indicate notable improvements: around 80% of women receive at least some ANC, skilled birth attendance reaches 70%, 75.7% of mothers receive essential ANC tests, 71% of deliveries occur in health facilities, and 77% of births are attended by skilled personnel (BBS, 2025; Agarwala et al., 2024). However, continuity gaps remain: only 43.4% of pregnant mothers receive four or more ANC visits, and postnatal care within two days remains low. This study's parent survey mirrors these patterns, showing most mothers attended only 1–3 ANC visits, reflecting limited preconception and community-level awareness. Similar barriers such as financial constraints, limited awareness, transport issues, and perceived low service quality have been documented in previous studies conducted upon Bangladesh and India (BBS, 2025; Girotra et al., 2023). In contrast, countries with higher rate of four or more ANC coverage, such as Indonesia, Zimbabwe, and the Philippines, benefit from financial support, better access, integrated services, and supportive policies (Andriani et al., 2022; Wulandari et al., 2021; Tessema & Minyihun, 2021).

Geographic disparities influence service access. Families in haor and char areas face substantial barriers, consistent with prior findings on remote regions' limited access to skilled care (Agarwala et al., 2024). Similarly, urban areas in India, Indonesia, and the Philippines show higher accessibility compared to rural vulnerable regions, and community-based action plans like in the Philippines may help reduce disparities to a certain extent (Wulandari et al., 2021). Community-level maternal health awareness initiatives implemented under the Health, Population and Nutrition Sector Programme (HPNSP) were reported to have limited geographic coverage and have remained suspended following the program's completion. Interruptions in program activities can therefore weaken community-level health promotion and reduce awareness regarding maternal and newborn care.

Family dynamics are influential. Although many mothers participating in this study reported receiving emotional and practical support from family members, healthcare decisions during pregnancy were often influenced by husbands, mothers-in-law, or other senior household members. Similar patterns have been widely documented in maternal health studies conducted across South Asia, where extended family structures frequently influence women's health-seeking behaviour during pregnancy and childbirth (Andriani et al., 2022; Tessema & Minyihun, 2021). Evidence from Bangladesh also suggests that traditional beliefs and misconceptions within households can sometimes discourage the adoption of recommended prenatal and postnatal practices. In some cases, families discourage women from taking nutritional supplements or seeking medical care due to fears of side effects or reliance on traditional remedies (Kraemer, 2023).

Another critical gap identified in this study relates to maternal mental health support. While recognized as essential for early child development, mothers reported limited access to counselling or psychosocial support during pregnancy and postpartum. Healthcare professionals cited insufficient training and resources to address maternal mental health, despite evidence from

countries with improved prenatal and perinatal care emphasizing psychosocial support alongside physical care (Schmidt & Bachmann, 2021).

Overall, Bangladesh has comprehensive policy frameworks for prenatal and perinatal care, yet uneven coverage, limited parental awareness, sociocultural influences, and absence of structured maternal mental health services constrain effective service delivery.

9.1.2 Quality of Services during Prenatal and Perinatal Stages

Despite national policies emphasizing improvements in maternal and neonatal care, service quality remains inconsistent across Bangladesh. Mothers reported limited trust in public healthcare due to perceived gaps in provider competency, inadequate monitoring during childbirth, and weak facility management. Shortages of trained personnel, high doctor–patient ratios, and inconsistent provider attitudes further compromise quality.

Infrastructure and facility readiness are critical challenges, particularly in remote areas such as hill tracts, chars, and haor regions. Many community clinics and health complexes lack essential equipment, counselling services, and specialized units such as neonatal intensive care facilities (NICUs). Even in urban areas, NICU scarcity often forces families to rely on private care, increasing financial pressure. Maternal nutrition programs also face frequent shortages of essential supplements like iron, folic acid, and calcium, reducing the effectiveness of preventive care interventions.

The study reveals discrepancies between policy intent and service realities. The CECCD Policy and its operational and implementation plan emphasize workforce competency, facility readiness, and emergency obstetric care (MoWCA, 2013a; 2013b), yet implementation gaps persist. High workloads, inadequate training, and insufficient supervision undermine the quality of care. Mothers frequently reported experiences of dismissive attitudes or rushed consultations, reducing confidence in healthcare facilities. Such patterns mirror findings from other South Asian countries, where disrespectful maternity care, lack of dignity during childbirth, and limited postnatal support undermine facility-based services despite increased institutional deliveries (Dey et al., 2017; Sudhinaraset et al., 2016; Varghese et al., 2014; Hameed & Avan, 2018; Maheen et al., 2020; Waqas et al., 2020).

Facility readiness is another constraint. Many health complexes are inadequately equipped to deliver comprehensive prenatal and neonatal services. Shortages in medical supplies, inconsistent availability of supplements, and lack of functional equipment limit service quality. Moreover, insufficient attention to counselling and psychosocial support reduces mothers' preparedness for childbirth and newborn care. In remote areas, mothers often rely on informal advice or phone consultations, highlighting gaps in both infrastructure and service delivery capacity. Comparable challenges have been observed in Nepal, where weak healthcare infrastructure and limited skilled

birth attendants restrict access to safe and quality care in rural and vulnerable communities (Baral et al., 2016; Devkota et al., 2018).

Maternal nutrition support programs demonstrate mixed effectiveness. While national strategies aim to provide essential supplements and nutritional counselling, frequent shortages and inconsistent follow-up reduce uptake. Iron, folic acid, and calcium are often unavailable at community clinics, and healthcare providers sometimes hesitate to promote these services due to institutional capacity limitations. This reduces continuity and efficacy of preventive maternal care interventions, leaving mothers at risk of anemia, micronutrient deficiencies, and other complications.

Workforce competency and capacity remain central to improving quality. Mothers in urban, rural, and hill tract areas reported concerns about provider knowledge, attitude, and communication skills. Training gaps, insufficient mentorship, and high patient volumes exacerbate these challenges. Similar concerns have been documented in previous studies in Bangladesh, which highlight that high workloads among healthcare workers, limited communication with patients, and inadequate patient engagement reduce maternal satisfaction and confidence in health services (Bogren et al., 2018; Dynes et al., 2011; Gamage et al., 2022). These challenges are not unique to Bangladesh but are widely observed across South Asian maternal healthcare systems. In India, disrespectful maternity care, lack of dignity during childbirth, and limited postnatal support undermine women's trust in facility-based delivery services despite increased institutional delivery rates (Dey et al., 2017; Sudhinaraset et al., 2016; Varghese et al., 2014). Similarly, evidence from Pakistan shows that women often prefer traditional birth attendants due to perceptions of more respectful and culturally sensitive care, especially where formal healthcare providers are perceived as dismissive or inaccessible (Hameed & Avan, 2018; Maheen et al., 2020; Waqas et al., 2020).

In sum, despite strong policy commitments, the quality of prenatal and perinatal services is undermined by workforce limitations, infrastructure gaps, insufficient supplies, and weak communication with communities. Strengthening provider training, improving facility readiness, ensuring consistent medical supplies, expanding NICU and specialized care access, and integrating counselling services are essential to improve reliability, maternal satisfaction, and newborn outcomes.

9.1.3 Equity and Inclusion in Services during Prenatal and Perinatal Stages

Significant disparities persist in prenatal and perinatal care services, despite policy commitments. Financial limitations force low-income families to rely on under-resourced public facilities, while private care remains unaffordable. Geographic disparities in climate-vulnerable and remote regions restrict access to infrastructure and skilled personnel. Long waiting times and high patient loads indirectly discriminate against disadvantaged mothers. Knowledge gaps regarding maternal programs further limit utilisation. Gender norms and cultural attitudes affect service prioritisation,

particularly in rural and hill tract communities. Targeted outreach exists for some indigenous populations, but marginalized groups and mothers with disabilities receive limited support. Existing policies neglect maternal healthcare accessibility for women with physical, sensory, or cognitive impairments.

Financial barriers remain critical, as low-income mothers face staff shortages and high patient volumes, affecting care quality. Similar trends occur in India, Pakistan, and Nepal, where financial limitations often restrict access to skilled prenatal and perinatal care services (Sudhinaraset et al., 2016; Baral et al., 2016; Mehata et al., 2017). On the contrary, countries like the Philippines and Finland demonstrate better access through equitable government initiatives, regardless of socioeconomic status (Schmidt & Bachmann, 2021; Bhowmik et al., 2020). Geographic barriers further exacerbate inequities in remote and climate-vulnerable regions. Mothers living in remote and climate-vulnerable areas such as coastal regions, chars, haors, and hill tracts often face limited access to healthcare infrastructure and specialized services. Comparable challenges have been reported in Nepal, where rural women experience difficulty accessing skilled birth attendants due to geographic isolation and weak healthcare infrastructure (Baral et al., 2016; Devkota et al., 2018).

Inclusion gaps persist for marginalized populations. While some indigenous communities benefit from outreach, consistent mechanisms for other vulnerable groups are absent. Besides, the existing policy framework ignores the specific healthcare needs of pregnant women with physical, sensory, or cognitive impairments, despite the fact that women with disabilities often face additional barriers related to physical accessibility, communication barriers, and social stigma when accessing healthcare services (Devkota et al., 2018).

Overall, equitable and inclusive prenatal and perinatal healthcare in Bangladesh requires simultaneous attention to structural and social barriers. Strengthening healthcare infrastructure in remote areas, expanding financial protection, improving awareness of available programs, and incorporating disability-inclusive strategies are essential to ensure all mothers receive respectful, high-quality care.

9.2 ECCE Services for Children Aged 0-3

This section discusses the current status of Early Childhood Care and Education (ECCE) services for children aged 0-3 in Bangladesh. The discussion draws on findings from surveys, IDIs, FGDs, KIIs, and observations, and compares them with existing national policies, reports, and relevant literature.

9.2.1 Access and Coverage of the ECCE Services for Children Aged 0-3

National policies and strategic guidelines, including The CECCD policy 2013 and The National Comprehensive ECCD Strategy in Bangladesh emphasizes a holistic ECCD approach, including healthcare, nutrition, protection, responsive caregiving, and early learning through promoting the Essential Service Package, linking primary health care centers with para centers, establishing daycare centers, and utilizing community-based and institutional supports (MoWCA, 2013a; MoHFW, 2022). However, in practice, the available services are largely health and nutrition-focused. Available services include birth registration, immunization (EPI), nutrition services (NNS), childhood illness management (IMCI), and growth monitoring, along with scattered day-care facilities and breastfeeding corners. Lack of services focusing on early learning, psycho-social care, safety and protection, parental coaching, and responsive caregiving presents a challenge for the holistic development of children.

The CECCD policy 2013, envisioning a comprehensive Essential Service Package (ESP) for children aged 0-3 years, integrating healthcare, nutrition, protection, responsive caregiving, and early learning, reflects a strong policy commitment towards a holistic developmental model, which recognizes the importance of development and safety-related services along with survival-related services for a child. This policy commitment aligns with global frameworks such as the Nurturing Care Framework, which emphasizes health care and nutrition, responsive caregiving, safety and security, and early learning opportunities services for children aged 0-3(WHO et al., 2018).

Parent-reported data on the Nurturing Care Framework reveal significant service access gaps. While 71.15% of parents reported access to healthcare and 59.62% to nutrition-related ECCD services, only 26.92% had early learning opportunities, and 20.19% accessed safety and psycho-social care. The most severe gap was in responsive caregiving, with just 10.58% of parents receiving support for engaging with their child's needs. This survival-centric trend is consistent with other lower-to-middle-income countries like the Philippines and Indonesia, where early learning and caregiver interaction are rarely integrated into routine service delivery (Suparto et al., 2021; Ulep et al., 2024). In contrast, in some high-income countries such as Finland, routine ECCD services incorporate play-based early learning to meet the developmental needs of children (Salminen, 2017; Narvi et al., 2020; Niu et al., 20240).

Limited integrated ECCD services through existing health and nutrition platforms are implemented in Bangladesh.

Access to integrated ECCD services through existing health and nutrition platforms is limited in some specific piloting areas in Bangladesh. Resource shortage, limited capacity, work overload, and limited training opportunities for workers make it challenging to deliver ECCE along with health care services in every corner of the country, including these piloting areas. Similarly, in India and Indonesia, frontline workers in community-based programs often lack training in early childhood development beyond basic health and nutrition (Gopalakrishnan et al., 2025; Suparto et al., 2021). Although health and nutrition services receive focused efforts, the MICS 2025 data

indicate that 64.8% of children aged 6-23 months experience food poverty. This indicates the preparation gap for enhancing integrated ECCD services.

National data indicate that the percentage of children (aged 24 to 59 months) receiving four or more stimulation activities from any household adult decreased from 78% to 35.1% over the decade. Father involvement remains extremely low at only 2.6%, and mother engagement, although higher than fathers', also dropped to 27.2% (BBS & UNICEF, 2025). This gap in stimulation and early learning opportunities persists at the household-level practices due to the rise of parents' additional engagement, nuclear families, and a lack of awareness initiatives for the families and communities.

Another challenge for children's protection, responsive caregiving, and structured early learning opportunities is the low utilization of daycare services. Only 14.42% of parents reported in the parents survey that they utilize daycare centre services for their children. The uptake of daycare services remains low due to strong socio-cultural stigma and insecurity regarding the service quality. The service quality of these daycare centers is lacking due to a shortage of trained ECCD personnel, inconsistent training opportunities, the absence of a safe and child-friendly environment, and weak inclusive practices. In contrast, Finland offers universally accessible daycare services that focus on holistic development, play-based learning, and inclusion. Daycare services in Finland are publicly financed, whereas in Bangladesh, they are largely managed by NGOs and private organizations. This difference may contribute to the quality gap observed in these services.

Overall, despite strong policy alignment with global frameworks, access to ECCE services for children aged 0-3 remains fragmented and disproportionately health-oriented. The absence of systematic integration between survival and developmental components limits the realization of a truly holistic ECCD model and weakens early developmental foundations.

9.2.2 Quality of the ECCE Services for Children Aged 0-3

To ensure safe, child-friendly, and stimulating environments in health centers, community clinics, and Early Childhood Care and Development (ECCD) facilities, national policies emphasize the importance of developing infrastructure, building a skilled workforce, and enhancing the capacities of stakeholders (MoWCA, 2013a). Strategic guidelines further stress the need to improve the quality of nurturing care by updating ECCD training materials, training service providers and caregivers, orienting managers at all levels, and introducing certification courses on child development (MoHFW, 2022). Despite these policy commitments and strategic recommendations, there is a significant gap in structural and regulatory implementation due to poor enforcement, lack of infrastructure, and not enough skilled workers.

In community health care centers and daycare facilities, the infrastructure for children aged 0 to 3 is inadequate. There is a shortage of space, a lack of child-friendly environments, insufficient play

areas, and inadequate safety measures in these organizations. Home-based daycare centers also face challenges, including poor-quality environments with a scarcity of toys and dark, humid rooms. These conditions raise concerns among parents about leaving their children in daycare. Additionally, there is a significant gap in inclusive practices, as most facilities lack the necessary physical accommodations for children with special needs, such as specialized equipment, ramps, walkers, and therapeutic facilities.

The challenges in early childhood care and development (ECCD) are exacerbated by an untrained and unregulated workforce, as well as an insufficient number of qualified professionals. The number of certified workers with knowledge in ECCD, such as understanding developmental milestones, child psychology, and early detection of abnormalities, is very low. Additionally, there is a lack of commitment and inadequate training resources for healthcare and community health workers. Educators and caregivers often lack the necessary skills to support children with special needs, which is why many daycare centers do not admit these children. In numerous institutions, there are no paraeducators or additional support staff to assist the primary teacher or caregiver. This trend mirrors challenges in Singapore, where care quality varies significantly due to workforce skill disparities and a reliance on minimum qualification thresholds rather than specialized ECCD expertise (Wu & Perisamy, 2021).

Overall, Quality gaps stem not from policy absence but from weak institutional capacity, insufficient professionalization, and limited regulatory oversight. Without strengthening workforce development and infrastructure standards, expanded access alone cannot ensure developmentally appropriate and inclusive care for children aged 0-3.

9.2.3 Equity and Inclusion in ECCE Services for Children Aged 0-3

Bangladesh's national policies, acts, and strategic guidelines focus on equitable Early Childhood Care and Development (ECCD) services for children from low-income backgrounds, remote areas, and with special needs. The policies advocate for Essential Service Packages, quality day care centers in factories for low-income families (MoWCA, 2013a), and strengthened National Nutrition Services for vulnerable children (MoF, 2022). Policies promote universality, but the service landscape primarily benefits the elite and the poorest, leaving the urban middle class underserved. Children under three in hard-to-reach areas, including indigenous communities and urban slums, have limited access to early childhood care and development (ECCD) services, particularly in their first 1,000 days. Additionally, services often lack early detection systems, trained staff, disability-friendly infrastructure, and effective referral mechanisms.

Socioeconomic status creates formidable barriers to accessing essential Early Childhood Care and Development (ECCD) services. While in the parents' survey, 13.46% of parents reported experiencing discrimination in service access, the vast majority of this group (92.86%) cited

financial hardship as the primary driver, followed by social status (28.57%). These findings indicate that for the most vulnerable families, discrimination is structural, rooted in an inability to meet the costs associated with quality care and development. Wealthier families can secure resources for their children's development, such as nutritious food and quality daycare. In contrast, low-income communities often benefit from targeted support from the government and NGOs, which provide trained caregivers and child-focused programs. However, urban middle-class families struggle to access these services due to limited income, as there are no low-cost options available for them.

In addition, there continue to be gaps in inclusion for marginalized populations. Children under the age of 3 in hard-to-reach areas, such as indigenous communities, regions affected by climate change, coastal areas, tea gardens, and urban slums, have very limited access to ECCD interventions, especially during their critical first 1000 days. Most initiatives by NGOs and the government focus on preschool-aged children, resulting in a disconnect between policy and practice for the 0-3 age group. A similar situation has been observed in Canada, despite it being a developed country. A study revealed that indigenous children in Canada experience poorer health and nutrition outcomes compared to national averages, highlighting the gaps in inclusion for marginalized populations (Findlay, 2019; Halseth & Greenwood, 2019).

There are not only structural but also systemic and cultural gaps that impede equitable early childhood care and development (ECCD) services for children with disabilities or developmental delays. The limited availability of services for the early detection of these disabilities poses a significant challenge in identifying individual needs and implementing necessary interventions for inclusive care. The absence of screening and referral mechanisms at the upazila level further complicates matters, as many children remain unidentified until they enter school. This situation parallels the Integrated Child Development Services in India, where developmental screening is also limited, leading to difficulties in identifying potential delays in movement, speech, cognition, or behavior (Chathukulam & Joseph, 2025; Kumar et al., 2022). Additionally, the challenges are worsened by a shortage of trained professionals, inadequate disability-friendly infrastructure, a lack of parental awareness, and hesitance in accessing services.

Overall, Equity challenges in ECCE for 0-3-year-olds are systemic rather than incidental. Geographic isolation, poverty, limited screening systems, and weak inclusive infrastructure collectively restrict developmental opportunities for the most vulnerable children. Addressing these disparities requires not only targeted programs but a structurally integrated, universally accessible ECCD ecosystem that bridges socioeconomic and geographic divides.

9.3 Services during Transition to Primary Stage

This section discusses the current status of Early Childhood Care and Development (ECCD) services supporting the transition to primary education for children aged 3–6 in Bangladesh. The discussion draws on findings from surveys, IDIs, FGDs, KIIs, and observations, and compares them with existing national policies, reports, and relevant literature.

9.3.1 Access and Coverage of Services Supporting Transition to Primary Stage for Children Aged 3–6

Bangladesh has established several policy commitments to support Early Childhood Care and Education (ECCE) for children aged 3–6 through frameworks such as the National Education Policy 2010 and the Comprehensive Early Childhood Care and Development (CECCD) Policy 2013. Despite these commitments, service coverage and participation remain uneven. While some children benefit from government, NGO, and private initiatives, many still lack consistent access to integrated services combining health, nutrition, protection, and early learning. Participation of children below five in ECCE remains particularly limited, and expansion of universal pre-primary education continues to face constraints related to resources, infrastructure, and parental awareness.

The findings reveal a clear gap between policy commitments and the actual provision of ECCE services. Although the CECCD Policy 2013 promotes integrated services, delivery in practice remains fragmented across multiple providers and sectors. Parents reported uneven availability of ECCE services, with access often depending on the presence of NGOs, private providers, or local initiatives. This reflects broader patterns observed in Bangladesh and other South and Southeast Asian contexts, where ECCE responsibilities are distributed across several ministries and service providers, creating coordination challenges and uneven service coverage (Bhatta et al., 2020; Iskandar, 2020; Malik & Behera, 2024; Rashid & Akkari, 2020). The findings also highlight the prominent role of NGOs in delivering ECCE services, particularly in urban and underserved communities where public provision is limited, a trend also noted in previous studies (Bhatta et al., 2020).

A major concern emerging from the findings is the limited participation of children below five years of age in ECCE programs. Many children begin structured early learning only after turning five, indicating a service gap for those aged three to below five. Similar gaps have been reported in several developing contexts where early childhood services emphasize health and nutrition for younger children, while structured education begins closer to primary school age, leaving children aged 3–5 comparatively underserved (Bhatta et al., 2020; Iskandar, 2020; Kouser & Popat, 2022; Ulep et al., 2024).

Pedagogical practices in many learning centers were also reported to be academically oriented rather than play-based. Such practices reflect the “schoolification” of early childhood education,

where early academic pressure limits opportunities for developmentally appropriate play and child-centered learning (Ang et al., 2021; Yang et al., 2021). Similar tendencies have been documented in Bangladesh, where early childhood programs often prioritize literacy skills over holistic developmental activities (Rashid & Akkari, 2020).

Despite these challenges, pre-primary education remains the most widely recognized ECCE service supporting school readiness. Parents and education officials noted that participation in pre-primary programs helps children adjust to school and develop foundational learning skills. International evidence similarly shows that quality preschool participation improves cognitive development and long-term educational outcomes (Alexiadou et al., 2024; Von Suchodoletz et al., 2022). However, Bangladesh currently provides only one year of pre-primary education, which may be insufficient for many children, particularly those with limited early learning exposure at home. The ongoing piloting of a two-year pre-primary program therefore represents an important step toward strengthening school readiness.

Parental engagement also influences children's early learning experiences. Many parents reported relying primarily on informal interactions such as playing with children, while structured learning activities were less common. Research suggests that diverse home-based activities, including storytelling and interactive communication, can significantly support children's cognitive and socio-emotional development (Enns et al., 2019; Kauts et al., 2025). Strengthening parental awareness may therefore complement institutional ECCE services and support children's transition to primary education.

Overall, while Bangladesh has made important policy commitments to strengthen ECCE, challenges remain in ensuring equitable access, coordinated service delivery, and developmentally appropriate learning environments for children aged 3–6.

9.3.2 Quality of Services Supporting Transition to Primary Stage for Children Aged 3–6

The findings present a mixed picture of the quality of ECCD services for children aged 3–6 in Bangladesh. Although national policies emphasize holistic development and quality early learning, service delivery remains uneven across providers and geographic contexts. Pre-primary education is the primary institutional service for this age group, yet its effectiveness is questioned due to weak learning outcomes reflected in national assessments. Workforce capacity is a major challenge, as many pre-primary teachers, particularly in government schools, have limited opportunities for continuous professional development. Despite the existence of a comprehensive play-based curriculum, classroom practices often fail to reflect its intent due to teacher capacity gaps, large class sizes, and resource constraints. Observational findings suggest moderate program quality, with relatively stronger performance in learning activities, child well-being, and family involvement, but weaker outcomes in inclusion, staffing support, and infrastructure.

The findings highlight a gap between policy aspirations and the actual quality of ECCD services delivered to children aged 3–6 in Bangladesh. While policies such as the National Education Policy 2010 and the CECCD Policy 2013 emphasize holistic child development and quality pre-primary education, implementation challenges limit their effectiveness. Similar policy–practice gaps have been observed in Bangladesh and other contexts where ECCE systems have expanded but struggle to maintain consistent quality and ensure integration among different sectors (Bhatta et al., 2020; Rashid & Akkari, 2020; Kouser & Popat, 2022; Malik & Behera, 2024). Comparable implementation challenges also exist in Indonesia and the Philippines, where policies support integrated child development but institutional coordination across sectors remains weak (Iskandar, 2020; Ulep et al., 2024).

A key issue emerging from the findings is the limited effectiveness of pre-primary education in improving learning outcomes despite its recognized role in school readiness. Concerns that children attending pre-primary do not demonstrate substantially different outcomes from those who do not raise questions about program quality and pedagogical practices. International evidence shows that high-quality preschool programs significantly improve children's cognitive and socio-emotional development and later academic achievement (Alexiadou et al., 2024; Von Suchodoletz et al., 2022). However, such outcomes depend heavily on implementation quality, including teacher competence and developmentally appropriate pedagogy. The study indicates that many teachers lack sufficient understanding of ECCD principles such as play-based pedagogy, child psychology, and early learning standards, and have limited opportunities for professional development. Similar workforce challenges have been reported in countries such as Australia, Malaysia, and India (Cahill et al., 2022; Tang et al., 2022; Malik & Behera, 2024), while developed contexts emphasize professionalization of the early childhood workforce through specialized qualifications and continuous training (Alexiadou et al., 2024; Laaninen et al., 2024).

Another issue highlighted by the findings is the disconnection between curriculum design and classroom practices. Although Bangladesh has a competency-based pre-primary curriculum promoting play-based learning and holistic development, implementation remains weak due to limited training, high teacher–child ratios, and insufficient support staff. Consequently, classroom practices often revert to academically oriented instruction rather than interactive learning. This pattern reflects the broader phenomenon of "schoolification" of early childhood education observed in several Asian countries, including Singapore and Malaysia (Ang et al., 2021; Yang et al., 2021; Kong, 2022; Tang et al., 2022).

Observational findings further indicate moderate but inconsistent programme quality across ECCE settings. While teachers generally demonstrated empathy toward children and avoided punitive discipline, structural limitations such as inadequate infrastructure, limited WASH facilities, insufficient play space, and the absence of para-teachers constrain effective classroom management and interactive learning. Similar resource and staffing shortages affecting programme quality have been reported in several developing contexts (Bhatta et al., 2020; Iskandar, 2020).

Parental satisfaction with ECCD services was generally high, but this should be interpreted cautiously. While many parents rated services positively, only a small proportion described them as “very good,” suggesting that satisfaction may reflect basic service availability rather than high-quality provision. Previous research indicates that parental perceptions of service quality are often shaped by limited exposure to alternative early childhood education models (Rashid & Akkari, 2020).

Overall, despite strong policy commitments to expanding ECCD services for children aged 3–6, ensuring consistent quality across programs remains a major challenge. Workforce capacity limitations, curriculum–practice gaps, infrastructure constraints, and uneven service access continue to affect program effectiveness, highlighting the need for stronger teacher professional development, improved coordination across sectors, and better alignment between policy goals and classroom practices.

9.3.3 Equity and Inclusion in Services Supporting Transition to Primary Stage for the Children Aged 3-6

While Bangladesh has established several policy commitments to promote equitable access to ECCD services for children aged 3–6, substantial disparities remain in practice. Access to services has improved in some geographically challenging areas through government and NGO initiatives; however, participation continues to be influenced by geographic barriers, financial constraints, and social inequalities. Economic hardship appears to be the most significant barrier affecting families’ ability to access services. While certain initiatives such as textbooks in mother language for indigenous children and para-centers in the hill tracts have expanded opportunities, service continuity and coverage remain inconsistent. In addition, support services for children with special needs are limited due to infrastructural barriers, lack of trained personnel, limited early identification mechanisms, and low community awareness, resulting in minimal inclusive practices within early learning environments.

The findings reveal significant disparities in service across geographic and socioeconomic contexts. Urban families, particularly those with greater financial resources, have access to private preschools and daycare centers where more structured and developmentally supportive approaches are followed, whereas even though in haor, char, coastal, and hill areas due to geographic isolation and poverty continue to restrict children’s participation in structured early learning opportunities, parents often express satisfaction with just the availability of services. This pattern reflects a broader global trend in ECCE systems where service quality and learning opportunities are strongly influenced by household income and geographic location (Kouser & Popat, 2022; Ulep et al., 2024). Similar inequalities have been observed in countries such as India, Indonesia, and Australia, where children in remote or disadvantaged communities often receive lower-quality early childhood services compared with their urban counterparts (Cahill et al., 2022; Cohrssen et al., 2023; Iskandar, 2020).The inequitable services contribute to noticeable development

vulnerabilities, particularly in terms of communication and general knowledge, creating an obstruction to a smoother and equitable transition to early primary education.

The limited support for children with special needs observed in this study also mirrors a broader global challenge in translating policy commitments into inclusive practice. While policies such as the CECCD Policy 2013 and the Persons with Disability Rights and Protection Act 2013 advocate for access, early identification, and tailored classroom support are often lacking. Similar implementation gaps are noted in low and middle-income contexts, where inclusive efforts struggle due to inadequate infrastructure, insufficient teacher training, lack of professionals in disability or developmental delay identification, limited referral services, and minimal awareness at the community level (Srinivasan et al., 2021). Even in developed contexts, inclusive pre-schooling practices are hardly implemented in spite of having strong inclusion-oriented policies due to practical limitations, such as the lack of special educators, limited understanding of inclusion, and classroom organisation (Ginner et al., 2022). These findings highlight the importance of strengthening institutional capacity and professional development in order to translate inclusive policy commitments into effective practice.

To sum, the discussion suggests that although Bangladesh has made meaningful progress in expanding ECCD opportunities for children aged 3–6, significant equity and inclusion challenges persist. Geographic disparities, socioeconomic barriers, and limited institutional capacity continue to affect children's access to services, while inclusive support for children with special needs remains insufficient.

9.4 Services during the Early Primary Education Stage

This section discusses the current status of Services during the Early Primary Education Stage for children aged 6-8 in Bangladesh. The discussion draws on findings from surveys, IDIs, FGDs, KIIs, and observations, and compares them with existing national policies, reports, and relevant literature.

9.4.1 Access and Coverage of Services during the Early Primary Education Stage for Children Aged 6-8

National commitments, particularly the National Education Policy and the Comprehensive Early Childhood Care and Development (CECCD) Policy, articulate a strong mandate for universal, compulsory, and quality primary education, alongside integrated support for nutrition, protection, retention, and child wellbeing. Policy provisions emphasize second-chance education, child labour prevention, and public awareness through ICT-based platforms. In practice, early primary education for children aged 6-8 is available through government, NGO, and private initiatives;

however, coverage remains uneven. Marginalized and remote areas continue to experience limited service access, financial barriers, and weak parental awareness, indicating a gap between policy aspiration and operational reach.

Survey findings reinforce this disparity. While 51.85% of respondents reported that their own children had access to necessary ECCD services, only 22.43% reported similar access for children within their wider social networks, suggesting localized rather than universal coverage. Nearly half of parents perceived services as unavailable or only slightly available in their locality, and only 15.07% considered them mostly available. Institutional utilization stands at 58.90%, constrained by supply-side limitations, fragmented awareness initiatives, and regional inequities. Government Primary Schools are the dominant provider, followed by NGOs and public health facilities, reflecting reliance on formal infrastructure but without cohesive integration of developmental services.

When compared with international experiences, Bangladesh's situation reflects both progress and persistent structural gaps. Countries such as Finland, Malaysia, Singapore, Indonesia, India, and the Philippines report near-universal enrollment in early primary grades, yet literature shows continuing disparities in infrastructure quality, inclusive education, and learning outcomes, particularly for rural, low-income, and marginalized children. Similar to findings from Indonesia and the Philippines, shortages in WASH facilities, teaching materials, and inclusive infrastructure affect consistent attendance and foundational learning (Susanti et al., 2020; Navarro, 2024). In contrast, higher-income contexts like Finland demonstrate stronger systemic coherence and quality assurance mechanisms (Jahnukainen et al., 2023; Saloviita, 2020; Eskelä- Haapanen et al., 2023), though even there, inclusive infrastructure requires continuous improvement. Bangladesh's challenges, therefore, align more closely with regional lower- and middle-income contexts, where access expansion has not fully translated into equitable or holistic service delivery.

Overall, the findings suggest that Bangladesh has achieved partial expansion of early primary access but not comprehensive developmental coverage. Policy frameworks envision integrated support encompassing nutrition, health, protection, and socio-emotional development; however, service delivery remains education-centered and fragmented. Comparative evidence indicates that enrollment alone is insufficient without coordinated infrastructure, inclusive systems, and sustained quality monitoring. The broader implication is that strengthening access at the 6-8 stage requires moving beyond numerical expansion toward an integrated, equity-focused ECCD ecosystem that ensures continuity of care, balanced developmental support, and consistent national coverage.

9.4.2 Quality of Services during the Early Primary Education Stage for Children Aged 6-8

The findings reveal a fragmented picture of service quality during the early primary years (Grades 1-2) in Bangladesh. Although the CECCD Policy 2013 and the National Education Policy 2010

articulate a vision of child-friendly environments, smooth transition, active learning, and strong quality monitoring, implementation remains inconsistent across government, NGO, and private schools. Variations in infrastructure, pedagogy, teacher capacity, and parental engagement result in uneven learning experiences for children aged 6–8. This divergence between policy aspiration and classroom reality reflects a broader challenge in translating holistic early learning commitments into sustained institutional practice.

A central concern emerging from the findings is the weak operationalization of smooth transition mechanisms from pre-primary to primary education. While policy guidelines emphasize structured transition strategies, child-friendly school environments, and strong parent–teacher collaboration, schools often lack clear frameworks to guide this process. The coexistence of multiple education streams without coordinated guidance creates confusion for parents and may undermine continuity in children's learning experiences. Similar policy-practice gaps have also been identified in another study conducted in Bangladesh and in a study conducted in Indonesia, where high enrollment rates mask uneven classroom quality and limited pedagogical coherence (Alam et al., 2021; Susanti et al., 2020). In contrast, countries such as Finland and Vietnam frame Grades 1-2 as a gradual and developmentally sensitive phase, supported by formative assessment and structured progression (Eskelä-Haapanen et al., 2023; Hoang et al., 2020). The findings suggest that Bangladesh's early primary stage remains more structurally expanded than pedagogically consolidated.

Pedagogical practices further illustrate tensions between policy commitments and implementation. Although national standards promote child-centered and activity-based learning, classroom observations indicate that instruction remains predominantly teacher-centered, with limited play-based activities, few instructional materials, and minimal classroom decoration to stimulate engagement. This pattern reflects the broader "formalization" or academic intensification of early primary education observed in Bangladesh, India, Singapore, and the Philippines, where early mastery of literacy and numeracy is prioritized, sometimes at the expense of developmentally appropriate approaches (Alcott et al., 2020; Roy et al., 2020; Heng & Lim, 2021; Librea et al., 2023). In contrast, systems such as Canada and Australia integrate foundational skills with creativity, well-being, and cross-cutting competencies within more flexible curricular frameworks (Bahri et al., 2024; Kauts et al., 2025). The Bangladeshi case, therefore, reflects a partial alignment with global trends emphasizing foundational skills, but with insufficient pedagogical support to ensure balanced and holistic learning.

Teacher capacity remains a decisive factor shaping service quality. Despite policy provisions calling for qualified recruitment, continuous professional development, and strong supervision, the findings indicate that recruitment processes prioritize subject knowledge over pedagogical competence, child psychology, and inclusive practices. Training opportunities for government primary teachers are limited in duration and scope, and ECCD-related content receives insufficient emphasis. These challenges reflect findings from a study conducted in Bangladesh, Indonesia,

India, and the Philippines, where underprepared teachers, high workloads, and weak supervision undermine instructional quality (Alam et al., 2021; Das & Biswas, 2021; Susanti et al., 2020). By contrast, high-performing systems such as Finland, Singapore, Canada, and Australia emphasize strong professional standards and sustained teacher development, although even these contexts face tensions between accountability pressures and responsiveness to diverse learners (Ro, 2020; Nguyen et al., 2022). The findings suggest that strengthening early-grade teacher preparation in Bangladesh requires not only expanded training but also deeper integration of child development principles and inclusive pedagogy.

Infrastructure and learning environments present additional constraints. While the CECCD Policy 2013 calls for attractive, inclusive, and technology-supported classrooms, many government schools struggle with limited space, inadequate playgrounds, insufficient WASH facilities, and shortages of para-teachers. Conditions are often more fragile in NGO-operated schools in rural and haor areas, where safe buildings and access to drinking water remain inconsistent. Inclusive infrastructure, such as ramps, braille materials, and assistive devices, is largely absent, and teachers lack specialized training to support children with diverse needs. These findings align with broader evidence from Bangladesh and comparable contexts where infrastructure deficits contribute to weak foundational learning and irregular attendance (Alam et al., 2023; Navarro, 2024). Although countries such as Malaysia and Finland demonstrate stronger facility standards, they continue to face challenges in disability-friendly infrastructure (UNICEF Malaysia, 2023), indicating that inclusion remains a global concern, though more pronounced in resource-constrained settings.

Attention to children's well-being during the early primary stage also appears limited. Although teachers generally demonstrate empathy, schools lack structured nutritional support, medical services, and systematic health coordination, particularly in hard-to-reach areas. Given that health and nutrition directly affect readiness to learn, limited access to quality health services may undermine the broader goals of integrated child development envisioned in national policy frameworks. This gap reflects persistent sectoral fragmentation, where education and health services operate without strong coordination, despite policy recognition of holistic child development.

Despite these structural and pedagogical limitations, parental satisfaction levels are notably high. A majority of parents reported full or moderate satisfaction, and none expressed complete dissatisfaction, even though some rated service quality as poor. This divergence between satisfaction and perceived quality suggests that parental approval may be influenced by access, affordability, or limited exposure to alternative educational models rather than objective service standards. High satisfaction, therefore, should not be interpreted as definitive evidence of strong program quality.

Overall, the findings indicate that while Bangladesh has established comprehensive policy commitments for ensuring quality early primary education for children aged 6-8, implementation

remains uneven. Persistent gaps in teacher preparation, inclusive infrastructure, monitoring systems, and child-centered pedagogy constrain the realization of policy goals. The contrast with higher-performing systems underscores the importance of sustained professionalization, coherent transition frameworks, inclusive design, and effective supervision. Without stronger alignment between policy vision and classroom practice, the early primary stage risks becoming academically formalized but pedagogically under-supported, limiting its potential to secure strong foundational learning and holistic development for all children.

9.4.3 Equity and Inclusion in Services during the Early Primary Education Stage for Children Aged 6-8

The findings indicate that although Bangladesh has articulated strong commitments to equity and inclusion in early primary education through the CECCD Policy 2013 and the National Education Policy 2010, implementation remains uneven. Policies propose residential and satellite schools, stipends, mid-day meals, social protection, and mother-tongue-based education for indigenous communities, particularly in remote and disaster-prone areas. However, children in hill tracts and haor regions continue to face transportation barriers, seasonal disruptions, and long distances to school. Coverage of residential facilities and flexible schooling arrangements remains limited, reflecting a gap between policy intent and local capacity. Similar geographic disparities are reported in India, Indonesia, and the Philippines, where rural and marginalized communities experience weaker infrastructure and limited instructional support (Das & Biswas, 2021; Susanti et al., 2020; Navarro, 2024).

Socioeconomic inequality emerges as the most significant barrier to equitable access. Although only a small proportion of parents reported discrimination in the parents' survey, financial hardship was the dominant factor, followed by social status. This suggests that inequity is shaped less by overt institutional exclusion and more by structural poverty and limited access to support mechanisms. While policy frameworks include stipends and cash transfers, these are not consistently accessible or clearly communicated to eligible families. This pattern aligns with broader evidence from low- and middle-income contexts, where children from poorer households face higher risks of low-quality schooling and weaker early-grade learning outcomes (Das & Biswas, 2021; Susanti et al., 2020). Compared to countries such as Canada and Australia, where regional disparities exist but are moderated by stronger institutional capacity (Kauts et al., 2025; Bahri et al., 2024), Bangladesh continues to struggle with translating redistributive policy commitments into effective practice.

Inclusion of indigenous children and those with special needs remains limited despite comprehensive policy provisions. Although both national policies emphasize mother-tongue instruction, recruitment of indigenous teachers, accessible infrastructure, and early identification of disabilities, actual coverage is narrow. Schools often lack ramps, Braille materials, assistive

devices, and teachers trained in inclusive or special education practices. Mechanisms for early identification and referral are weak, resulting in delayed or missed support for children with physical, sensory, or intellectual disabilities. Similar implementation gaps are evident in Indonesia and the Philippines, where children with disabilities experience lower participation despite inclusive policy frameworks (UNICEF Indonesia, 2025; Navarro, 2024). Thus, inclusion in Bangladesh remains more aspirational than institutionalized.

Gender disparities appear relatively limited at the institutional level, yet household-level economic pressures and social norms still influence participation patterns for some children. Overall, the findings suggest that while Bangladesh has developed a strong normative framework for equitable and inclusive early primary education, persistent poverty, geographic isolation, and limited institutional capacity constrain its realization. Without stronger implementation mechanisms, improved targeting of financial support, and systematic investment in inclusive infrastructure and teacher preparation, early primary education risks reinforcing rather than reducing existing social inequalities during this foundational stage.

9.5 Financing and Resource Allocation in ECCD

The findings of this study reveal significant challenges in the financing and resource allocation landscape for Early Childhood Care and Development (ECCD) in Bangladesh. National policies, such as the Comprehensive Early Childhood Care and Development (CECCD) Policy 2013 and the National Education Policy 2010, emphasize the importance of sustainable financing and multisectoral resource mobilization. However, in practice, the financing structure remains fragmented and insufficient. ECCD service providers rely heavily on international donor funding and organizational self-financing, while government contributions are relatively limited. Budget allocations for ECCD are embedded within broader sectoral budgets for health, nutrition, and education, making it difficult to track expenditures specifically dedicated to early childhood development. Practitioners consistently reported that severe budget constraints affect service quality, infrastructure, nutrition provision, and recreational facilities. At the household level, parents in rural and economically disadvantaged areas experience a substantial financial burden when accessing ECCD services, whereas families in more affluent urban settings generally perceive service costs as reasonable.

A substantial gap exists between policy commitments and actual financing mechanisms supporting ECCD implementation. The CECCD Policy calls for integrated financing across ministries, costed action plans, and collaboration among government, private, and development partners. Yet, the current system remains largely donor-dependent and fragmented across multiple institutions. This reliance on external funding raizes sustainability concerns, as donor-funded programs are typically time-bound and vulnerable to withdrawal. Sustained public investment is therefore essential to ensure equitable access to quality ECCD services and to scale successful pilot initiatives. It mirrors the similar situation as the Philippines mentioned in the Green Paper by the Second Congressional

Committee of Education published in 2023, where ECCD implementation under Local Government Units is limited by insufficient government funding, restricting service expansion.

However, increasing public spending alone does not guarantee improvements in accessibility and quality; the structure and facilitation of financing mechanisms are equally critical. In liberal welfare states such as the United Kingdom, New Zealand, Australia, and Quebec, public spending on ECCD is relatively high, but it is delivered largely through demand-side mechanisms such as parental subsidies, tax credits, or rebates, rather than direct public provision. This approach has encouraged the rapid expansion of private and for-profit childcare providers, transforming ECCD systems into competitive markets rather than coordinated public service networks (White & Friendly, 2020). Operational challenges within ECCD service delivery are closely linked to budget allocation practices. Practitioners across institutions reported that limited budgets directly affect the availability of essential services, including nutrition support, safe infrastructure, adequate sanitation, and age-appropriate learning resources. Similar financial constraints have been observed in other developing contexts where ECCD lacks a dedicated budget, resulting in inconsistent and unpredictable funding (EDCOMII, 2023).

Household-level findings demonstrate how financial barriers influence access to ECCD services. Many parents reported difficulties covering the costs associated with childcare, healthcare, and early education, particularly in low-income rural communities. Previous research indicates that socioeconomic status plays a significant role in accessing ECCD (Enns et al., 2019; Kauts et al., 2025). While some urban families perceive ECCD services as valuable investments in their children's development, families in disadvantaged regions often struggle to meet basic expenses, which may discourage participation in structured early learning programs. In the developed contexts, the parents' are often subsidized. Subsidies help parents manage childcare costs, reducing out-of-pocket expenses. Thus, access to structured ECCD services remain higher (White and Friendly, 2020). In developing contexts like Bangladesh, as the public funding is limited, parents often cover food, transportation, and other basic needs of the child.Thus, even though public investment reduces costs for families, it does not fully eliminate financial burdens, especially for low-income households (Tongson, 2023).

Overall, the current ECCD financing structure in Bangladesh remains fragmented, donor-dependent, and insufficient to sustain service delivery. The absence of a dedicated national financing framework, limited transparency in public expenditure, and reliance on household contributions create significant barriers to equitable access.

9.6 Monitoring, Evaluation and Research in ECCD

The findings of this study indicate that monitoring, evaluation, and research systems supporting Early Childhood Care and Development (ECCD) in Bangladesh remain fragmented and inconsistent, despite strong policy recognition of their importance. While the CECCD Policy 2013

and other national frameworks emphasize systematic monitoring, data collection, and evidence-based planning, the implementation of these provisions varies widely across regions and service providers. Record-keeping practices are limited, often restricted to basic administrative documents such as birth certificates and vaccination cards, with comprehensive developmental data on children rarely collected or analyzed. Monitoring activities exist across both government and NGO-led initiatives, but they are primarily administrative and compliance-oriented rather than focused on improving service quality or child development outcomes. Furthermore, the study highlights significant gaps in ECCD research and locally generated data, with much of the evidence used in policy discussions derived from international studies rather than the national context.

The findings reveal a considerable disconnect between policy intentions and the actual functioning of monitoring and evaluation systems within ECCD services. National policies advocate for participatory monitoring, integrated data systems, and evidence-based decision-making; however, in practice, monitoring remains fragmented and inconsistent across sectors. Many ECCD service providers rely on periodic supervision or reporting mechanisms rather than systematic evaluation frameworks that track developmental outcomes or program effectiveness. Monitoring practices in both the education and health sectors were largely compliance-driven rather than quality-focused. Education officials and institutional supervisors primarily emphasize administrative oversight, paying limited attention to pedagogical quality or holistic child development outcomes. Similarly, monitoring in health-related ECCD services depends heavily on routine reporting systems, with minimal field-level verification. While some NGO-led initiatives employ structured monitoring tools such as checklists and development manuals, these systems tend to be project-specific and are rarely integrated into a unified national monitoring framework. This fragmentation is not unique to Bangladesh but is observed across other South Asian countries as well. The distribution of ECCD responsibilities across multiple ministries and service providers, without a dedicated workforce for implementation and monitoring, adds to the workload of monitoring officials and leads to duplication of administrative oversight (Iskandar, 2020; Malik & Behera, 2024). Research suggests that administrative or compliance-based monitoring often fails to contribute meaningfully to quality enhancement, whereas calm observation, constructive feedback, appreciation, and open discussion with ECCD providers are more effective approaches for improving outcomes (Schäfer & Eberhart, 2017).

Weak record-keeping practices further illustrate the challenges of building a robust monitoring ecosystem despite its recognized importance for ensuring optimal child development, informing policy, and evaluating program effectiveness (Raikes et al., 2023). In many regions, data collection remains limited to basic administrative records such as birth registration or vaccination cards, while systematic information on children's health, nutrition, and developmental progress is rarely maintained. Even when indicators such as height and weight are recorded, the data are often not analyzed for planning or program improvement. Given the critical role of monitoring, evaluation,

and record-keeping in guiding policy and program decisions, it is recommended that child development be tracked consistently so that policymakers and practitioners can identify developmental risks, evaluate program outcomes, and allocate resources effectively (Raikes et al., 2023).

The study also underscores substantial gaps in research and evidence generation within the ECCD sector. Stakeholders consistently emphasized that locally generated research remains limited, with only a few institutions conducting small-scale studies. Consequently, policy discussions and advocacy often rely heavily on international evidence rather than context-specific data from Bangladesh. Similar challenges are observed in other low- and middle-income countries. Alongside limited research, data misalignment persists (Raikes et al., 2023), highlighting the need for a coordinated national research agenda and an integrated ECCD data hub to support evidence-based policymaking.

In summary, the findings suggest that despite strong policy commitments to monitoring, evaluation, and research within ECCD, the current system in Bangladesh remains fragmented, administratively focused, and weakly linked to service quality improvement. Strengthening the ECCD monitoring and research ecosystem will require the development of integrated data systems, systematic child development tracking mechanisms, expanded local research initiatives, and stronger coordination across sectors responsible for child development.

9.7 Key Stakeholders and Coordination

The policy framework in Bangladesh assigns comprehensive and clearly differentiated roles to multiple ministries and stakeholders under the leadership of the Ministry of Women and Children's Affairs (MoWCA). The CECCD Policy 2013 envisions a holistic, life-cycle approach, linking the Ministry of Health and Family Welfare for maternal and child health, the Ministry of Primary and Mass Education for early learning and transition to school, the Department of Social Services for child protection and disability support, Bangladesh Shishu Academy for early stimulation, local government institutions for grassroots coordination, and development partners, NGOs, and research bodies for capacity building and innovation. It further proposes formal ECCD committees at national and subnational levels, ECCD cells, and a Directorate of Child Affairs to ensure coordinated planning and accountability. This architecture aligns with global practice, where many Asian countries, including Cambodia, Indonesia, India, and the Philippines, rely on designated lead ministries and inter-ministerial committees, while countries such as Finland and Thailand embed coordination within stronger legal and institutional accountability structures (Rodriguez & Chua, 2021; Alexiadou et al., 2024).

However, field evidence reveals a substantial gap between this comprehensive design and operational reality. Although 19 ministries are formally recognized, stakeholders at the community level are largely familiar with only a few key actors, mainly the Ministry of Health and Family

Welfare, the Ministry of Women and Children's Affairs, and, to some extent, the Ministry of Primary and Mass Education, while other designated ministries remain invisible in day-to-day service delivery. Formal coordination committees and mechanisms exist on paper but are mostly inactive, constrained by weak leadership authority, bureaucratic fragmentation, and limited operational mandates. As a result, ECCD services are delivered in parallel rather than through an integrated ecosystem linking health, nutrition, early learning, protection, and parenting support. Referral systems are weak, shared monitoring frameworks are absent, and collaboration often depends on individual initiative rather than institutionalized processes. Compared to more institutionalized models in Finland or legislated intergovernmental agreements in Canada (Alexiadou et al., 2024; UNESCO, 2024), Bangladesh's coordination remains structurally ambitious but functionally underdeveloped.

Non-state and community actors further illustrate this fragmented landscape. NGOs provide valuable, often innovative, community-based services, yet their contributions are geographically concentrated and project-dependent, limiting scale and sustainability. Research institutions and ECCD networks generate evidence and training opportunities, but their engagement is typically urban-focused and not systematically linked to government planning, resulting in limited translation of research into policy reform. Private sector engagement is minimal, and local government bodies, though assigned central coordinating roles, have limited visibility and capacity at the field level. Parents remain the primary caregivers across all age groups, with mothers playing the dominant role and fathers and extended family members providing additional support. Despite policy emphasis on parental empowerment, structured parenting education and community-level guidance mechanisms are largely absent, leaving families reliant on informal knowledge sources.

Survey data also reveal uneven stakeholder awareness across ECCD domains. While knowledge of basic health and protection is relatively strong for younger children, awareness declines for the 6-8 age group, and understanding of responsive caregiving and early learning remains consistently low. This indicates that the multisectoral vision has not translated into a shared understanding of holistic child development among frontline actors.

Overall, Bangladesh has established a broad and inclusive coordination framework consistent with international norms and the Nurturing Care approach, yet weak institutionalization, fragmented implementation, and limited integration of state and non-state actors constrain the emergence of a coherent national ECCD ecosystem. Strengthening functional coordination, clarifying operational mandates, and embedding accountability mechanisms across sectors remain critical for realizing the policy's integrated vision.

9.8 Overarching Questions

Based on the findings of the study, an effort is made to address the overarching questions that guided the entire research. Specifically, the analysis examines whether existing ECCD

interventions collectively contribute to a comprehensive, integrated, and developmentally appropriate system of support for children, and whether an effective ECCD ecosystem exists where stakeholders effectively coordinate and collaborate. The discussion below therefore assesses the extent to which an integrated, holistic and coordinated approach is followed in current ECCD policies, services, and institutional practices.

Status of ECCD Service Delivery Across Developmental Stages

The field evidence suggests that ECCD services in Bangladesh are structured across prenatal, 0-3, 3-6, and 6-8 stages; however, functional continuity between these stages remains weak. In the prenatal and perinatal phase, limited pre-conception awareness and the absence of maternal mental health support create an early gap in nurturing care. Although national policies promote a life-cycle approach, services are not systematically designed to prepare families for the next developmental stage. As a result, the foundational link between maternal well-being and early childhood development is not institutionally reinforced.

For children aged 0-3, services are predominantly health-oriented, centered on immunization and basic survival needs. While pilot initiatives attempt to integrate early stimulation and nurturing care messages with health platforms, these efforts are inconsistent and poorly disseminated. Importantly, there is no structured mechanism ensuring that developmental screening outcomes, parenting guidance, or early learning messages inform service planning for the 3-6 stage. Weak referral systems and limited early detection capacity further disrupt developmental continuity, especially for children with delays or disabilities.

At the 3-6 stage, early learning opportunities expand, particularly through pre-primary education initiatives, yet these are not systematically linked to children's earlier health and developmental records. School readiness efforts operate largely independently from the 0-3 health-focused interventions. Similarly, during the transition to early primary (6-8 years), service provision becomes more education-centered, with limited integration of nutrition, psychosocial care, or developmental monitoring. The absence of coordinated child tracking systems prevents smooth transitions across stages and weakens the cumulative impact of earlier interventions.

Overall, while policy frameworks envision integrated and collaborative ECCD service delivery, implementation reflects fragmentation rather than continuity. Coordination structures remain largely non-functional, financing is fragmented, and monitoring systems are compliance-driven rather than child-centered. Consequently, services across age groups operate in parallel rather than as a connected developmental pathway. This lack of an integrated ECCD ecosystem limits the potential for holistic child development and undermines the intended life-cycle approach.

Status of the ECCD Ecosystem: Assessing Whole-of-Government and Whole-of-Society Coordination

The current ecosystem for Early Childhood Care and Development (ECCD) in Bangladesh demonstrates strong policy recognition but weak system integration, indicating that a comprehensive whole-of-government and whole-of-society approach has not yet been operationalized. National frameworks, particularly the Comprehensive Early Childhood Care and Development Policy 2013 and its operational and implementation plan, formally assign responsibilities to 19 ministries and government agencies, and multiple non-state actors, reflecting an intention to build a multisectoral ecosystem supporting children's holistic development. However, the evidence suggests that coordination across sectors remains limited in practice. Engagement is largely concentrated within the health and education sectors, while institutions responsible for child protection, disability services, local governance, social welfare and other institutions have comparatively limited visibility in community-level ECCD delivery. As a result, services frequently operate in sectoral silos rather than through coordinated platforms linking health, nutrition, early learning, protection, and parenting support. The absence of an operational whole-of-government coordination mechanism further reinforces this fragmentation. Although national policies envision inter-ministerial committees and multisectoral coordination structures, these mechanisms are largely inactive, resulting in parallel planning and weak referral linkages across ministries and service providers. At the community level, frontline workers such as health staff, teachers, and local representatives tend to operate independently, and families typically interact with isolated services rather than a coordinated support system for children's development.

Financing patterns also illustrate the limited institutionalization of a unified ECCD ecosystem. Funding for ECCD remains disintegrated across ministries, development partners, NGOs, and private initiatives, with no consolidated national financing framework guiding investment priorities. Government allocations are embedded within broader sectoral budgets and rarely disaggregated, making it difficult to track ECCD-specific spending or coordinate resource allocation across sectors. At the same time, many ECCD initiatives rely heavily on time-bound, project-based donor funding, which restricts continuity and long-term institutionalization of successful interventions. The absence of coordinated national financing mechanisms limits the ability to scale effective models and sustain integrated services across regions.

Similarly, monitoring, evaluation, and data systems remain fragmented along sectoral lines, further weakening coordinated governance. Monitoring responsibilities are typically divided by sector, with health officials overseeing health-related interventions and education authorities monitoring early learning initiatives, while NGO and private sector programs are largely monitored internally. In the absence of a national ECCD monitoring and evaluation framework, there are no shared indicators, common reporting standards, or integrated oversight mechanisms linking these efforts. Data collection practices are therefore inconsistent and largely administrative, focusing on individual program requirements rather than child development outcomes across sectors. The lack of an integrated national child data platform further limits the ability to generate system-wide evidence for policy decision-making. Research and data generation remain scattered across

universities, NGOs, and development partners, with limited coordination or mechanisms to synthesize findings into accessible national evidence. Consequently, research outputs, administrative data, and program experiences are not systematically consolidated to inform planning, budgeting, or program improvement.

Despite these structural gaps, non-state actors, including NGOs, academic institutions, and ECCD networks, continue to play important roles in advocacy, service delivery, and innovation. However, their contributions remain insufficiently integrated into formal governance and coordination structures, limiting the development of a truly whole-of-society ecosystem. At the household level, parents remain the primary providers of care and early stimulation, yet structured parenting support initiatives are limited. Overall, the findings suggest that while Bangladesh has established policy foundations for a multisectoral ECCD ecosystem, the system currently functions through fragmented institutional efforts rather than a coordinated national platform that mobilizes all sectors and stakeholders. Strengthening ECCD therefore requires moving beyond policy commitment toward operationalizing whole-of-government coordination, integrated financing frameworks, unified monitoring and data systems, and structured engagement of non-state actors and communities.

9.9 Key Recommendations

- **Strengthen Regional and Socio-Economic Equity in ECCD Services**

ECCD services should ensure equitable access for children from underserved regions and socio-economically disadvantaged families across all life stages. Prenatal and postnatal care must be scaled up through home visits and community health worker models in haor, char, hill tract, and flood-prone areas for early risk identification and continuous follow-up. For children aged 0–3 years, inclusive daycare services, mobile outreach, and NGO-supported centers should provide flexible, accessible, and quality care. Children aged 3–6 years should benefit from alternative learning methods, community-based early learning centers, and sustained financial and material support to reduce household barriers. For children aged 6–8 years, early primary education should be strengthened through satellite schools, flexible arrangements, and government-NGO partnerships to overcome geographic and seasonal barriers.

- **Institutionalize Inclusive ECCD Services for Children with Disabilities or Special Needs**

Children with disabilities or special needs should be fully integrated into ECCD programming from prenatal to early primary education. It should start with the necessary facilities for early identification of disability. Prenatal and postnatal care must follow disability-inclusive guidelines, provide accessible facilities, and equip health workers with disability sensitive training. For children aged 0–3 years, daycare centers should implement inclusive caregiving practices,

psychosocial support, and gender-sensitive routines delivered by trained caregivers. Children aged 3–6 years require standardized assessment tools, mandatory teacher training on disability inclusion, and strengthened parental awareness through NGO-government collaboration, particularly in remote and disaster-prone areas. Children aged 6–8 years should access early primary education programs with accessible classrooms, tailored learning support, and trained teachers. Integrating early screening, referral pathways, and inclusive practices across all life stages will promote equity, reduce barriers, and ensure meaningful participation for children with special needs.

- **Strengthen ECCD Workforce Capacity and Resource Availability Across the Early Childhood Continuum**

To address shortages in skilled personnel and essential resources, ECCD services must strengthen workforce capacity, facility readiness, and infrastructure across all life stages. Prenatal and postnatal care should ensure adequate deployment of trained health workers, quality assurance mechanisms, and essential medicines and diagnostic tools in public and private facilities. For children aged 0–3 years, daycare and home-based services should meet minimum quality standards, provide accessible play and breastfeeding spaces, and implement standardized training and competency frameworks for ECCD personnel. Children aged 3–6 years require professionalized pre-primary teaching, improved teacher-student ratios, child-centered pedagogy, inclusive infrastructure, and structured in-service and refresher training. For children aged 6–8 years, early primary education should ensure sufficient qualified teachers, continuous professional development, inclusive classrooms, adequate learning materials, and safe, child-friendly infrastructure.

- **Promote Awareness and Engagement Across ECCD Stakeholders**

Coordinated efforts should be made to enhance knowledge and understanding of ECCD across all levels. Preconception, prenatal, and maternal health information should be integrated into school curricula, pre-marriage counseling, and community health programs, ensuring adolescents, newly married couples, and families receive structured guidance. Maternal physical and mental health counseling should be actively involved in home based and community, with community health workers trained in culturally sensitive support and stigma-reduction. Parents and caregivers should be informed about early childhood development, daycare benefits, and available services through school meetings, community platforms, media, and mobile messaging.

- **Adopt an Ecosystem Approach for Multisectoral Integration in ECCD**

ECCD service delivery should adopt an ecosystem approach that reduces bureaucratic fragmentation and aligns all relevant actors - government ministries, local government institutions, NGOs, development partners, and the private sector under a unified national framework to improve coordination, accountability, and service coherence. This requires reactivating multisectoral coordination committees outlined in the CECCD Policy (2013) at national, district, and upazila levels, while simplifying approval, reporting, and coordination processes. Clarifying institutional authority and decision-making responsibilities across MoWCA, MoHFW, MoPME, local government bodies, and partners and establishing a separate Directorate of Child Affairs would

help minimize procedural delays and power imbalances. Formal mechanisms for NGO engagement, streamlined information-sharing systems, and policy incentives for private sector participation would further reduce administrative barriers and enable integrated planning and implementation.

- **Institutionalize Sustainable and Equitable Financing for ECCD**

Sustainable ECCD outcomes require the institutionalization of a dedicated and predictable public financing framework that reduces reliance on short-term donor funding and ensures continuity beyond project cycles. This can be achieved by consolidating ECCD-related budget allocations and costed action plans across relevant ministries under a coordinated financing mechanism, alongside progressively increasing government investment. Disaggregating ECCD budgets within national and sectoral allocations and linking them to need-based planning would improve transparency, accountability, and efficiency, particularly in addressing regional disparities and quality gaps. Complementary targeted financial support for economically disadvantaged families, combined with strengthened parental awareness on the long-term benefits of ECCD, would reduce household financial burdens, promote equitable access, and support sustained participation in ECCD services.

- **Establish a Unified and Integrated ECCD Monitoring System**

To address fragmented monitoring in ECCD, a unified and digitalized monitoring system should be established to integrate child data and service information across health, education, and social protection sectors. This requires standardizing core child indicators and record-keeping practices at local government, school, daycare, and community levels, while linking existing administrative databases. Strengthening staff capacity, integrating NGO and community-based reporting in underserved areas, and institutionalizing participatory monitoring involving local institutions and parents would enhance accountability and data use. A coordinated monitoring framework would support quality assurance, evidence-informed planning, and equitable ECCD service delivery.

- **Establish a Comprehensive ECCD Data, Research, and Record-Keeping System**

A nationally standardized ECCD data and record-keeping system should be established to capture key indicators, including birth registration, vaccination, nutrition, growth, and developmental milestones. A national ECCD data hub must be developed at the Union Parishad level, serving as a centralized repository where all child-related information is systematically stored. Local governments, schools, daycare centers, and community-based organizations should maintain updated records using standardized tools, linked across sectors, supported by training of ECCD personnel, regular audits, and participatory monitoring. Complementing this, a national ECCD research hub should integrate local evidence into planning, define research priorities, improve access to data, and promote collaboration among government agencies, research institutions, and service providers.

Conclusion

The findings demonstrate that Bangladesh has established a strong normative and policy foundation for ECCD; however, implementation remains fragmented across developmental stages

and sectors. While access to services has expanded, particularly in health and primary education, quality, equity, financing sustainability, and coordination mechanisms remain inconsistent and unevenly institutionalized. Comparative literature suggests that countries achieving stronger child development outcomes tend to align integrated governance, dedicated financing, professionalized workforce systems, and unified monitoring frameworks—areas where Bangladesh continues to face structural challenges. The absence of functional whole-of-government coordination, integrated data systems, and sustained financing limits the realization of a coherent ECCD ecosystem. As a result, services often operate in parallel rather than as a continuous developmental pathway. The broader implication is that advancing ECCD in Bangladesh requires shifting from policy commitment to systemic integration, embedding accountability, inclusivity, and life-cycle continuity at the core of governance, financing, and service delivery.

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ANNEX

Annex 1

Key Informant Interview Guide

Consent Form

Title of the Study : Scoping Study on Status of Pre-natal to Transition to Schooling including Early Primary Education in Bangladesh

Purpose of the Study:
Assalamu Alaikum, I am Dr. Mohammad Mahboob Morshed. Bangladesh ECD Network (BEN) is conducting this study under the'Enhancement of favourable environment for the promotion of ECCD (EFEP-ECCD) project to understand the overall state of Early Childhood Care and Development (ECCD) in Bangladesh.

Methodology:
You have been selected as a participant in this study as an experienced and expert professional in the field of Early Childhood Care and Development in Bangladesh. Your valuable insights as a Key Informant will greatly enrich this research. The interview will take approximately 40 to 60 minutes. A questionnaire will be used during the interview. To accurately capture your views, the interview will be audio-recorded.

Risks and Benefits:
There are no risks or benefits associated with participating in this study. However, the findings may help inform effective policies and programs for Early Childhood Care and Development in Bangladesh.

Confidentiality:
Your information will be kept completely confidential and will only be used for research purposes. The information you share will be combined with others' responses and presented in the report. Your name will not appear anywhere in the report.

Voluntary Participation:
Your participation is entirely voluntary. You may ask me any questions you have. You may also choose not to answer any question if you wish. Even after giving consent, you may stop the interview at any time. If needed, you may continue the interview later at a time convenient for you.

Rights of the Participant:
If you have any questions regarding this study, you may contact the researcher Dr. Mohammad Mahboob Morshed (Mobile: 01767903624), Research Associate Sayeba Bintay Zahir (Mobile: 01771535038), or Bangladesh ECD Network representatives Syeda Sazia Zaman (Mobile: 01716418275) / Mahmuda Akter (Mobile: 01755592937).

Do you consent to participate in this interview? (Please tick)

Yes ☐ **No** ☐

Signature of Key Informant & Date :
Name:
Organization:

I have read this consent form aloud to the participant, and they have given / not given their consent.

মূখ্য তথ্যদাতার জন্য সাক্ষাৎকার প্রশ্নমালা

তারিখঃ

নামঃ

প্রতিষ্ঠানের নামঃ

প্রতিষ্ঠানের ঠিকানাঃ বিভাগঃ জেলাঃ উপজেলাঃ

Access and Coverage of ECD Services in Bangladesh

১. বাংলাদেশে বর্তমান প্রেক্ষাপটে শিশুর প্রারম্ভিক যত্ন ও বিকাশ সেবার আওতাধীন কী কী প্রোগ্রাম চালু আছে? (যেমন, গর্ভ ও প্রসবকালীন স্বাস্থ্যসেবা, ডে-কেয়ার, প্রাক-প্রাথমিক শিক্ষা, প্রাথমিক শিক্ষা, মনোসামাজিক কাউন্সেলিং/ Psychosocial counselling ইত্যাদি)

ক) মা, শিশু ও শিশুর যত্নকারীদের জন্য পৃথক পৃথক প্রোগ্রাম আছে কি? এগুলো শিশু, অভিভাবক ও শিশুর যত্নকারীদের কীভাবে উপকৃত করছে?

খ) শিশুর বয়সভেদে প্রোগ্রামগুলোতে কেমন ভিন্নতা থাকে? উদাহরণ দিয়ে বলুন। (যেমন, গর্ভ ও প্রসবকালীন সেবা, শিশুর ০-৩ বছর, ৩-৬ বছর এবং ৬-৮ বছর বয়সকালীন সেবা)

গ) প্রোগ্রামগুলোর প্রতি জনসাধারণের চাহিদা এবং অংশগ্রহণ কেমন?

২. যত্ন ও বিকাশ সংক্রান্ত বিভিন্ন কার্যক্রমে সবার অংশগ্রহণ নিশ্চিতকরণে বর্তমানে বেশ কিছু নীতিমালা ও কর্মকৌশল (যেমন, শিশুর প্রারম্ভিক যত্ন ও বিকাশের সমন্বিত নীতি ২০১৩, নার্চারিং কেয়ার ফ্রেমওয়ার্ক, শিশু দিবাযত্ন কেন্দ্র আইন ২০২১ ইত্যাদি) অনুসরণ করা হয়।

ক) এই নীতিমালা বা কর্মকৌশলগুলো সম্পর্কে আপনার ধারণা আছে কি?

খ) ধারণা থাকলে, এই নীতিমালা বা কর্মকৌশলগুলো কতোটা সফলভাবে বাস্তবায়িত হচ্ছে বলে মনে করেন? যেমন, শিশুর যত্ন, বিকাশ, নিরাপত্তা, মর্যাদা, স্নেহ-ভালোবাসা নিশ্চিতকরণের লক্ষ্যে শিশুর প্রারম্ভিক যত্ন ও বিকাশের সমন্বিত নীতি ২০১৩ গৃহিত হয়েছে। আমরা এই লক্ষ্য অর্জনে কতোটা সফল? উদাহরণ দিয়ে বলুন।

গ) এই নীতিমালাগুলো সফলভাবে বাস্তবায়নের ক্ষেত্রে আমাদের দুর্বলতাগুলো কী কী?

Stakeholder Mapping

৩. বাংলাদেশে শিশুর প্রারম্ভিক যত্ন এবং বিকাশ সংক্রান্ত সেবার ক্ষেত্রে প্রধান স্টেকহোল্ডার বা অংশীজন কারা?

ক) এই স্টেকহোল্ডার বা অংশীজনরা শিশুর প্রারম্ভিক যত্ন এবং বিকাশ সংক্রান্ত সেবা ও কার্যক্রম বাস্তবায়নের ক্ষেত্রে কে কেমন ভূমিকা রাখছে? (যেমন, সরকারের বিভিন্ন মন্ত্রণালয় ও সংস্থা, এনজিও, স্থানীয় সরকার, অভিভাবক, বেসরকারি প্রতিষ্ঠান ইত্যাদি)

খ) স্টেকহোল্ডারদের চাহিদা, স্বার্থ এবং প্রভাব/ ক্ষমতা শিশুর প্রারম্ভিক যত্ন এবং বিকাশ সংক্রান্ত সেবা ও কার্যক্রমকে কীভাবে প্রভাবিত করছে? উদাহরণ দিয়ে বলুন।

গ) স্টেকহোল্ডার বা অংশীজনদের মধ্যে কনফ্লিক্ট অব ইন্টারেস্ট তৈরি হয় কি? এটি শিশুর প্রারম্ভিক যত্ন এবং বিকাশ সংক্রান্ত সেবা ও কার্যক্রমকে কীভাবে প্রভাবিত করে? উদাহরণ দিয়ে বলুন।

Coordination and Collaboration

৪. একটি শিশুর জন্মের আগ থেকে শুরু করে তার জন্মগ্রহণ, প্রারম্ভিক যত্ন, বিকাশ, সুরক্ষা এবং প্রাক প্রাথমিক ও প্রাথমিক শিক্ষায় অগ্রসর হওয়া পর্যন্ত একটি পর্যায়ক্রমিক ধারা রয়েছে। এই বয়সভিত্তিক সেবার ক্ষেত্রে যেমন শিক্ষা, স্বাস্থ্য, পুষ্টি, নিরাপত্তা ইত্যাদি খাতের সমন্বয়ের প্রয়োজন রয়েছে, তেমনি বিভিন্ন সরকারি, বেসরকারি প্রতিষ্ঠান, এনজিও, দাতা সংস্থার সংশ্লিষ্টতা রয়েছে।

ক) বিভিন্ন বয়সভিত্তিক সেবা যেমনঃ গর্ভ ও প্রসবকালীন, ০-৩, ৩-৬, ৬-৮ - কি বিচ্ছিন্নভাবে দেওয়া হচ্ছে, নাকি এসব সেবার মধ্যে সুসমন্বয় রয়েছে? এ সম্পর্কে আপনার ধারণা আছে কি? সেবাসমূহের মধ্যে এই সমন্বয় বাড়ানোর উপায় কী?

খ) বিশেষ করে, স্বাস্থ্য ও শিক্ষা খাতের মধ্যে কেমন সমন্বয় রয়েছে বা কেমন সমন্বয় থাকা প্রয়োজন? উদাহরণ দিয়ে বলুন।

গ) প্রাক-শৈশব যত্ন ও বিকাশ সেবা প্রদানকারী প্রতিষ্ঠানগুলোর মধ্যে কি কোন সুসমন্বিত ইকো-সিস্টেম তৈরি হয়েছে? এ সম্পর্কে আপনার ধারণা আছে কি?

ঘ) তৈরি হয়ে থাকলে, সবার শিশুর জন্য মানসম্মত প্রারম্ভিক যত্ন ও বিকাশ নিশ্চিতকরণে এই ইকো-সিস্টেম কীভাবে ভূমিকা রাখছে? উদাহরণ দিয়ে বলুন।

ঙ) তৈরি না হয়ে থাকলে, ইকো-সিস্টেম গড়ে তোলার মাধ্যমে প্রারম্ভিক যত্ন ও বিকাশ বা উঈঈউ সেবা বাস্তবায়নে কী ধরণের সুবিধা পাওয়া যেতে পারে?

Equity and Inclusion

৫. শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবা প্রাপ্যতা কি সর্বস্তরে সমানভাবে নিশ্চিত করা সম্ভব হয়েছে?

ক) বসবাসের এলাকা (গ্রাম/ শহর) এবং অর্থনৈতিক অবস্থাভেদে কি সেবাপ্রাপ্তির ক্ষেত্রে ভিন্নতা রয়েছে?

খ) সেবা প্রাপ্তির ক্ষেত্রে কারা সবচেয়ে সুবিধাবঞ্চিত এবং কেন? এই সেবা সবার জন্য সুলভ করতে করণীয় কী?

গ) সেবাসমূহের আওতাবহির্ভূত কিংবা বঞ্চিত জনগোষ্ঠী, বিশেষ করে, বিশেষ চাহিদাসম্পন্ন শিশু, ক্ষুদ্র নৃ-গোষ্ঠীর শিশু, জলবায়ু অভিঘাতের শিকার এবং দারিদ্র্যপীড়িত ও দুর্গম এলাকার পিছিয়ে পড়া শিশুদের কীভাবে সেবায় অন্তর্ভুক্ত করা যায়?

Quality

৬. গর্ভ ও প্রসবকালীন সময় থেকে শিশুর প্রারম্ভিক শিক্ষা অর্থাৎ ১ম কিংবা ২য় শ্রেণী পর্যন্ত অগ্রসর হওয়ার ক্ষেত্রে বিভিন্ন পর্যায় সফলভাবে শেষ করতে হয়।

ক) শিশু তার ০ থেকে ৮ বছর পর্যন্ত প্রতিটি ধাপে স্বাস্থ্য, শিক্ষা, নিরাপত্তাসহ প্রতিটি ক্ষেত্রে গুণগত সেবা পাচ্ছে কি?

খ) শিশুর প্রাক-শৈশবের প্রধান চারটি পর্যায় যেমন, গর্ভ ও প্রসবকাল, ০-৩ বছর, ৩-৬ বছর এবং ৬-৮ বছর পর্যন্ত কোন ধাপে সেবার মান কেমন এবং সেবার মান বাড়াতে কী করণীয়? উদাহরণ দিয়ে বলুন।

গ) মানসম্মত শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবা নিশ্চিতকরণের জন্য আমাদের যথেষ্ট দক্ষ জনবল আছে কি? শিশুর প্রাক-শৈশবকালীন যত্ন ও বিকাশে অংশগ্রহণকারীদের দক্ষতা বৃদ্ধিতে করণীয় কী? (যেমন, অভিভাবক, যত্নকারী, ডে কেয়ার সেন্টারের কর্মীবৃন্দ, স্বাস্থ্যকর্মী, প্রাক-প্রাথমিক শিক্ষকদের দক্ষতা বৃদ্ধির জন্য বিশেষ প্রশিক্ষণ)

৭. বিশেষ করে, প্রাক-শৈশব কালীন শিক্ষা যেন শিশুকে শিক্ষার পরবর্তী ধাপগুলোর জন্য তৈরি করতে পারে সেক্ষেত্রে শিক্ষাক্রম/ পাঠ্যসূচি, শিখন শিক্ষণ পদ্ধতি, শিক্ষকের যোগ্যতা কেমন হওয়া উচিত বলে মনে করেন? উদাহরণ দিয়ে বলুন।

Financing

৮. বাংলাদেশে শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবা-এর ক্ষেত্রে অর্থায়ন কীভাবে হয়?

ক) এই খাতে অর্থায়নের উৎস কারা?

খ) বর্তমান অর্থায়ন কি যথেষ্ট? অর্থের সীমাবদ্ধতার কারণে কি কোনো গুরুত্বপূর্ণ সেবার পরিধি সীমিত হয়ে যাচ্ছে?

গ) বর্তমানে নির্ধারিত বাজেট ব্যবহারের ক্ষেত্রে দক্ষতা ও স্বচ্ছতাকে (efficiency, transparency and governance) কীভাবে মূল্যায়ন করবেন?

ঘ) অর্থায়ন বৃদ্ধি পেলে স্বাভাবিকভাবে সেবার পরিধিও বৃদ্ধি পাবে। অর্থায়ন বাড়াতে করণীয় কী হতে পারে?

ঙ) অর্থায়ন ও জনসাধারণের কাছে সেবা পৌঁছানোর ক্ষেত্রে পাবলিক, এনজিও এবং প্রাইভেট সেক্টরের মধ্যে কীভাবে সমন্বয় করে ভালো ফলাফল পাওয়া যেতে পারে?

Monitoring and Evaluation

৯. শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত পলিসি এবং কর্মসূচির মান নিশ্চিতকরণে ক্ষেত্রে পরিবীক্ষণ ও মূল্যায়ন (Monitoring and Evaluation) কতোটা গুরুত্বপূণ?

ক) বর্তমানে পরিবীক্ষণ ও মূল্যায়নের ক্ষেত্রে কে বা কারা দায়িত্বপালন করছে? এ সম্পর্কে আপনার ধারণা আছে কি?

খ) এক্ষেত্রে প্রয়োজনীয় জবাবদিহিতার অভাব রয়েছে কি?

গ) পরিবীক্ষণ বা মনিটরিং-এর ক্ষেত্রে আরো কী কী ব্যবস্থা নেওয়া উচিত বলে মনে করেন? উদাহরণ দিয়ে বলুন।

Research

১০. বাংলাদেশে শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত গবেষণালব্ধ তথ্য-উপাত্তের পরিমাণ সীমিত।

ক) এ সংক্রান্ত গবেষণার কাজে কারা নিয়োজিত?

খ) শিশুর প্রারম্ভিক যত্ন ও বিকাশ সেবার কোন কোন বিষয়গুলো নিয়ে আরো গবেষণা হওয়া প্রয়োজন বলে মনে করেন? উদাহরণ দিয়ে বলুন। (যেমন, অভিগম্যতা বা ধপপবংং, মান বা য়ঁধষরঃু, সমতা বা বয়ঁরঃু, পরিধি বা পড়াবৎধমব)

গ) তথ্য ও গবেষণার পরিসর ও মান বাড়ানোর জন্য কী কী করণীয়? এক্ষেত্রে গবেষণা প্রতিষ্ঠান ও বিশ্ববিদ্যালয়গুলো কেমন ভূমিকা রাখতে পারে?

Effectiveness, Barriers and Facilitators

১১. সার্বিক বিবেচনায় ০ থেকে ৮ বছর বয়স পর্যন্ত শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবার কার্যকারিতা কেমন দেখছেন?

১২. এক্ষেত্রে কোন বিষয়গুলোকে বাধা হিসেবে চিহ্নিত করবেন? এবং কোন সুযোগ/ সুবিধাগুলো শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবাকে তরান্বিত করে?

Recommendation and Future Guidelines

১৩. বাংলাদেশে শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত পরিসেবার ভবিষ্যত কেমন?

ক) পলিসি এবং প্র্যাক্টিস আরো জোরদারকরণে করণীয় কী?

খ) জাতীয় এবং আন্তর্জাতিক পর্যায়ে এমন কোনো সিস্টেম বা মডেল প্রচলিত আছে কি যেটি বাংলাদেশের ক্ষেত্রে পথ প্রদর্শনে সক্ষম? উদাহরণ দিয়ে বলুন।

আপনার মূল্যবান মতামত এবং সময়ের জন্য অসংখ্য ধন্যবাদ।

Annex 2

In-Depth Interview Guide for Health Officer/ Education Officer/ ECCD Service Provider

<u>সাক্ষাৎকার প্রদানে উপজেলা/মাঠ পর্যায়ের ইসিডি সংশ্লিষ্ট কর্মকর্তা বা প্র্যাক্টিশনারের সম্মতিপত্র (পড়হংবহঃ ভড়ৎস)</u>

গবেষণার নামঃ **Scoping Study on Status of Pre-natal to Transition to Schooling including Early Primary Education in Bangladesh**

গবেষণার উদ্দেশ্যঃ আসসালামুআলাইকুম/আদাব, আমি--। বাংলাদেশ ইসিডি নেটওয়ার্ক (BEN) বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের সামগ্রিক অবস্থা সম্পর্কে ধারণা পাওয়ার জন্যওউহযধহপবসবহঃ ড়ভ ভধাড়ঁৎধনষব বহারৎড়হসবহঃ ভড়ৎ ঃযব ঢ়ৎড়সড়ঃরড়হ ড়ভ উঈঈউ (উঋউচ-উঈঈউ) প্রকল্পের আওতায় গবেষণাটি পরিচালনা করছে।

পদ্ধতিঃ বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশ বিষয়ে উপজেলা/মাঠ পর্যায়ের একজন অভিজ্ঞ কর্মকর্তা বা প্র্যাক্টিশনার হিসেবে গবেষণার অংশগ্রহণকারী হিসেবে আপনাকে বেছে নেয়া হয়েছে। উপজেলা/মাঠ পর্যায়ে ইসিডি বিষয়ক কার্যক্রম বাস্তবায়নে নিযুক্ত একজন অভিজ্ঞ কর্মকর্তা/প্র্যক্টিশনার হিসেবে আপনার মূল্যবান মতামত এই গবেষণাকে সমৃদ্ধ করবে। আপনার সাক্ষাৎকারের জন্য আনুমানিক ১-১.৫ ঘণ্টা সময়ের প্রয়োজন হবে। এই সাক্ষাৎকার গ্রহণ করার জন্য একটি প্রশ্নমালা ব্যবহার করা হবে। নির্ভুলভাবে আপনার মতামত লিপিবদ্ধ করার জন্য সাক্ষাৎকারটি অডিও রেকর্ড করা প্রয়োজন হবে।

ঝুঁকি এবং সুবিধাদিঃ এই গবেষণায় অংশগ্রহণের কোন ঝুঁকি বা সুবিধা নেই। তবে এই গবেষণা থেকে প্রাপ্ত তথ্য বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের ক্ষেত্রে কার্যকর নীতি এবং কর্মসূচি নির্ধারনে সহায়ক হতে পারে।

গোপনীয়তাঃ আপনার দেয়া তথ্যের গোপনীয়তা সম্পূর্ণভাবে রক্ষা করা হবে এই তথ্য শুধু গবেষণার কাজে ব্যবহার করা হবে। আপনি যে তথ্যগুলো দেবেন তা অন্যদের তথ্যের সাথে একত্র করে একটি প্রতিবেদন (রিপোর্ট) আকারে প্রকাশ করা হবে। প্রতিবেদনে কোথাও আপনার নাম থাকবে না।

স্বেচ্ছায় অংশ অংশগ্রহণঃ আপনার অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাপ্রণোদিত। আপনি ইচ্ছা করলে আমাকে যে কোন প্রশ্ন করতে পারেন; ইচ্ছা হলে কোন প্রশ্নের উত্তর দানে বিরতও থাকতে পারেন। এমনকি আপনার সম্মতি (Consent) প্রদান করার পরও বা যে কোন সময় এই সাক্ষাৎকার প্রদান বন্ধ করতে পারেন। প্রয়োজনে আপনার সুবিধাজনক সময়ে পরবর্তীতে এই সাক্ষাৎকারে অংশগ্রহণ করতে পারেন।

অংশগ্রহণকারীর অধিকারঃ গবেষণার ব্যাপারে কোন প্রশ্ন থাকলে আপনি গবেষক ড. মুহাম্মদ মাহবুব মোর্শেদ (মোবাইল ০১৭৬৭৯০৩৬২৪)/ গবেষণা সহযোগী সায়েবা বিনতে জহির (মোবাইল ০১৭৭১৫৩৫০৩৮) অথবা বাংলাদেশ ইসিডি নেটওয়ার্ক-এর সৈয়দা সাজিয়া জামান (মোবাইল ০১৭১৬৪১৮২৭৫)/ মাহমুদা আক্তার (মোবাইল ০১৭৫৫৯২৯৩৭) কে ফোন করতে পারেন।

এই সাক্ষাৎকারে অংশগ্রহণ করার ব্যাপারে আপনার কি সম্মতি রয়েছে? (টিক চিহ্ন দিন)

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উপজেলা/মাঠ পর্যায়ের কর্মকর্তা বা প্র্যাক্টিশনারের স্বাক্ষর ও তারিখ

নাম:

প্রতিষ্ঠান:

আমি এই সম্মতিপত্র অংশগ্রহণকারীকে পড়ে শুনিয়েছি এবং তিনি সম্মতি দিয়েছেন/দেননি।

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সাক্ষাৎকার গ্রহণকারীর স্বাক্ষর ও তারিখ

সাক্ষাৎকার গ্রহণকারীর নাম:

উপজেলা/মাঠ পর্যায়ের ইসিডি সংশ্লিষ্ট কর্মকর্তা বা প্র্যাক্টিশনারের জন্য সাক্ষাৎকার প্রশ্নমালা

তারিখ:

নাম:

প্রতিষ্ঠানের নাম:

প্রতিষ্ঠানের ঠিকানা: **বিভাগ:** **জেলা:** **উপজেলা:**

Access and Coverage

১.আপনার উপজেলায়/ প্রতিষ্ঠান কর্তৃক শিশুর প্রারম্ভিক যত্ন ও বিকাশের ক্ষেত্রে কী কী সেবা সেবা দেওয়া হয়? (যেমন, কিশোর-কিশোরীদের গর্ভধারণ বিষয়ক সচেতনতামূলক সভা, গর্ভ ও প্রসবকালীন স্বাস্থ্যসেবা, মনোসামাজিক কাউন্সেলিং, প্রাক-প্রাথমিক শিক্ষা, প্রাথমিক শিক্ষা ইত্যাদি)

ক) বর্তমানে আপনার কর্মস্থলের আশেপাশের অঞ্চলে আনুমানিক কতগুলো প্রতিষ্ঠান এ ধরণের সেবা দিচ্ছে এ সম্পর্কে আপনার ধারণা আছে কি? প্রতিষ্ঠানগুলোর লক্ষ্যদল কারা?

খ) সাধারণ মানুষেরা কি উঈঈউ সম্পর্কে জানে বা এটিকে গুরুত্বপূর্ণ মনে করে?

গ) সাধারণ মানুষের কাছে কোন ধরণের সেবা বা কার্যক্রমের চাহিদা বেশি? চাহিদার সাথে মিল রেখে কোন কোন সেবা প্রাপ্তির ক্ষেত্রে সহজলভ্যতা রয়েছে এবং কোন কোন সেবা পর্যাপ্ত নয়?

ঘ) প্রাপ্ত সেবার প্রতি মানুষের আগ্রহ ও দৃষ্টিভঙ্গি কেমন? (যেমন, মায়েরা গর্ভ ও প্রসবকালীন স্বাস্থ্যসেবা নেন কিনা, শিশুকে নিয়মিত টিকা দিতে নিয়ে আসেন কিনা, শিশুর লালন-পালন বিষয়ে পরামর্শ চান কিনা, অভিভাবক শিশুকে ডে কেয়ার সেন্টার বা প্রি-স্কুলে পাঠাতে চান কিনা ইত্যাদি)

ঙ) ECCD সেবার চাহিদা সময়ের সাথে সাথে বাড়ছে কি? বিগত বছরগুলোর সাথে বর্তমান সময়ে সেবা গ্রহণের মধ্যে কেমন পার্থক্য দেখতে পান? উদাহরণ দিয়ে বলুন।

Stakeholder Mapping

২. আপনি যে এলাকায় কাজ করেন সেখানে শিশুর প্রারম্ভিক যত্ন এবং বিকাশ সংক্রান্ত সেবার ক্ষেত্রে প্রধান স্টেকহোল্ডার বা অংশীজন কারা এ সম্পর্কে আপনার ধারণা আছে কি? (যেমন, সরকারি প্রতিষ্ঠান, এনজিও, বেসরকারি সংস্থা, কমিউনিটি নেতা, অভিভাবক, স্থানীয় সরকার ইত্যাদি)

ক) সরকারি প্রতিষ্ঠান, এনজিও, বেসরকারি সংস্থা, কমিউনিটি নেতা, অভিভাবক, স্থানীয় সরকার ইত্যাদির মধ্যে অংশীজন বা স্টেকহোল্ডার হিসেবে কারা সবচেয়ে প্রভাবশালী ভূমিকা পালন করেন?

খ) শিশুর প্রারম্ভিক যত্ন এবং বিকাশ সংক্রান্ত কার্যক্রম বাস্তবায়নের ক্ষেত্রে একজন অংশীজন বা স্টেকহোল্ডার হিসেবে শিক্ষা/স্বাস্থ্য কর্মকর্তা/ প্রোগ্রাম কো-অর্ডিনেটর/ প্র্যাক্টিশনার -এর জায়গা থেকে আপনাকে কী ধরণের ভূমিকা এবং দায়িত্ব পালন করতে হয়? উদাহরণ দিয়ে বলুন।

৩. বিভিন্ন স্টেকহোল্ডারদের চাহিদা, স্বার্থ, প্রভাব/ক্ষমতা কীভাবে শিশুর প্রারম্ভিক যত্ন এবং বিকাশ সংক্রান্ত সেবা ও কার্যক্রমকে প্রভাবিত করে বলে মনে করেন?

৪. শিশুর প্রারম্ভিক যত্ন ও বিকাশ নিশ্চিতকরণে আপনার এলাকায় পরিবার ও সমাজের অংশগ্রহণ বর্তমানে কি মাত্রায় রয়েছে? এক্ষেত্রে, পরিবারের পাশাপাশি ধর্মীয় প্রতিষ্ঠান, স্থানীয় সরকার, এলাকার নেতৃস্থানীয় ব্যক্তিবর্গ, কমিউনিটি স্বাস্থ্য কর্মী, শিক্ষকসহ বিভিন্ন অংশীজনদের কার্যকর অংশগ্রহণ কীভাবে নিশ্চিত করা যায়?

Coordination and Collaboration

৫. একটি শিশুর জন্মের আগ থেকে শুরু করে তার জন্মগ্রহণ, শিশুর প্রারম্ভিক যত্ন, বিকাশ, সুরক্ষা এবং প্রাক প্রাথমিক ও প্রাথমিক শিক্ষায় অগ্রসর হওয়া পর্যন্ত একটি পর্যায়ক্রমিক ধারা রয়েছে। এই বয়সভিত্তিক সেবার ক্ষেত্রে যেমন শিক্ষা, স্বাস্থ্য, পুষ্টি, নিরাপত্তা ইত্যাদি বিষয়ের সমন্বয় রয়েছে, তেমনি বিভিন্ন সরকারি, বেসরকারি প্রতিষ্ঠান, এনজিও, দাতা সংস্থার সংশ্লিষ্টতা রয়েছে।

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Equity

৬. ECCD সেবা প্রদানের ক্ষেত্রে সরাসরি কাজ করতে গিয়ে মাঠ পর্যায়ে সমতা ও অন্তর্ভুক্তির কেমন চিত্র দেখতে পাচ্ছেন? উদাহরণ দিয়ে বলুন।

ক) সামাজিক ও অর্থনৈতিকভাবে পিছিয়ে পড়া জনগোষ্ঠী, দুর্গম এলাকাবাসী, ক্ষুদ্র নৃ-গোষ্ঠী, জলবায়ু অভিঘাতের শিকার, সুবিধাবঞ্চিত এবং বিশেষ চাহিদা সম্পন্ন শিশু ও তাদের পরিবার কি সমানভাবে সেবা পাচ্ছে? এ সম্পর্কে আপনার ধারণা আছে কি?

খ) ECCD সেবা প্রাপ্তির ক্ষেত্রে সমতা এবং মানসম্মত সেবা নিশ্চিত করার জন্য কী করা প্রয়োজন?

Quality

৭. গর্ভ ও প্রসবকালীন সময় থেকে শিশুর প্রারম্ভিক শিক্ষা অর্থাৎ ১ম কিংবা ২য় শ্রেণী পর্যন্ত অগ্রসর হওয়ার ক্ষেত্রে বিভিন্ন পর্যায় সফলভাবে শেষ করতে হয়। শিশু তার ০ থেকে ৮ বছর পর্যন্ত প্রতিটি ধাপে স্বাস্থ্য, শিক্ষা, নিরাপত্তাসহ প্রতিটি ক্ষেত্রে গুণগত সেবা পাচ্ছে কি?

ক) চাহিদা অনুযায়ী প্রাপ্ত সেবা কি যথেষ্ট এবং মানসম্মত?

খ) সেবার মান রক্ষার জন্য কি কোনো ন্যাশনাল কোয়ালিটি স্ট্যান্ডার্ড মেনে চলা হয়? এই বিষয়ে আপনারা কিছু জানা আছে কি?

গ) সেবার মান বাড়াতে কী করণীয়?

৮. বিশেষ করে, শিশুদের প্রারম্ভিক শিখনের জন্য কী ধরনের শিক্ষাক্রম/ পাঠ্যসূচি ব্যবহার করা হয়? শিখনফল অর্জন হয়েছে কিনা তা কীভাবে যাচাই করা হয়? এ বিষয়গুলো সম্পর্কে আপনার ধারণা আছে কি? উদাহরণ দিয়ে বলুন।

ক) শিশুকে প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবা প্রদানকারীদের কি স্বাস্থ্য শিক্ষা (যবধষঃয বফঁপধঃরড়হ) বিষয়ে কোনো বিশেষ প্রশিক্ষণ দেওয়া হয়? এ বিষয়ে আপনারা কিছু জানা আছে কি?

৯. শিশুর প্রারম্ভিক যত্ন ও বিকাশ সেবার মান নিশ্চিতকরণে কাজ করতে গিয়ে কী ধরণের চ্যালেঞ্জের মুখোমুখি হন? এ অবস্থা থেকে উত্তরণে কী করণীয়?

১০. বর্তমানে উঈঈউ সেবার সাথে সংশ্লিষ্ট ব্যক্তিবর্গের দক্ষতা ও মানকে কীভাবে মূল্যায়ন করবেন? এই শ্রমশক্তির দক্ষতা ও মানোন্নয়নের জন্য কী কী পদক্ষেপ নেওয়া যেতে পারে?

১১. স্তরভিত্তিক উঈঈউ সেবা কি শিশুর বিকাশের এক ধাপ থেকে পরবর্তী ধাপে অগ্রগতির ক্ষেত্রে ভূমিকা পালন করে? (যেমন, প্রারম্ভিক শিখনের মধ্য দিয়ে স্কুলের জন্য প্রস্তুত হওয়া) করে থাকলে, উদাহরণ দিয়ে বলুন।

Financing and Management

১২. শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত কার্যক্রম পরিচালনার ক্ষেত্রে কি যথেষ্ট বাজেট রয়েছে? বাজেট সম্পর্কে আপনার যথেষ্ট ধারণা আছে কি?

ক) ধারণা থাকলে, সেবার পরিধি ও মান বাড়াতে আপনি পরিকল্পনা, ব্যবস্থাপনা, বাজেটিং ও সম্পদ বন্টনের ক্ষেত্রে কী কী ব্যবস্থা নেন? উদাহরণ দিয়ে বলুন।

খ) নির্ধারিত বাজেট ব্যবহারে ক্ষেত্রে দক্ষতা ও স্বচ্ছতা নিশ্চিত করেন কীভাবে?

গ) এ ক্ষেত্রে বাজেট বাড়লে কোন ধরণের কার্যক্রম বাড়াতেন?

Monitoring and Evaluation

১৩. আপনাদের পরিচালিত উঈঈউ কার্যক্রম পরিবীক্ষণ ও মূল্যায়ন (Monitoring and Evaluation) করা হয় কীভাবে?

এ বিষয়ে আপনারা কিছু জানা আছে কি? ধারণা থাকলে, এক্ষেত্রে কে বা কারা দায়িত্বশীল ভূমিকা পালন করেন? উদাহরণ দিয়ে বলুন।

ক) ECCD সেবার মান রক্ষার্থে পর্যবেক্ষণ, মূল্যায়ন ও জবাবদিহিতা কতোটা প্রয়োজনীয় বলে মনে করেন?

খ) পর্যবেক্ষণ ও মূল্যায়নের ক্ষেত্রে কার্যকরী পদক্ষেপ গুলো কী কী হতে পারে?

Research

১৪. ECCD কার্যক্রম পরিচালনার ক্ষেত্রে কোনো ধরণের তথ্য ও উপাত্ত সংরক্ষণ করা হয় কি? (যেমন, টিকা কার্ড, জন্ম সনদ, শিশুর বিকাশ সংক্রান্ত তথ্য- ওজন, উচ্চতা) । হলে, তা কী প্রয়োজনে ব্যবহার করা হয়?

ক) তথ্য-উপাত্ত সংশ্লিষ্ট কোনো ধরণের সমস্যার সম্মুখীন হয়েছেন কি? উদাহরণ দিয়ে বলুন। (যেমন, হালনাগাদকৃত তথ্যের অভাব)

খ) হালনাগাদকৃত তথ্য ও গবেষণা উঈঈউ কার্যক্রম পরিচালনার ক্ষেত্রে কীভাবে সহায়ক হতে পারে?

গ) সামগ্রিকভাবে শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত তথ্য-উপাত্ত ও গবেষণার পরিমাণ কি যথেষ্ট বলে মনে করেন? কোন ক্ষেত্রগুলোতে তথ্যের ঘাটতি রয়েছে?

Effectiveness, Barriers and Facilitators

১৫. সার্বিক বিবেচনায় ০ থেকে ৮ বছর বয়স পর্যন্ত শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবার কার্যকারিতা কেমন দেখছেন? ১৬. এক্ষেত্রে কোন বিষয়গুলোকে বাধা হিসেবে চিহ্নিত করবেন? এবং কোন সুযোগ/ সুবিধাগুলো শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবাকে তরান্বিত করে?

Recommendations and Future Guidelines

১৭. সর্বোপরি, শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবার চাহিদা, পরিধি এবং এ সম্পর্কিত সচেতনতা বৃদ্ধির জন্য কী করণীয়? এ বিষয়ে আপনার ভবিষ্যৎ পরিকল্পনা এবং প্রত্যাশা সম্পর্কে বলুন।

আপনার মূল্যবান মতামত এবং সময়ের জন্য অসংখ্য ধন্যবাদ।

Annex 3

Parents' Focus Group Discussion Guide

ফোকাস দল আলোচনায় (এফজিডি) অংশগ্রহণে ০-৮ বছর বয়সী শিশুর বাবা/মা/অভিভাবকের সম্মতিপত্র (consent form)

গবেষণার নাম: Scoping Study on Status of Pre-natal to Transition to Schooling including Early Primary Education in Bangladesh

গবেষণার উদ্দেশ্য: আসসালামুআলাইকুম/আদাব, আমি-- ---। বাংলাদেশ ইসিডি নেটওয়ার্ক (ইউঘ) বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের সামগ্রিক অবস্থা সম্পর্কে ধারণা পাওয়ার জন্যঙউহযধহপবসবহঃ ড়ভ ভধাড়ঁৎধনষব বহারৎড়হসবহঃ ভড়ৎ ঃযব ঢ়ৎড়সড়ঃরড়হ ড়ভ উঈঈউ (উঋউচ-উঈঈউ) প্রকল্পের আওতায় গবেষণাটি পরিচালনা করছে। পোর্টিকাস নামক আন্তর্জাতিক প্রতিষ্ঠান এই প্রকল্পে সহায়তা প্রদান করছে।

পদ্ধতি: ০-৮ বছর বয়সী শিশুর বাবা/মা/অভিভাবক হিসেবে আপনাদের মূল্যবান মতামত এই গবেষণাকে সমৃদ্ধ করবে। আপনার সাক্ষাৎকারের জন্য আনুমানিক ১.৫ ঘণ্টা সময়ের প্রয়োজন হবে। এই আলোচনার জন্য একটি প্রশ্নমালা ব্যবহার করা হবে। নির্ভুলভাবে আপনাদের মতামত লিপিবদ্ধ করার জন্য সাক্ষাৎকারটি অডিও রেকর্ড করা প্রয়োজন হবে।

ঝুঁকি এবং সুবিধাদি: এই গবেষণায় অংশগ্রহণের কোন ঝুঁকি বা সুবিধা নেই। তবে এই গবেষণা থেকে প্রাপ্ত তথ্য বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের ক্ষেত্রে কার্যকর নীতি এবং কর্মসূচি নির্ধারনে সহায়ক হতে পারে।

গোপনীয়তা: আপনাদের দেয়া তথ্যের গোপনীয়তা সম্পূর্ণভাবে রক্ষা করা হবে এই তথ্য শুধু গবেষণার কাজে ব্যবহার করা হবে। আপনারা যে তথ্যগুলো দেবেন তা অন্যদের তথ্যের সাথে একত্র করে একটি প্রতিবেদন (রিপোর্ট) আকারে প্রকাশ করা হবে। প্রতিবেদনে কোথাও আপনাদের কারো নাম থাকবে না।

স্বেচ্ছায় অংশ অংশগ্রহণ: এই আলোচনায় আপনাদের অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাপ্রণোদিত। আপনারা ইচ্ছা করলে আমাকে যে কোন প্রশ্ন করতে পারেন; ইচ্ছা হলে কোন প্রশ্নের উত্তর দানে বিরতও থাকতে পারেন। এমনকি সম্মতি (ঈড়হংবহঃ) প্রদান করার পরও বা যে কোন সময় এই আলোচনায় অংশগ্রহণ বন্ধ করতে পারেন।

অংশগ্রহণকারীর অধিকারঃ এই গবেষণার ব্যাপারে কোন প্রশ্ন থাকলে গবেষক ড. মুহাম্মদ মাহবুব মোর্শেদ (মোবাইল ০১৭৬৭৯০৩৬২৪)/ গবেষণা সহযোগী সায়েবা বিনতে জহির (মোবাইল ০১৭৭১৫৩৫০৩৮) অথবা বাংলাদেশ ইসিডি নেটওয়ার্ক-এর সৈয়দা সাজিয়া জামান (মোবাইল ০১৭১৬৪১৮২৭৫)/ মাহমুদা আক্তার (মোবাইল ০১৭৫৫৯২৯৩৭) কে ফোন করতে পারেন।

এই আলোচনায় অংশগ্রহণ করার ব্যাপারে সম্মতি থাকলে নিচের ছকটি পূরণ করুন।

ক্রম	অভিভাবকের নাম	লিঙ্গ (পুরুষ/মহিলা)	শিক্ষাগত যোগ্যতা	যেই ইসিসিডি প্রতিষ্ঠানের সেবাগ্রহীতা (যদি থাকে)	সম্মতিসূচক স্বাক্ষর ও তারিখ
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আমি এই সম্মতিপত্র আলোচনায় অংশগ্রহণকারীদের পড়ে শুনিয়েছি এবং তারা সম্মতি দিয়েছেন ।

এফজিডি পরিচালনাকারীর স্বাক্ষর ও তারিখ

এফজিডি পরিচালনাকারীর নাম:

০-৮ বছর বয়সী শিশুর বাবা/মা/অভিভাবকের সাথে ফোকাস দল আলোচনার প্রশ্নমালা

তারিখ:

এফজিডি-তে অংশগ্রহণকারীদের ঠিকানা:

গ্রাম/এলাকা/সড়ক:

বিভাগ: জেলা: উপজেলা:

এফজিডি পরিচালনার স্থান:

Access and Coverage

১. আপনাদের এলাকায় গর্ভধারণ থেকে শুরু করে শিশুর ৮ বছর বয়স পর্যন্ত কী কী সেবা চালু আছে? উদাহরণ দিয়ে বলুন। (গর্ভকালীন ও প্রসব পরবর্তী সময়ে মা ও শিশুর স্বাস্থ্যসেবা, পুষ্টি, দিবাযত্ন কেন্দ্র, প্রাক প্রাথমিক শিক্ষা কেন্দ্র ইত্যাদি)

ক) আপনার আশেপাশের অন্যান্য অভিভাবকদের মধ্যে এই সেবাসমূহের প্রতি আগ্রহ বা চাহিদা কেমন? সাধারণত কারা এই সেবাগুলো নিতে চায়? (যেমন, অবস্থাপন্ন বাবা-মা, শিক্ষিত বাবা-মা ইত্যাদি)

২. গর্ভধারণের আগে এবং গর্ভকালীন ও প্রসব পরবর্তী সময়ে (শিশুর ০ থেকে ৩ বছর, ৩ থেকে ৬ বছর এবং ৬ থেকে ৮ বছর) আপনারা, আপনাদের শিশু এবং আপনাদের পরিবার কী কী সার্ভিস বা সহায়তা পেয়েছেন? (যেমন, গর্ভধারণের আগে প্রয়োজনীয় তথ্য, গর্ভকালীন ও প্রসব পরবর্তী সময়ে স্বাস্থ্যকর্মীদের নিয়মিত ভিজিট, শিশুর যত্ন, বিকাশ ও নিরাপত্তা সম্পর্কিত সেবা ও নির্দেশনা, টিকা ইত্যাদি)

ক) আপনার এলাকায় এ ধরণের সেবা কতোটা সহজলভ্য?

খ) সেবা গ্রহণের ক্ষেত্রে অভিভাবক হিসেবে আপনারা কোনো ধরণের সমস্যার সম্মুখীন হয়েছেন কি? উদাহরণ দিয়ে বলুন। (যেমন, আর্থিক সমস্যা, যাতায়াতের সমস্যা, শিশুর নিরাপত্তাজনিত সমস্যা, সামাজিক দৃষ্টিভঙ্গিজনিত সমস্যা ইত্যাদি)

৩. গর্ভকালীন ও এর পরবর্তী সময়ে শিশুর পাশাপাশি মা ও পরিবারের সদস্যদের জন্যও কিছু সেবা গুরুত্বপূর্ণ। এক্ষেত্রে আপনারা বিভিন্ন প্রতিষ্ঠান কর্তৃক কী কী সেবা পেয়েছেন? উদাহরণ দিয়ে বলুন। (যেমন, মায়ের মনোসামাজিক কাউন্সেলিং, মায়ের পুষ্টি চাহিদা পূরণে বিভিন্ন ওষুধ/ সাপ্লিমেন্ট প্রদান, প্যারেন্টিং বিষয়ক শিক্ষা, মা ব্যতীত পরিবারের অন্যান্য সদস্যদের শিশুর যত্ন বিষয়ক প্রশিক্ষণ ইত্যাদি)

৪. অভিভাবক হিসেবে আপনি বাড়িতে শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার বিভিন্ন ক্ষেত্রে কেমন ভূমিকা পালন করেছেন কিংবা কী কী পদক্ষেপ নিয়েছেন? উদাহরণ দিয়ে বলুন।

ক) আপনাদের এলাকায় পরিবারে শিশুর যত্নকারীরা শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার বিষয়গুলো সম্পর্কিত কোনো প্রাতিষ্ঠানিক নির্দেশনা বা প্রশিক্ষণ পায় কি? (যেমন, শিশুর ০ থেকে ৮ বছর বয়স পর্যন্ত যত্ন ও বিকাশের ক্ষেত্রে কী কী করতে হবে বা কোন কাজগুলো করা যাবেনা, শিশুকে কোন ধরণের খাবার খাওয়াতে হবে, শিশুর সাথে কেমন ব্যবহার করতে হবে, শিশুকে কীভাবে উদ্দীপনা দিতে হবে, শিশুকে বাড়িতে কীভাবে প্রাক-প্রাথমিক শিক্ষা দিতে হবে ইত্যাদি)

খ) পেয়ে থাকলে, সেগুলো সম্পর্কে বলুন। আর না পেয়ে থাকলে, কেমন পদক্ষেপ প্রয়োজন বলে মনে করেন?

গ) যথাযথ দিক নির্দেশনা না পাওয়া বা প্রশিক্ষণ না থাকার কারণে বাড়িতে শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা সংক্রান্ত কোন ধরণের অসুবিধার সম্মুখীন হয়েছেন কি? হলে, উদাহরণ দিয়ে বলুন।

Stakeholder Mapping

৫. গর্ভধারণের আগে, গর্ভকালীন ও প্রসব পরবর্তী সময়ে, আপনারা ও আপনাদের পরিবার কাদের কাছ থেকে বিভিন্ন ধরণের সেবা পেয়েছেন? উদাহরণ দিন।

৬. শিশুর জন্মের প্রথম তিন বছরে শিশুর যত্ন ও বিকাশের ক্ষেত্রে আপনাদের কে বা কারা সহযোগিতা করেছে? উদাহরণ দিন। (যেমন, পরিবারের অন্যান্য সদস্যবৃন্দ, প্রতিবেশী, গৃহকর্মী, কমিউনিটি ক্লিনিক, স্বাস্থ্যকর্মী, এনজিওর মাঠকর্মী ইত্যাদি)

৭. শিশুর প্রাক-শৈশবের ৩ থেকে ৬ বছর বয়স সময়কালে শিশুর যত্ন, বিকাশ, সুরক্ষা ও নিরাপত্তা, শিক্ষা ইত্যাদি বিষয়ে কাদের থেকে সহায়তা পেয়েছেন? উদাহরণ দিন। (যেমন, পরিবারের অন্যান্য সদস্যবৃন্দ, কমিউনিটি ক্লিনিক, স্বাস্থ্যকর্মী, এনজিওর মাঠকর্মী, ডে কেয়ার সেন্টাররের পরিচালক ও অন্যান্য কর্মচারীবৃন্দ, ধর্মীয় প্রতিষ্ঠান, প্রাক-প্রাথমিক স্কুলের শিক্ষক ইত্যাদি)

৮. শিশুর ৬ থেকে ৮ বছর বয়স পর্যন্ত যত্ন, বিকাশ, সুরক্ষা, শিক্ষা ইত্যাদি বিষয়ে কে বা কারা সহযোগিতা করেছে? উদাহরণ দিন। (যেমন, পরিবারের অন্যান্য সদস্যবৃন্দ, প্রতিবেশী, কমিউনিটি ক্লিনিক, স্বাস্থ্যকর্মী, এনজিওর মাঠকর্মী, ডে কেয়ার সেন্টাররের পরিচালক ও অন্যান্য কর্মচারীবৃন্দ, ধর্মীয় প্রতিষ্ঠান, প্রাথমিক স্কুলের শিক্ষক ইত্যাদি)

Quality

৯. শিশুর প্রাক-শৈশব যত্ন, বিকাশ, নিরাপত্তা ও শিক্ষা ক্ষেত্রে বিভিন্ন বয়সভিত্তিক (০ থেকে ৮ বছর) সেবার মান ও কার্যকারিতা কেমন ছিল? উদাহরণ দিয়ে বলুন।

ক) শিশুর পাশাপাশি মা এবং পরিবারের অন্যান্য সদস্যদের প্রাপ্ত সেবার মান ও কার্যকারিতা সম্পর্কে উদাহরণ দিয়ে বলুন। (যেমন, মায়ের মনোসামাজিক কাউন্সেলিং, মায়ের পুষ্টি চাহিদা পূরণে বিভিন্ন ওষুধ/ সাপ্লিমেন্ট প্রদান, প্যারেন্টিং বিষয়ক শিক্ষা, মা ব্যতীত পরিবারের অন্যান্য সদস্যদের শিশুর যত্ন বিষয়ক প্রশিক্ষণ ইত্যাদি)

খ) প্রাপ্ত সেবার কোন বিষয়গুলো ভালো এবং কোন বিষয়গুলোর আরো উন্নতি করা প্রয়োজন?

গ) প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা সংশ্লিষ্ট প্রাপ্ত সেবার ফলাফল হিসেবে আপনার শিশুর মধ্যে ইতিবাচক কোনো পরিবর্তন দেখতে পান বা পেয়েছেন কী? উদাহরণ দিয়ে বলুন।

ক) শিশুর প্রারম্ভিক শিখন অভিজ্ঞতা কি তাকে শিক্ষার পরবর্তী স্তর বা স্কুলে যাওয়ার জন্য তৈরি হতে সাহায্য করেছে?

Equity and Inclusion

১০. গর্ভধারণ থেকে শুরু করে শিশুর ০ থেকে ৮ বছর বয়স পর্যন্ত প্রাপ্য বিভিন্ন সেবা কি সবার জন্য একই রকম সহজলভ্য?

ক) আপনাদের এলাকার পিছিয়ে পড়া কিংবা সুবিধাবঞ্চিত জনগোষ্ঠী, (যেমনঃ দরিদ্র পরিবারের শিশু, মেয়ে শিশু, বিশেষ চাহিদাসম্পন্ন শিশু, ক্ষুদ্র-নৃগোষ্ঠীভুক্ত শিশু ও তার পরিবার) কি একইভাবে এসব সুবিধা ভোগ করে?

- এক্ষেত্রে কেউ কোনো ধরণের অবহেলার শিকার হয়ে থাকলে উদাহরণ দিয়ে বলুন।

Collaboration and Coordination

১১. গর্ভধারণ, শিশুর জন্ম এবং শিশুর ধীরে ধীরে বড় হওয়ার ক্ষেত্রে বিভিন্ন ধাপে বিভিন্ন প্রতিষ্ঠান থেকে সেবা নেওয়া হয় (যেমন, জন্মের পরপর হাসপাতাল থেকে টিকা নেওয়া, সুস্বাস্থ্যের জন্য স্বাস্থ্যকর্মীর পরামর্শ নেওয়া, আরেকটু বড় হলে স্কুলে যাওয়া ইত্যাদি)। এই প্রতিষ্ঠানগুলোর কি একটির সাথে অপরটির যোগাযোগ বা সম্পর্ক রয়েছে? থাকলে কেমন? উদাহরণ দিয়ে বলুন।

১২. আপনি, আপনার পরিবার এবং আপনার সন্তান বিভিন্ন প্রতিষ্ঠান থেকে সেবা নেওয়ার সময়, সেই প্রতিষ্ঠানগুলোর কার্যক্রম পরিচালনা এবং সিদ্ধান্তগ্রহণের ক্ষেত্রে কি সক্রিয় অংশগ্রহণের সুযোগ পান? পেলে, কীভাবে অংশগ্রহণ করেন? উদাহরণ দিয়ে বলুন। (যেমন, অভিভাবক সমাবেশ, মত বিনিময় সভা, প্রাক প্রাথমিকের ক্লাসে স্বেচ্ছাসেবী হিসেবে ভূমিকা পালন ইত্যাদি)

Financing/ Household Expense

১৩. শিশুর জন্য প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা সংশ্লিষ্ট নিশ্চিত করা কতোটা খরচ সাপেক্ষ?

ক) গর্ভ ও প্রসবকালীন সময়, শিশুর ০ থেকে ৩ বছর, ৩ থেকে ৬ বছর এবং ৬ থেকে ৮ বছর সময়কালে এই খাতে ন্যূনতম কেমন ব্যয় হয়? উদাহরণ দিয়ে বলুন।

খ) এক্ষেত্রে অভিভাবক হিসেবে আপনারা কী ধরণের সহায়তা আশা করেন?

Monitoring and Evaluation

১৪. আপনারা শিশুর জন্য সঠিকভাবে প্রারম্ভিক যত্ন, বিকাশ, ও শিক্ষা সেবা পাচ্ছেন কিনা, এই বিষয়ে কেউ কি এসে নিয়মিত খোঁজ-খবর নেয়?

ক) সেবার মান সম্পর্কে অভিভাবকদের মতামত বা অভিযোগ নেওয়া হয় কি?

খ) আপনি যদি কোনো অভিযোগ করেন, সেটা সমাধান করা হয় কি? হলে, কীভাবে হয়? উদাহরণ দিয়ে বলুন।

Data and Research

১৫. শিশুর জন্ম ও বিকাশ সংশ্লিষ্ট তথ্য (যেমন, জন্ম সনদ, টিকা কার্ড, ওজন, উচতার পরিমাপ) ইত্যাদি সেবা প্রদানকারী প্রতিষ্ঠান থেকে সংগ্রহ ও সংরক্ষণ করা হয় কি? হলে তা কী প্রয়োজনে ব্যবহার করা হয়?

ক) শিশুর প্রারম্ভিক যত্ন, বিকাশ, ও শিক্ষা সেবা বিষয়ে আপনাদের অভিজ্ঞতা, মতামত বা সমস্যাগুলো কি কেউ লিখে রাখে বা তথ্য হিসেবে সংগ্রহ করে?

খ) এই তথ্যগুলো সংগ্রহ করা হলে তা কীভাবে ভবিষ্যতে সেবার মান উন্নয়নে কাজে লাগানো যেতে পারে বলে মনে করেন?

Effectiveness, Barriers and Facilitators

১৬. সার্বিক বিবেচনায় ০ থেকে ৮ বছর বয়স পর্যন্ত শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবার কার্যকারিতা কেমন দেখছেন? ১৭. এক্ষেত্রে কোন বিষয়গুলোকে বাধা হিসেবে চিহ্নিত করবেন? এবং কোন সুযোগ/ সুবিধাগুলো শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবাকে তরান্বিত করে?

ক) কী কী কারণে মা, শিশু ও তাদের পরিবার প্রয়োজনীয় সেবা পায়না?

খ) কোন বিষয়গুলো সেবা পাওয়ার ক্ষেত্রে সুযোগ বা সুবিধা তৈরি করে?

Recommendations and Future Guidelines

১৮. বাংলাদেশের বর্তমান প্রেক্ষাপটে শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা সংশ্লিষ্ট সেবা সংক্রান্ত কোনো প্রত্যাশা কিংবা এর আরো উন্নয়নের জন্য দিক নির্দেশনা থাকলে তা উল্লেখ করুন।

আপনাদের মূল্যবান মতামত এবং সময়ের জন্য অসংখ্য ধন্যবাদ।

Annex 4

ECCD Practitioners' Survey Questionnaire

অনলাইন জরিপে অংশগ্রহণে বাংলাদেশ ইসিডি নেটওয়ার্কের সদস্য প্রতিষ্ঠানের সাথে যুক্ত ইসিডি প্র্যাকটিশনারের সম্মতিপত্র (consent form)

গবেষণার নামঃ Scoping Study on Status of Pre-natal to Transition to Schooling including Early Primary Education in Bangladesh

গবেষণার উদ্দেশ্যঃ আসসালামুআলাইকুম/আদাব, আমি--। বাংলাদেশ ইসিডি নেটওয়ার্ক (ইউঘ) বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের সামগ্রিক অবস্থা সম্পর্কে ধারণা পাওয়ার জন¨ 'Enhancement of favourable environment for the promotion of ECCD (EFEP-ECCD)' প্রকল্পের আওতায় গবেষণাটি পরিচালনা করছে।

পদ্ধতিঃ বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশ বিষয়ে বাংলাদেশ ইসিডি নেটওয়ার্কের সদস্য প্রতিষ্ঠনের সাথে যুক্ত একজন অভিজ্ঞ ইসিডি প্র্যাকটিশনার হিসেবে আপনার মূল্যবান মতামত এই গবেষণাকে সমৃদ্ধ করবে। এই জরিপে অংশগ্রহণের জন্য আনুমানিক ২৫-৩০ মিনিট সময়ের প্রয়োজন হবে। জরিপের জন্য একটি প্রশ্নমালা ব্যবহার করা হবে।

ঝুঁকি এবং সুবিধাদিঃ এই গবেষণায় অংশগ্রহণের কোন ঝুঁকি বা সুবিধা নেই। তবে এই গবেষণা থেকে প্রাপ্ত তথ্য বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের ক্ষেত্রে কার্যকর নীতি এবং কর্মসূচি নির্ধারনে সহায়ক হতে পারে।

গোপনীয়তাঃ আপনার দেয়া তথ্যের গোপনীয়তা সম্পূর্ণভাবে রক্ষা করা হবে এই তথ্য শুধু গবেষণার কাজে ব্যবহার করা হবে। আপনি যে তথ্যগুলো দেবেন তা অন্যদের তথ্যের সাথে একত্র করে একটি প্রতিবেদন (রিপোর্ট) আকারে প্রকাশ করা হবে। প্রতিবেদনে কোথাও আপনার নাম থাকবে না।

স্বেচ্ছায় অংশ অংশগ্রহণঃ আপনার অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাপ্রণোদিত। এমনকি আপনার সম্মতি (Consent) প্রদান করার পরও বা যে কোন সময় এই জরিপে অংশগ্রহণ বন্ধ করতে পারেন। প্রয়োজনে আপনার সুবিধাজনক সময়ে পরবর্তীতে এই জরিপে অংশগ্রহণ সম্পন্ন করতে পারেন।

অংশগ্রহণকারীর অধিকারঃ এই গবেষণার ব্যাপারে কোন প্রশ্ন থাকলে আপনি গবেষক ড. মুহাম্মদ মাহবুব মোর্শেদ (মোবাইল ০১৭৬৭৯০৩৬২৪)/ গবেষণা সহযোগী সায়েবা বিনতে জহির (মোবাইল ০১৭৭১৫৩৫০৩৮) অথবা বাংলাদেশ ইসিডি নেটওয়ার্ক-এর প্রতিনিধি সৈয়দা সাজিয়া জামান (মোবাইল ০১৭১৬৪১৮২৭৫)/ মাহমুদা আক্তার (মোবাইল ০১৭৫৫৫৯২৯৩৭) কে ফোন করতে পারেন।

এই সাক্ষাৎকারে অংশগ্রহণ করার ব্যাপারে আপনার কি সম্মতি রয়েছে? (টিক চিহ্ন দিন)

হ্যাঁ	না

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ইসিডি প্র্যাক্টিশনারের স্বাক্ষর ও তারিখ

নামঃ

প্রতিষ্ঠান:

বাংলাদেশ ইসিডি নেটওয়ার্কের সদস্য প্রতিষ্ঠানের সাথে যুক্ত ইসিডি প্র্যাকটিশনারের জন্য অনলাইন জরিপের প্রশ্নমালা

ব্যক্তিগত ও পেশা সংক্রান্ত তথ্য

আপনার প্রতিষ্ঠানের নাম ও অবস্থান ও অবস্থান:

নাম:

ঠিকানা:

বিভাগ __________ জেলা _______ উপজেলা _________

১. আপনার নামঃ

২. বয়সঃ

ক) ১৮-৩০ বছর

খ) ৩১-৪০ বছর

গ) ৪১-৫০ বছর

ঘ) ৫১-৬০ বছর

ঙ) ৬১ বা তদুর্ধ্ব

৩. লিঙ্গঃ

ক) নারী

খ) পুরুষ

গ) অন্যান্য (লিখুন):--------------------

৪. শিক্ষাগত যোগ্যতাঃ

ক) মাধ্যমিক

খ) উচ্চমাধ্যমিক

গ) স্নাতক

ঘ) স্নাতকোত্তর

ঙ) অন্যান্য _________

৫. শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা বা সংশ্লিষ্ট বিষয়ে আপনার কোন ধরনের পেশাগত ডিগ্রী বা প্রশিক্ষণ রয়েছে?

ক) স্নাতক বা স্নাতকোত্তর পর্যায়ের

খ) ডিপ্লোমা পর্যায়ের

গ) এক বা একাধিক স্বল্পমেয়াদি প্রশিক্ষণ

ঘ) কোন পেশাগত ডিগ্রী বা প্রশিক্ষণ নেই

ঙ) অন্যান্য __________

৬. আপনার শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা নিয়ে কাজ করার ক্ষেত্রে কতদিনের অভিজ্ঞতা রয়েছে?

ক) ২ বছরের কম

খ) ২ থেকে ৫ বছর

গ) ৫-১০ বছর

ঘ) ১০-২০ বছর

ঙ) ২০ বছরের বেশি

৭. আপনার বর্তমান প্রতিষ্ঠানে আপনার প্রধান কাজ কোন সংক্রান্ত? (একাধিক উত্তর হতে পারে)

ক) ব্যবস্থাপনা বা প্রশাসনিক কাজ সংক্রান্ত

খ) প্রশিক্ষণ সংক্রান্ত

গ) শিক্ষকতা বা ফ্যাসিলিটেশন সংক্রান্ত

ঘ) মনিটরিং ও গবেষণা সংক্রান্ত

ঙ) অন্যান্য __________

৮. আপনার প্রতিষ্ঠানের প্রদত্ত সেবার ধরণ কী? (একাধিক উত্তর হতে পারে)

ক) প্রাথমিক বিদ্যালয়কেন্দ্রিক

খ) প্রিস্কুল কেন্দ্রিক

গ) দিবা-যত্ন কেন্দ্রিক

ঘ) হোম-বেইজড

ঙ) কমিউনিটি-কেন্দ্রিক

চ) আউটরিচ কেন্দ্রিক

ছ) অন্যান্য __________

৯. আপনার প্রতিষ্ঠানটি মূলত কী ধরণের??

ক) স্থানীয় এনজিও

খ) জাতীয় এনজিও

গ) আন্তর্জাতিক এনজিও

ঘ) সরকারি

ঙ) বেসরকারি/ ব্যক্তিমালিকানাধীন

চ) বিশ্ববিদ্যালয়/ গবেষণা প্রতিষ্ঠান

ছ) অন্যান্য __________

আপনার প্রতিষ্ঠানের কার্যপরিধি, অভিগম্যতা এবং অর্ন্তভূক্তি

১০. আপনার প্রতিষ্ঠানে গর্ভ ও প্রসবকালীন সময় থেকে শিশুর ৮বছর বয়স পর্যন্ত সুস্বাস্থ্য রক্ষার্থে নিচের কোন কোন সেবা বা কার্যক্রম চালু আছে? (একাধিক উত্তর গ্রহণযোগ্য)

ক) পরিবার পরিকল্পনা বিষয়ক তথ্য ও পরামর্শ প্রদান

খ) প্রসবকালীন ও প্রসব পরবর্তী সময়ে শিশুর যত্ন ও পরিচর্যা

গ) মা এবং/ অথবা শিশুর জন্য টিকা, ওষুধ, ভিটামিন ও অন্যান্য সাপ্লিমেন্ট প্রদান

ঘ) মা এবং/ অথবা শিশুর জন্য মানসম্মত স্বাস্থ্যসেবা প্রদান

ঙ) মা এবং/ অথবা শিশুর যত্নকারীদের মনোসামাজিক (ঢ়ংুপযড়ংড়পরধষ) সাহায্য প্রদান

চ) শিশুর বিকাশজনিত সমস্যা চিহ্নিতকরণ বিষয়ক তথ্য ও পরামর্শ প্রদান

ছ) শিশুর বিকাশজনিতসমস্যা বা বিশেষ চাহিদা অনুযায়ী সেবা প্রদান

জ) কোনোটিই নয়

ঝ) অন্যান্য

১১. আপনার প্রতিষ্ঠানে গর্ভ ও প্রসবকালীন সময় থেকে শিশুর ৮বছর বয়স পর্যন্ত পুষ্টিচাহিদা সংক্রান্ত নিচের কোন কোন সেবা বা কার্যক্রম চালু আছে? (একাধিক উত্তর গ্রহণযোগ্য)

ক) মায়ের পুষ্টিচাহিদা পুরণ ও প্রয়োজনীয় তথ্য প্রদান

খ) দুধদান বিষয়ক তথ্য ও পরামর্শ প্রদান

গ) মা ও শিশুর অনুপুষ্টির চাহিদা পূরণ ও প্রয়োজনীয় তথ্য প্রদান

ঘ) শিশুর জন্য পুষ্টিকর বিকল্প খাদ্যের চাহিদা পূরণ ও প্রয়োজনীয় পরামর্শ প্রদান

ঙ) শিশুর বিকাশ পরিবীক্ষণ (monitoring)

চ) অপুষ্ট বা স্থূল শিশুর প্রয়োজনীয় পুষ্টিচাহিদা পূরণ চাহিদা পূরণ ও প্রয়োজনীয় পরামর্শ প্রদান

ছ) কোনোটিই নয়

জ) অন্যান্য

১২. আপনার প্রতিষ্ঠানে গর্ভ ও প্রসবকালীন সময় থেকে শিশুর ৮বছর বয়স পর্যন্ত শিশুর চাহিদানুযায়ী যত্ন সংক্রান্ত নিচের কোন কোন সেবা বা কার্যক্রম চালু আছে? (একাধিক উত্তর গ্রহণযোগ্য)

ক) শিশুর শারীরিক অবস্থা (যেমন, কম ওজন, অপুষ্টি) বিবেচনায় রেখে শিশুর যত্ন নেওয়া এবং পরিবারের সদস্যদের পরামর্শ প্রদান

খ) শিশুর বিভিন্ন চাহিদা বুঝে সে অনুযায়ী শিশুর যত্ন নেওয়া এবং পরিবারের সদস্যদের পরামর্শ প্রদান (যেমন, শিশুর ক্ষুধা বুঝে খাবার দেওয়া)

গ) শিশুর সাথে উপযুক্ত খেলাধুলা করা এবং পরিবারের সদস্যদের পরামর্শ প্রদান

ঘ) শিশুর যত্নে মা-বাবাসহ পরিবারের অন্যান্য সদস্য ও সমাজকে সম্পৃক্ত করা

ঙ) কোনোটিই নয়

চ) অন্যান্য

১৩. আপনার প্রতিষ্ঠানে গর্ভ ও প্রসবকালীন সময় থেকে শিশুর ৮বছর বয়স পর্যন্ত শিশুর প্রারম্ভিক শিখন সংক্রান্ত নিচের কোন কোন সেবা বা কার্যক্রম চালু আছে? (একাধিক উত্তর গ্রহণযোগ্য)

ক) শিশুর প্রারম্ভিক শিখন সেবা ও প্রয়োজনীয় পরামর্শ প্রদান

খ) শিশুর প্রারম্ভিক শিখনের জন্য বিভিন্ন উপকরণ ও খেলা ব্যবহার এবং বাড়িতে এসব উপকরণ তৈরি ও ব্যবহারের ক্ষেত্রে পরামর্শ প্রদান

গ) শিশুর সাথে খেলা, বই পড়া, গান গাওয়া এবং বাড়িতে এসব কার্যক্রম করার ক্ষেত্রে পরামর্শ প্রদান

ঘ) দিবাযত্ন কেন্দ্র, প্রাক-প্রাথমিক ও প্রাথমিক শিক্ষা প্রতিষ্ঠানে শিশুর প্রারম্ভিক শিখন সুযোগ তৈরি করা

ঙ) কোনোটিই নয়

চ) অন্যান্য

১৪. আপনার প্রতিষ্ঠানে গর্ভ ও প্রসবকালীন সময় থেকে শিশুর ৮বছর বয়স পর্যন্ত শিশুর সুরক্ষা ও নিরাপত্তা নিশ্চিতকরণে নিচের কোন কোন সেবা বা কার্যক্রম চালু আছে? (একাধিক উত্তর গ্রহণযোগ্য)

ক) শিশুর জন্ম নিবন্ধন করা বা এক্ষেত্রে সহায়তা কয়রা

খ) শিশুর জন্য নিরাপদ পানি ও স্যানিটেশনের ব্যবস্থা করা

গ) বাড়িতে শিশুর নিরাপত্তা নিশ্চিত করা এবং এ বিষয়ক প্রয়োজনীয় নির্দেশনা প্রদান

ঘ) শিশুর খেলাধুলার স্থানে সুরক্ষা ও নিরাপত্তা নিশ্চিত করা

ঙ) শিশুর প্রতি যেকোনো ধরণের সহিংসতা ও বৈষম্য প্রতিরোধে প্রয়োজনীয় পদক্ষেপ নেওয়া

চ) কোনোটিই নয়

ছ) অন্যান্য

১৫. আপনার প্রতিষ্ঠান/ সংগঠনের কার্যক্রমের লক্ষ্যদল কারা? (একাধিক উত্তর গ্রহণযোগ্য)

ক) যুবক-যুবতী/ নব দম্পতি

খ) গর্ভবতী নারী

গ) নতুন মা

ঘ) সদ্য ভূমিষ্ঠ শিশু

ঙ) ০-৩ বছর বয়সী শিশু

চ) ৩-অনূর্ধ ৬ বছর বয়সী শিশু

ছ) ৬-৮ বছর বয়সী শিশু

জ) শিশুর পরিবার ও কমিউনিটি

ঝ) অন্যান্য _________

১৬. সেবা প্রদানকালে কোন লক্ষ্যদল/সমূহকে অগ্রাধিকার দেওয়া হয়? (সর্বোচ্চ তিনটি উত্তর গ্রহণযোগ্য)

ক) যুবক-যুবতী/ নব দম্পতি

খ) গর্ভবতী নারী

গ) নতুন মা

ঘ) সদ্য ভূমিষ্ঠ শিশু

ঙ) ০-৩ বছর বয়সী শিশু

চ) ৩-অনূর্ধ ৬ বছর বয়সী শিশু

ছ) ৬-৮ বছর বয়সী শিশু

জ) শিশুর পরিবার ও কমিউনিটি

ঝ) অন্যান্য _________

১৭. আপনার প্রতিষ্ঠান/ সংগঠনের কার্যক্রম কোথায় পরিচালিত হয়? (একাধিক উত্তর গ্রহণযোগ্য)

ক) শহরাঞ্চলে

খ) গ্রামাঞ্চলে

গ) চরাঞ্চলে

ঘ) হাওর এলাকায়

ঙ) উপকূলবর্তী দুর্যোগপ্রবণ এলাকায়

চ) চা বাগানে

ছ) নৃগোষ্ঠী অধ্যুষিত পার্বত্য এলাকায়

জ) নৃগোষ্ঠী অধ্যুষিত সমতল এলাকায়

ঝ) শহুরে বস্তি এলাকায়

ঞ) অতি দারিদ্র্যপীড়িত এলাকায়

ট) অন্যান্য _________

১৮. আপনার প্রতিষ্ঠান/ সংগঠনের কাজের ভৌগোলিক পরিধি কেমন?

ক) জাতীয়

খ) একাধিক বিভাগ

গ) একক বিভাগ

ঘ) জেলা পর্যায়

ঙ) উপজেলা পর্যায়

চ) ইউনিয়ন পর্যায়

ছ) গ্রাম/ মহল্লা পর্যায়

জ) অন্যান্য _________

১৯. আপনার প্রতিষ্ঠান বিগত এক বছরে আনুমানিক কতজনকে সেবা দিয়েছে?

ক) ৫০ জনের কম

খ) ৫০-১০০ জন

গ) ১০০-২০০ জন

ঘ) ২০০-৫০০ জন

ঙ) ৫০০-১০০০ জন

চ) ১০০০-১০,০০০ জন

ছ) ১০,০০০ এর বেশি

২০. নিম্নলিখিত শিশুদের অন্তর্ভূক্তি নিশ্চিত করার জন্য আপনাদের কোন বিশেষ ব্যবস্থা বা কার্যক্রম রয়েছে কি?

	হ্যাঁ	না
২০.১ দারিদ্র্যপীড়িত ও দুর্গম এলাকার শিশু		
২০.২ বিশেষ চাহিদাসম্পন্ন শিশু		
২০.৩ ক্ষুদ্র নৃগোষ্ঠীর শিশু		
২০.৪ জলবায়ু অভিঘাতের ঝুঁকিতে থাকা শিশু		

২১.১. আপনার প্রতিষ্ঠানের কর্মীদের জন্য শিশুর নিরাপত্তা এবং সেইফগার্ডিং বিষয়ক নীতিমালা এবং/অথবা প্রশিক্ষণের ব্যবস্থা রয়েছে কি?

ক) হ্যাঁ

খ) না

২১.২. আপনার প্রতিষ্ঠানের কর্মীদের জন্য লিঙ্গ সমতা এবং লিঙ্গ সংবেদনশীলতা বিষয়ক নীতিমালা এবং/অথবা প্রশিক্ষণের ব্যবস্থা রয়েছে কি?

ক) হ্যাঁ

খ) না

২২. আপনার প্রতিষ্ঠান থেকে সেবা বা সুবিধাগ্রহণের ক্ষেত্রে কারা সাধারণত সবচেয়ে বেশি বাধার সম্মুখীন হয়? (সর্বোচ্চ তিনটি উত্তর গ্রহণযোগ্য)

ক) গ্রামীণ দরিদ্র জনগোষ্ঠী

খ) ক্ষুদ্র নৃগোষ্ঠী

গ) শহরাঞ্চলের সুবিধাবঞ্চিত জনগোষ্ঠী

ঘ) চর, হাওর বা দুর্গম এলাকার জনগোষ্ঠী

ঙ) দুর্যোগপ্রবণ অঞ্চলবাসী

চ) বিশেষ চাহিদাসম্পন্ন শিশু ও তাদের পরিবার

ছ) অন্যান্য ________

২৩. আপনার প্রতিষ্ঠান যেসব অঞ্চলে প্রাক-শৈশব সংক্রান্ত সেবা প্রদান করে, সেসব অঞ্চলে কোন ধরণের প্রোগ্রামের চাহিদা সর্বাধিক? (সর্বোচ্চ তিনটি উত্তর গ্রহণযোগ্য)

ক) মা ও শিশুর পুষ্টি ও সুস্বাস্থ্য

খ) গর্ভকালীন পরামর্শ ও সেবা

গ) প্রসব-পরবর্তী মায়ের শারীরিক ও মানসিক সুস্থতা

ঘ) শিশুর বিলম্বিত বিকাশজনিত সমস্যা (যেমন, স্পিচ ডিলে, সামাজিক যোগাযোগে অনীহা) প্রতিকার

ঙ) ০ থেকে ৩ বছর বয়সী শিশুদের যত্ন ও বিকাশ

চ) ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সীদের প্রারম্ভিক/ প্রাক প্রাথমিক শিক্ষা

ছ) ৬ থেকে ৮ বছর বয়সী শিশুদের জন্য প্রাথমিক শিক্ষা

জ) প্যারেন্টিং বিষয়ক শিক্ষা

ঝ) কর্মজীবী পরিবারে সন্তানদের জন্য ডে-কেয়ার

ঞ) শিশুর যত্নকারীদের প্রশিক্ষণ

ট) অন্যান্য ________

২৪. কোনো শিশু ও তার পরিবারকে আপনাদের প্রোগ্রামে অংশগ্রহণ করানো বা অনিয়মিত শিশুদের উপস্থিতি বাড়ানো জন্য কোন ব্যবস্থাগুলো কার্যকর মনে করেন? (সর্বোচ্চ তিনটি উত্তর গ্রহণযোগ্য)

ক) প্রোগ্রামের মান বজায় রাখা

খ) শিশু ও তার পরিবারকে আর্থিক সাহায্য করা

গ) শিশুর পুষ্টি চাহিদা পূরণ করা

ঘ) শিশুর খেলাধুলার জন্য আনন্দায়ক পরিবেশ ও সরঞ্জাম নিশ্চিত করা

ঙ) প্রোগ্রামে শিশুর নিরাপত্তা ব্যবস্থা জোরদার করা

চ) হোম ভিজিটের মাধ্যমে পরিবারের সদস্যদের সচেতনতা বৃদ্ধি করা

ছ) কমিউনিটির সাহায্য নেওয়া

জ) অন্যান্য

প্রাক-শৈশব যত্ন ও বিকাশ সংক্রান্ত সেবার গুণগত মান ও প্রভাব

২৫. আপনার প্রতিষ্ঠান কর্তৃক প্রদত্ত প্রাক-শৈশব যত্ন ও বিকাশসংক্রান্ত সেবার মান্ প্রভাব বিষয়ে নিচের বিবৃতিগুলোর ক্ষেত্রে আপনার মতামত প্রযোজ্য বক্সে টিক চিহ্ন (√) দিয়ে প্রকাশ করুন।

বিবৃতি	পুরোপুরি একমত	মোটামুটি একমত	কিছুটা একমত	একদমই একমত নই	প্রযোজ্য নয়
২৫.১ আমাদের কার্যক্রমের মাধ্যমে মা এবং/অথবা শিশুর স্বাস্থ্যের উন্নতি হয়েছে।					
২৫.২ আমাদের কার্যক্রমের মাধ্যমে মা এবং/অথবা শিশুর পুষ্টি চাহিদা পূরণ হয়েছে।					
২৫.৩ আমাদের কার্যক্রমের মাধ্যমে প্রসব পরবর্তী মায়েদের মানসিক সুস্থতা নিশ্চিত হয়েছে।					
২৫.৪ আমাদের কার্যক্রমের মাধ্যমে শিশুর যত্নকারীদের চাহিদা অনুযায়ী যত্নের ব্যাপারে মনোযোগী হয়েছেন।					
২৫.৫ আমাদের কার্যক্রমের শিশুকে উদ্দীপনা প্রদানের মাধ্যমে প্রারম্ভিক শিক্ষা / বধৎষু ষবধৎহরহম -র জন্য যথাযথভাবে প্রস্তুত করা হয়েছে।					
২৫.৬ আমাদের কার্যক্রমের মাধ্যমে শিশু প্রাথমিক শিক্ষার জন্য যথাযথভাবে প্রস্তুত হয়েছে।					
২৫.৭ আমাদের কার্যক্রমের মাধ্যমে সমাজ ও জনসাধারণের মধ্যে সচেতনতা বেড়েছে।					
২৫.৮ আমাদের কার্যক্রমের মাধ্যমে বিশেষ চাহিদাসম্পন্ন শিশু এবং/ অথবা বিলম্বিত বিকাশের শিকার শিশু এবং/ অথবা তাদের পরিবার ও যত্নকারীদের জন্য সমান সেবা নিশ্চিত হয়েছে।					
২৫.৯ আমাদের কার্যক্রমের মাধ্যমে ক্ষুদ্র নৃগোষ্ঠীর শিশু/ সুবিধাবঞ্চিত/ পিছিয়ে পড়া জনগোষ্ঠির শিশু এবং অথবা তাদের পরিবার ও যত্নকারীদের জন্য সমান সেবা নিশ্চিত হয়েছে।					

২৫.১০ আমাদের কার্যক্রমের মাধ্যমে আমাদের সাথে বিভিন্ন প্রতিষ্ঠান ও স্থানীয় সরকারের সাথে স্বাস্থ্য-শিক্ষা-পুষ্টি খাতে সেবা প্রদানের ক্ষেত্রে সমন্বয় তৈরি হয়েছে।					
২৫.১১ আমাদের কার্যক্রমের মানসম্মতভাবে পরিচালনার ক্ষেত্রে সরকারের পক্ষ থেকে প্রয়োজনীয় নির্দেশনা ও সমর্থন রয়েছে।					
২৫.১২ আমাদের কার্যক্রমে শিশুর সর্বোচ্চ সুরক্ষা ও নিরাপত্তা নিশ্চিত করা হয়।					
২৫.১৩ আমাদের কার্যক্রমে শিক্ষক এবং শিশুর যত্নকারীদের জন্য মানসম্মত প্রশিক্ষণ নিশ্চিত করা হয়।					
২৫.১৪ আমাদের কার্যক্রম মানসম্মত ও পরিবেশ শিশু বান্ধব।					
২৫. ১৫ শিশু, শিশুর পরিবার এবং যত্নকারীরা আমাদের সেবা ও প্রশিক্ষণ নিয়ে সন্তুষ্ট।					

২৬. আপনার প্রতিষ্ঠান/ সংগঠনে যারা পেশাদার হিসেবে শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার সাথে যুক্ত তাদের কতজনের এ বিষয়ে পেশাগত ডিগ্রী রয়েছে?

ক) ২৫% এর কম

খ) ২৫% থেকে ৫০%

গ) ৫০% থেকে ৭৫%

ঘ) ৭৫% এর বেশি

২৭.১ আপনাদের জন্য কি প্রতিষ্ঠানের পক্ষ থেকে কি নিয়মিত ইন-হাউজ প্রশিক্ষণের ব্যবস্থা রয়েছে?

ক) হ্যাঁ

খ) না

২৭.২ হ্যাঁ হলে, বছরে কতবার এই ইন-হাউজ প্রশিক্ষণের ব্যবস্থা করা হয়?

ক) বছরে ১-২ বার

খ) বছরে ৩-৫ বার

গ) বছরে ৬ বারের বেশি

ঘ) অন্যান্য

২৮. আপনাদের প্রোগ্রাম পরিচালনার ক্ষেত্রে কোন ধরণের কাঠামো, নীতিমালা বা কারিকুলাম অনুসরণ করা হয়?

(একাধিক উত্তর গ্রহণযোগ্য)

ক) চাইল্ড ডে কেয়ার সেন্টার এক্ট

খ) শিশুর প্রারম্ভিক যত্ন ও বিকাশের সমন্বিত নীতি

গ) সরকার অনুমোদিত প্রাক প্রাথমিক শিক্ষাক্রম/ কারিকুলাম

ঘ) সরকার অনুমোদিত প্রাথমিক শিক্ষাক্রম/ কারিকুলাম

ঙ) নিজস্ব শিক্ষাক্রম/ কারিকুলাম

চ) নিজস্ব ও সরকার অনুমোদিত শিক্ষাক্রম/ কারিকুলাম

ছ) অন্যান্য _________

২৯. আপনাদের প্রোগ্রামে শিশুর প্রারম্ভিক শিক্ষার ক্ষেত্রে প্রধানত কোন বিষয়গুলোর প্রতি জোর দেওয়া হয়? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর ভাষা বিকাশ

খ) শিশুর সামাজিক যোগাযোগ

গ) শিক্ষার একস্তর থেকে অন্য স্তরে সহজে উত্তরণ (বাড়ি থেকে প্রাক প্রাথমিক, প্রাক প্রাথমিক থেকে প্রাথমিক)

ঘ) অন্যান্য

৩০. আপনাদের প্রোগ্রামে শিশুর প্রারম্ভিক শিক্ষার ক্ষেত্রে প্রধানত কোন কোন শিখন পদ্ধতি ব্যবহার করা হয়? ((সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) খেলার মাধ্যমে শিখন

খ) পঠনের মাধ্যমে শিখন

গ) গান, ছড়া, গল্পের মাধ্যমে শিখন

ঘ) অভিনয় ও অঙ্গভঙ্গির মাধ্যমে শিখন

ঙ) ছবি আঁকা

চ) অন্যান্য ________

৩১. আপনাদের প্রোগ্রামে শিশুর প্রারম্ভিক শিক্ষার ক্ষেত্রে শিখনফল অর্জন হয়েছে কিনা তা মূল্যায়নের জন্য প্রধানত কোন পদ্ধতি ব্যবহার করা হয়? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) পর্যবেক্ষণ

খ) খেলা

গ) লিখিত পরীক্ষা

ঘ) মৌখিক পরীক্ষা

চ) অন্যান্য ________

৩২. আপনাদের প্রোগ্রামে শিশুর প্রারম্ভিক শিক্ষা পরিচালনার জন্য প্রয়োজনীয় উপকরণ কতোটা পর্যাপ্ত?

ক) পর্যাপ্ত

খ) সীমিত

গ) একেবারেই পর্যাপ্ত নয়

অর্থায়ন, তথ্য ও গবেষণা

৩৩.১ আপনার প্রতিষ্ঠান/ সংগঠনের প্রাক-শৈশব সংক্রান্ত কার্যক্রমে প্রধান অর্থায়নের উৎস কী? ((সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সরকারি অর্থায়ন

খ) দাতা বা আন্তর্জাতিক সংস্থার সাহায্য

গ) নিজস্ব তহবিল

ঘ) কমিউনিটির সদস্যদের থেকে প্রাপ্ত অনুদান

ঙ) সেবাগ্রহীতাদের থেকে সংগৃহিত ফি

চ) অন্যান্য _________

৩৩.২ এই অর্থায়ন মানসম্মত সেবা প্রদানের ক্ষেত্রে কতোটুকু পর্যাপ্ত?

ক) সম্পূর্ণভাবে

খ) মোটামুটিভাবে

গ) সীমিতভাবে

ঘ) একেবারেই পর্যাপ্ত নয়

৩৪. আপনারা প্রোগ্রাম পরিকল্পনা বা প্রোগ্রাম সম্পর্কিত সিদ্ধান্ত নেওয়ার ক্ষেত্রে বিভিন্ন তথ্য প্রধানত কীভাবে ব্যবহার করেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) কর্মসূচি প্রণয়নের পূর্বে চাহিদা নিরূপণের মাধ্যমে

খ) সেবাগ্রহিতার বিস্তারিত তথ্য সম্বলিত রেকর্ড বা ডাটাবেজ তৈরির মাধ্যমে

গ) কার্যক্রমের মান সম্পর্কে সেবাগ্রহিতার মতামত গ্রহণের মাধ্যমে

ঘ) নিয়মিত মনিটরিং ও সুপারভিশনের মাধ্যমে

ঙ) স্বাধীন গবেষক দ্বারা কর্মসূচির মান যাচাইয়ের মাধ্যমে

চ) প্রতিষ্ঠানে গবেষক নিয়োগ করে কর্মসূচি সংক্রান্ত তথ্য বিশ্লেষণের মাধ্যমে

ছ) অন্য সেবাদাতা প্রতিষ্ঠানের সাথে তথ্য আদান-প্রদানের মাধ্যমে

জ) অন্যান্য _______

পরিবীক্ষণ ও মূল্যায়ন

৩৫.১ আপনার প্রতিষ্ঠানের কার্যক্রম নিয়মিত পরিবীক্ষণ ও মূল্যায়ন (সড়হরঃড়ৎরহম ধহফ বাধষঁধঃরড়হ) এর ব্যবস্থা আছে কি?

ক) হ্যাঁ

খ) না

৩৫.২ হ্যাঁ হলে, কোন বিষয়গুলো নিয়মিত পরিবীক্ষণ (monitoring) করা হয়? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সেবা.গ্রহণকারীদের উপস্থিতি

খ) শিশুর সামগ্রিক বিকাশ

গ) সেবাগ্রহণকারীর সার্বিক উন্নয়ন

ঘ) অভিভাবকদের অংশগ্রহণ

ঙ) অবকাঠামো ও অন্যান্য সুবিধা

চ) শিক্ষক/ যত্নকারীদের প্রশিক্ষণ ও দক্ষতা

ছ) অন্যান্য _______

ক.৩ পরিবীক্ষণের ক্ষেত্রে কোন পদ্ধতি ব্যবহার করা হয়? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) চেকলিস্ট/ সার্ভে ফর্ম

খ) অভিভাবকের ফিডব্যাক/ মতামত

গ) শিক্ষক/ যত্নকারীদের রিপোর্ট

ঘ) মূল্যায়ন পরীক্ষা

ঙ) অন্যান্য _______

অংশীজন ও সমন্বয়

৩৬.১ আপনারা যে এলাকায়/ অঞ্চলে প্রাক-শৈশব যত্ন ও বিকাশ সেবা দিয়ে থাকেন, সেখানে সেবা প্রদানের ক্ষেত্রে কোন ধরণের প্রতিষ্ঠানের ব্যাপ্তি ও কার্যক্রম বেশি? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) স্থানীয় সরকারের স্বাস্থ্য বিভাগ

খ) স্থানীয় সরকারের শিক্ষা বিভাগ

গ) এনজিও/ আইএনজিও

ঘ) আন্তর্জাতিক দাতা সংস্থা

ঙ) বেসরকারি/ ব্যক্তিগত উদ্যোগ

চ) অন্যান্য ___________

৩৬.২ আপনার মতে, প্রাক-শৈশব যত্ন ও বিকাশ সেবা প্রদানের ক্ষেত্রে কোন অংশীজন সবচেয়ে বেশি প্রভাবশালী? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) স্থানীয় সরকারের স্বাস্থ্য বিভাগ

খ) স্থানীয় সরকারের শিক্ষা বিভাগ

গ) এনজিও/ আইএনজিও

ঘ) আন্তর্জাতিক দাতা সংস্থা

ঙ) বেসরকারি/ ব্যক্তিগত উদ্যোগ

চ) অভিভাবক ও স্থানীয় জনগণ

ছ) অন্যান্য ________

৩৭.১ প্রাক-শৈশব যত্ন ও বিকাশ সেবায় নিয়োজিত প্রতিষ্ঠানগুলোর মধ্যে সমন্বয় কতোটা কার্যকর বলে মনে করেন?

ক) খুব কার্যকর

খ) মোটামুটি কার্যকর

গ) কিছুটা কার্যকর

ঘ) অকার্যকর

৩৭.২ প্রাক-শৈশব যত্ন ও বিকাশ সেবা প্রদানে সমন্বয়ের ক্ষেত্রে আপনি কী কী সমস্যার সম্মুখীন হয়েছেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) একই ধরণের সেবা অপ্রয়োজনীয়ভাবে বিভিন্ন প্রতিষ্ঠান থেকে প্রদান

খ) দায়িত্বশীলদের মধ্যে যোগাযোগ বা তথ্য আদান-প্রদানের অভাব

গ) সম্পদের সীমাবদ্ধতা

ঘ) সমন্বয়ের ক্ষেত্রে যথোপযুক্ত কাঠামো বা নীতির অভাব

ঙ) পৃথক দায়িত্ব ও ভূমিকা নির্ধারণের অভাব

চ) নেতৃত্বের অভাব

ছ) অন্যান্য _______

চ্যালেঞ্জ এবং ভবিষ্যত নির্দেশনা

৩৮. প্রাক-শৈশব বিকাশ সংক্রান্ত উঈঈউ সেবা প্রদানের ক্ষেত্রে আপনার প্রতিষ্ঠান/ সংগঠনের প্রধান কী কী চ্যালেঞ্জ রয়েছে? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) দক্ষ জনবলের অভাব

খ) পরিধির সল্পতা

গ) সরকারি সাহায্য সল্পতা

ঘ) বিভিন্ন প্রতিষ্ঠানের মধ্যে সমন্বয়ের অভাব

ঙ) ECCD সেবা প্রদান বিষয়ক সার্বজনীন নির্দেশনার অভাব

চ) পরিবার ও সমাজে উঈঈউ সম্পর্কিত সচেতনতার অভাব

ছ) অবকাঠামোগত দূর্বলতা

জ) সীমিত সম্পদ

ঝ) অর্থায়নের ঘাটতি

ঞ) অন্যান্য _______

৩৯. প্রাক-শৈশব যত্ন এবং বিকাশ বিষয়ক সেবা সবার জন্য সহজলভ্য করা এবং গুণগত সেবা প্রদান করার জন্য কোনটি/কোনগুলো সবচেয়ে বেশি কার্যকর হবে? (সর্বোচ্চ তিনটি উত্তর গ্রহণযোগ্য)

ক) সেবার পরিধি বৃদ্ধি

খ) সেবার প্রাসঙ্গিকতা বৃদ্ধি

গ) অর্থ বরাদ্দ বাড়ানো

ঘ) সাশ্রয়ী মূল্যে মানসম্মত সেবা প্রদান

ঙ) ECCD সংক্রান্ত সচেতনতা বৃদ্ধি

চ) সেবা প্রদানের পূর্বে চাহিদা নিরূপণ

ছ) অন্যান্য প্রতিষ্ঠান বা সংগঠনের সাথে সমন্বয় করা

জ) অন্যান্য ________

৪০. প্রাক-শৈশব যত্ন ও বিকাশ নিয়ে কাজ করার অভিজ্ঞতা থেকে, এই খাতের উন্নয়নের জন্য ভবিষ্যতে কী কী করণীয় বলে মনে করেন? (২-৩ বাক্যে লিখুন)

আপনার মূল্যবান মতামত এবং সময়ের জন্য অসংখ্য ধন্যবাদ।

Annex 5

Parents' Survey Questionnaire

জরিপে অংশগ্রহণে ০-৮ বছর বয়সী শিশুর বাবা/মা/অভিভাবকের সম্মতিপত্র (consent form)

গবেষণার নামঃ Scoping Study on Status of Pre-natal to Transition to Schooling including Early Primary Education in Bangladesh

গবেষণার উদ্দেশ্যঃ আসসালামুআলাইকুম/আদাব, আমি--। বাংলাদেশ ইসিডি নেটওয়ার্ক (ইউঘ) বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের সামগ্রিক অবস্থা সম্পর্কে ধারণা পাওয়ার জন্যঙউহযধহপবসবহঃ ড়ভ ভধাড়ঁৎধনষব বহারৎড়হসবহঃ ভড়ৎ ঃযব ঢ়ৎড়সড়ঃরড়হ ড়ভ ঊঈঈউ (ঊঋউচ-ঊঈঈউ) প্রকল্পের আওতায় গবেষণাটি পরিচালনা করছে।

পদ্ধতিঃ ০-৮ বছর বয়সী শিশুর বাবা/মা/অভিভাবক হিসেবে_আপনার মূল্যবান মতামত এই গবেষণাকে সমৃদ্ধ করবে। এই জরিপে অংশগ্রহণের জন্য আনুমানিক ৩০ মিনিট সময়ের প্রয়োজন হবে। জরিপের জন্য একটি প্রশ্নমালা ব্যবহার করা হবে।

ঝুঁকি এবং সুবিধাদিঃ এই গবেষণায় অংশগ্রহণের কোন ঝুঁকি বা সুবিধা নেই। তবে এই গবেষণা থেকে প্রাপ্ত তথ্য বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের ক্ষেত্রে কার্যকর নীতি এবং কর্মসূচি নির্ধারনে সহায়ক হতে পারে।

গোপনীয়তাঃ আপনার দেয়া তথ্যের গোপনীয়তা সম্পূর্ণভাবে রক্ষা করা হবে এই তথ্য শুধু গবেষণার কাজে ব্যবহার করা হবে। আপনি যে তথ্যগুলো দেবেন তা অন্যদের তথ্যের সাথে একত্র করে একটি প্রতিবেদন (রিপোর্ট) আকারে প্রকাশ করা হবে। প্রতিবেদনে কোথাও আপনার নাম থাকবে না।

স্বেচ্ছায় অংশ অংশগ্রহণঃ আপনার অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাপ্রণোদিত। এমনকি আপনার সম্মতি (Consent) প্রদান করার পরও বা যে কোন সময় এই জরিপে অংশগ্রহণ বন্ধ করতে পারেন। প্রয়োজনে আপনার সুবিধাজনক সময়ে পরবর্তীতে এই জরিপে অংশগ্রহণ সম্পন্ন করতে পারেন।

অংশগ্রহণকারীর অধিকারঃ এই গবেষণার ব্যাপারে কোন প্রশ্ন থাকলে আপনি গবেষক ড. মুহাম্মদ মাহবুব মোর্শেদ (মোবাইল ০১৭৬৭৯০৩৬২৪)/ গবেষণা সহযোগী সায়েবা বিনতে জহির (মোবাইল ০১৭৭১৫৩৫০৩৮) অথবা বাংলাদেশ ইসিডি নেটওয়ার্ক-এর প্রতিনিধি সৈয়দা সাজিয়া জামান (মোবাইল ০১৭১৬৪১৮২৭৫)/ মাহমুদা আক্তার (মোবাইল ০১৭৫৫৫৯২৯৩৭) কে ফোন করতে পারেন।

এই সাক্ষাৎকারে অংশগ্রহণ করার ব্যাপারে আপনার কি সম্মতি রয়েছে? (টিক চিহ্ন দিন)

হ্যাঁ	না

____

বাবা/মা/অভিভাবকের স্বাক্ষর ও তারিখ

নামঃ

আমি এই সম্মতিপত্র অংশগ্রহণকারীকে পড়ে শুনিয়েছি এবং তিনি সম্মতি দিয়েছেন/দেননি।

____

জরিপকারীর স্বাক্ষর ও তারিখ

জরিপকারীর নাম:

ব্যক্তিগত ও পেশা সংক্রান্ত তথ্য

১. আপনার নামঃ

২. বয়সঃ

ক) ১৮-৩০ বছর

খ) ৩১-৪০ বছর

গ) ৪১-৫০ বছর

ঘ) ৫১-৬০ বছর

ঙ) ৬১ বা তদুর্ধ্ব

৩. লিঙ্গঃ

ক) নারী

খ) পুরুষ

গ) অন্যান্য (লিখুন):--------------------

৪.১ বিভাগ __________ ৪.২ জেলা _______ ৪.৩ উপজেলা ________

৫. শিক্ষাগত যোগ্যতা: ________

৬. আপনার পেশা: __________

৭. পরিবারের আনুমানিক মাসিক আয়:

ক) ১০,০০০ টাকার কম

খ) ১০,০০০-২০,০০০

গ) ২০,০০০-৫০,০০০

ঘ) ৫০,০০০+

৮. আপনার সন্তান সংক্রান্ত তথ্য:

শিশুর বয়স	ছেলে শিশুর সংখ্যা	মেয়ে শিশুর সংখ্যা	মোট শিশুর সংখ্যা	এদের মধ্যে কতজন প্রাক-শৈশব সেবা পায় বা গ্রহণ করে
১ দিন থেকে ১ মাস				
১ মাস থেকে-৩ বছর				
৩-৬ বছর				
৬-৮ বছর				
৮ বছরের বেশি				
মোট				

৯. আপনার আবাস এলাকার ধরনঃ

ক) শহরাঞ্চল

খ) গ্রামাঞ্চল

গ) শহুরে বস্তি এলাকা

ঘ) দারিদ্র্যপীড়িত অঞ্চল

ঙ) চর/ নদীভাঙন এলাকা

চ) হাওড় এলাকা

ছ) পার্বত্য অঞ্চল

জ) দুর্যোগপ্রবণ অঞ্চল

১০. আপনার নিকটজনদের/পরিচিতদের (নিকটাত্মীয় বা বন্ধু যাদের সাথে আপনার নিয়মিত যোগাযোগ আছে এবং/অথবা যাদের পরিবার সম্পর্কে আপান যথেষ্ট ধারণা রাখেন), তাদের মধ্যে কতজন ০-৮ বছরের শিশু আছে? তাদের মধ্যে কতজন কোন না কোন ধরনের প্রাক-শৈশব সেবা পায় বা গ্রহণ করে? (পুষ্টি, স্বাস্থ্য, প্রারম্ভিক শিখন ইত্যাদি)?

শিশুর বয়স	শিশুর সংখ্যা	এদের মধ্যে কতজন প্রাক-শৈশব সেবা পায় বা গ্রহণ করে
১ দিন থেকে ১ মাস		

১ মাস থেকে-৩ বছর		
৩-৬ বছর		
৬-৮ বছর		
মোট		

বিগত ৩ বছরে গর্ভধারণ করলে **১১.১** থেকে **১২.১৯** নং প্রশ্নগুলোর উত্তর দিন (বাকিদের জন্য এই প্রশ্নগুলো প্রযোজ্য নয়)

১১. ১. গর্ভধারণের পূর্বে প্রজনন স্বাস্থ্য এবং গর্ভধারণের প্রস্তুতি বিষয়ক সচেতনতামূলক কোনো কার্যক্রমে অংশ নিয়েছেন কি?

ক) হ্যাঁ

খ) না

১১.২. হ্যাঁ হলে, কাদের মাধ্যমে আপনি এই সচেতনতা মূলক কার্যক্রমে অংশ নিয়েছেন?

ক) কমিউনিটি স্বাস্থ্য ক্লিনিক

খ) স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র

গ) এনজিও

ঘ) বেসরকারি সংস্থা / ব্যক্তিমালিকানাধীন প্রতিষ্ঠান

ঙ) অন্যান্য

১১. ৩ গর্ভাবস্থায় আপনি কি নিয়মিত ডাক্তারের কাছে গেছেন?

ক) হ্যাঁ

খ) না

১১.৪. গর্ভকালীন সময়ে আপনি কতবার স্বাস্থ্য পরীক্ষা করেছেন?

ক) একবারও না

খ) ১-৩ বার

গ) ৪-৬ বার

ঘ) ৬ বারের বেশি

১১.৫. গর্ভাবস্থায় পুষ্টি, ওষুধ, ভ্যাকসিন, বা সাপ্লিমেন্ট (যেমন আয়রন, ফোলিক এসিড, ক্যালসিয়াম, ভিটামিন) পেয়েছিলেন কি?

ক) হ্যাঁ

খ) না

১১.৬ সন্তান জন্মের পর নবজাতকের জন্য টিকা দেওয়া হয়েছিল কি?

ক) হ্যাঁ

খ) না

১১.৭ সন্তান জন্মদান থেকে পরবর্তী এক মাসের ভেতরে মা এবং শিশু উভয়েই প্রসব পরবর্তী কোনো সেবা পেয়েছেন কি?

ক) হ্যাঁ

খ) না

১১.৮ হ্যাঁ হলে, কোন ধরনের সেবা পেয়েছেন? (একাধিক উত্তর গ্রহণযোগ্য)

ক) সন্তান ও মায়ের পুষ্টি পরামর্শ

খ) শিশুকে দুধদান বিষয়ক নির্দেশনা

গ) শিশুর যত্ন সম্পর্কিত নির্দেশনা

ঘ) শিশুর নিরাপত্তা সম্পর্কিত নির্দেশনা

ঙ) স্বাস্থ্যকর্মীদের দ্বারা হোম ভিজিট

চ) মায়ের মানসিক সুস্বাস্থ্য বিষয়ক নির্দেশনা

ছ) মায়ের ব্যক্তিগত সুরক্ষা ও পরিচ্ছন্নতা বিষয়ক পরামর্শ

জ) শিশুর উদ্দীপনামূলক যত্ন নেওয়া বিষয়ক নির্দেশনা (যেমন, স্পর্শ করা, কথা বলা)

ঝ) শিশু বান্ধব পরিবেশ তৈরি বিষয়ক নির্দেশনা

ঞ) অন্যান্য _________

১১.৯ গর্ভকালীন ও প্রসব পরবর্তী সময়ে প্রাপ্ত সেবার মান কেমন ছিল?

ক) খারাপ

খ) মাঝারি

গ) ভালো

ঘ) খুব ভালো

১১.১০ পরিবারের সদস/ বন্ধু/ সহকর্মীরা কি গর্ভকালীন সময়ে আপনাকে মানসিক ও শারীরিকভাবে সহায়তা করেছেন?

ক) হ্যাঁ

খ) না

১১.১১ হ্যাঁ হলে, তারা প্রধানত কীভাবে সাহায্য করেছে? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শারীরিক পরিশ্রম কমিয়ে

খ) মানসিকভাবে সাহস দিয়ে

গ) পর্যাপ্ত বিশ্রামের সুযোগ দিয়ে

ঘ) পুষ্টি চাহিদা পূরণে সাহায্য করে

ঙ) গর্ভধারণ ও প্রসব সংক্রান্ত তথ্য বা পরামর্শ দিয়ে

চ) অন্যান্য __________

১১.১২ গর্ভকালীন ও প্রসব পরবর্তী সময়ে মায়ের মানসিক সুস্থতা নিশ্চিত করতে কোনো ধরণের সেবা বা পরামর্শ পেয়েছেন কি? (যেমন, কাউন্সেলিং, প্রসব পরবর্তী বিষণ্ণতা দূরীকরণের পরামর্শ)

ক) হ্যাঁ

খ) না

১১.১৩ গর্ভ, প্রসবকালীন ও প্রসব পরবর্তী সেবা নিতে গিয়ে আপনি কোনো বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন কি?

ক) হ্যাঁ

খ) না

১১.১৪ হ্যাঁ হলে, আপনি কী ধরণের বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন? (একাধিক উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতার কারণে সেবা না পাওয়া বা অবহেলা

খ) মেয়ে/ ছেলে শিশুর জন্য ভিন্ন ব্যবহার

গ) প্রতিবন্ধিতা বা বিশেষ চাহিদাসম্পন্ন হওয়ার কারণে উপেক্ষা বা অবহেলা

ঘ) ক্ষুদ্র নৃ-গোষ্ঠীর সদস্য হওয়ায় বৈষম্য বা অবহেলা

চ) সামাজিক অবস্থানগত কারণে বৈষম্য

ছ) অন্যান্য _____________

১১.১৫ গর্ভ ও প্রসবকালীন স্বাস্থ্যকর্মী/ মাঠকর্মী বা অন্যান্য সেবাদানকারীরা খোঁজ-খবর নিয়েছেন কি?

ক) সবসময়

খ) প্রায়ই

গ) মাঝে মাঝে

ঘ) একেবারেই না

১১.১৬ গর্ভ ও প্রসবকালীন যে সেবা পেয়েছেন তার মান ও আপনাদের চাহিদা সম্পর্কে কি আপনার কাছ থেকে কোনো মতামত নেওয়া হয়েছে?

ক) হ্যাঁ

খ) না

১১.১৭. গর্ভ ও প্রসবকালীন প্রাপ্ত সেবা সম্পর্কিত সমস্যা ও অভিযোগ জানানোর বা সমাধান চাওয়ার কোনো ব্যবস্থা ছিল কি?

ক) হ্যাঁ

খ) না

১১.১৮ গর্ভ, প্রসবকালীন ও প্রসব পরবর্তী মা ও শিশুর যত্ন ও শিশুর বিকাশ নিশ্চিতকরণের ক্ষেত্রে প্রধান বাধা কোনগুলো? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতা

খ) সচেতনতার অভাব

গ) সেবা প্রদানকারী প্রতিষ্ঠানের অভাব

ঘ) বাড়ি থেকে সেবাদানকারী প্রতিষ্ঠানের দূরত্ব

ঙ) অন্যান্য

১১.১৯ গর্ভকালীন ও প্রসব পরবর্তী সময়ে শিশুর প্রারম্ভিক যত্ন ও বিকাশের ক্ষেত্রে আপনি মা ও শিশুর জন্য আরো কী কী সেবা ও সহায়তা আশা করেন?

আপনার ০ থেকে ৩ বছর বয়সী কোনো সন্তান থেকে থাকলে ১২.১ থেকে ১২.২৪ নম্বর প্রশ্নের উত্তর দিন। (বাকিদের জন্য এই প্রশ্নগুলো প্রযোজ্য নয়)

১২.১ জন্মের পর থেকে আপনার ০ থেকে ৩ বছরের শিশু নিয়মিত স্বাস্থ্য পরীক্ষা পায় বা পেয়েছে কি?

ক) হ্যাঁ

খ) না

১২.২. আপনার ০ থেকে ৩ বছরের শিশু কি নিয়মিত টিকা পেয়েছে?

ক) হ্যাঁ

খ) না

১২.৩. শিশুকে প্রথম দুই বছরে বুকের দুধ খাওয়ানো হয়েছে কি?

ক) হ্যাঁ

খ) না

১২.৪. আপনার ০ থেকে ৩ বছরের শিশুর কি জন্ম নিবন্ধন করানো রয়েছে?

ক) হ্যাঁ

খ) না

১২. ৫. অভিভাবক হিসেবে ০ থেকে ৩ বছরের শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখন সম্পর্কে আপনার ধারণা কতটুকু?

ক) কোনো ধারণা নেই

খ) কিছুটা

গ) ভালো

ঘ) খুব ভালো

১২.৬ আপনার ০ থেকে ৩ বছরের শিশুর যত্ন ও বিকাশের ক্ষেত্রে নিম্নোক্ত কোন কোন বিষয়গুলো সম্পর্কে আপনি ভালোভাবে জানেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর পুষ্টি চাহিদা

খ) শিশুর সুস্বাস্থ্য

গ) শিশুর সুরক্ষা ও নিরাপত্তা

ঘ) শিশুর প্রারম্ভিক শিখন সুযোগ

ঙ) শিশুর প্রতি চাহিদানুযায়ী যত্ন

চ) কোনোটিই নয়

ছ) অন্যান্য ______

১২.৭ উপরিউক্ত বিষয়গুলো সম্পর্কে আপনি কীভাবে জেনেছেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) নিজ উদ্যোগে

খ) পরিবারের সদস্যদের কাছ থেকে

গ) অন্য অভিভাবকদের কাছ থেকে

ঘ) গণমাধ্যম থেকে

ঙ) সামাজিক যোগাযোগ মাধ্যম থেকে

চ) এলাকায় আয়োজিত সচেতনতামূলক কার্যক্রমে অংশগ্রহণ করে

ছ) শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা নিশ্চিতকরণে নিয়োজিত প্রতিষ্ঠানসমূহের কার্যক্রমের মাধ্যমে

ঝ) স্বাস্থ্যকর্মীদের কাছ থেকে

ঞ) অন্যান্য _______

১২.৮ আপনার এলাকায় ০ থেকে ৩ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে প্রাতিষ্ঠানিক সেবা সহজলভ্য কতোটা সহজলভ্য?

ক) একেবারেই সহজলভ্য নয়

খ) কিছুটা সহজলভ্য

গ) মোটামুটি সহজলভ্য

ঘ) অনেকটা সহজলভ্য

ঙ) ধারণা নেই

ক.৯ আপনার এলাকায় ০ থেকে ৩ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখন সেবার মান আপনি কেমন মনে করেন?

ক) খারাপ

খ) মাঝারি

গ) ভালো

ঘ) খুব ভালো

ঙ) ধারণা নেই

১২.১০ আপনার ০ থেকে ৩ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে কি আপনি কোনো ধরণের প্রতিষ্ঠান বা সংগঠনের সাহায্য নিয়ে থাকেন?

ক) হ্যাঁ

খ) না

***১২.১০** নম্বর প্রশ্নের উত্তর হ্যাঁ হয়ে থাকলে, **১২.১১** থেকে **১২.২৪** নম্বর প্রশ্নের উত্তর দিন।*

১২.১১ সন্তানের প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার ক্ষেত্রে আপনি কোন ধরণের প্রতিষ্ঠানের সাাহায্য নিয়ে থাকেন? (একাধিক উত্তর গ্রহণযোগ্য)

ক) কমিউনিটি ক্লিনিক

খ) স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র

গ) এনজিও

ঘ) বেসরকারি / ব্যক্তিমালিকানাধীন প্রতিষ্ঠান

ঙ) দিবাযত্ন কেন্দ্র

চ) প্রি-স্কুল

ছ) অন্যান্য ________

১২.১২ সন্তানের প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার ক্ষেত্রে আপনি প্রধানত কোন কোন কারণে প্রাতিষ্ঠানিক সাহায্য নিয়ে থাকেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সন্তানের পুষ্টি ও সুসস্বাস্থ্য নিশ্চিত করা

খ) সন্তানের সুরক্ষা ও নিরাপত্তা নিশ্চিত করা

গ) সন্তানের প্রতি তার চাহিদানুযায়ী যত্ন নিশ্চিত করা

ঘ) সন্তানের প্রারম্ভিক শিখন ও বিকাশের জন্য উদ্দীপনা দেওয়া

ঙ) বিলম্বিত বিকাশ (যেমন, স্পিচ ডিলে/ দেরিতে কথা বলা, সামাজিক যোগাযোগে অনীহা) প্রতিরোধ ও প্রতিকার

চ) শিশুর ভাষাগত বিকাশ নিশ্চিত করা

ছ) শিশুর সামাজিকীকরণ

জ) চাকুরি বা অন্যান্য কারণে শিশুকে সময় না দিতে পারা

ঝ) শিশুর মোবাইল বা ডিভাইস ব্যবহার নিয়ন্ত্রণ করা

ঞ) অন্যান্য ________

১২.১৩ উক্ত প্রতিষ্ঠান থেকে আপনি ও আপনার সন্তান প্রধানত কোন ধরণের সেবা পেয়ে থাকেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর পুষ্টি চাহিদা পূরণ

খ) শিশুর স্বাস্থ্যসেবা প্রদান

গ) অভিভাবকের অনুপস্থিতিতে শিশুর প্রতি তার চাহিদানুযায়ী যত্ন

ঘ) শিশুর সুরক্ষা ও নিরাপত্তা নিশ্চিতকরণ

ঙ) শিশুর প্রারম্ভিক শিখনের সুযোগ তৈরি

চ) মা ও শিশুর মনোসামাজিক যত্ন

ছ) শিশুর পরিবার ও যত্নকারীদের মধ্যে শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা সম্পর্কে সচেতনতা সৃষ্টি

জ) বাড়িতে শিশুবান্ধব পরিবেশ তৈরি বিষয়ক নির্দেশনা

ঝ) কোনোটিই নয়

ঞ) অন্যান্য ________

১২.১৪ উক্ত প্রতিষ্ঠান বা সংগঠন থেকে প্রদানকৃত সেবার মান বা কার্যকারিতা সম্পর্কে আপনাদের মতামত গ্রহণ করা হয় কি?

ক) নিয়মিত

খ) মাঝে মাঝে

গ) কখনো কখনো

ঘ) কখনোই না

১২.১৫ হ্যাঁ হলে, কীভাবে মতামত নেওয়া হয়? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সভা আয়োজন করে

খ) মোবাইলে যোগাযোগের মাধ্যমে

গ) সরাসরি সাক্ষাতের মাধ্যমে

ঘ) সার্ভে ফর্মের মাধ্যমে

ঙ) অন্যান্য

১২.১৬ উক্ত প্রতিষ্ঠান থেকে প্রাপ্ত সেবা নিয়ে আপনি কতটুকু সন্তুষ্ট?

ক) পুরোপুরি সন্তুষ্ট

খ) মোটামুটি সন্তুষ্ট

গ) কিছুটা সন্তুষ্ট

ঘ) একেবারেই সন্তুষ্ট নই

১২.১৭ সেবা নিতে গিয়ে আপনি কোনো বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন কি?

ক) হ্যাঁ

খ) না

১২.১৮ হ্যাঁ হলে, আপনি কী ধরণের বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন? (একাধিক উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতার কারণে সেবা না পাওয়া বা অবহেলা

খ) মেয়ে/ ছেলে শিশুর জন্য ভিন্ন ব্যবহার

গ) প্রতিবন্ধিতা বা বিশেষ চাহিদাসম্পন্ন হওয়ার কারণে উপেক্ষা বা অবহেলা

ঘ) ক্ষুদ্র নৃ-গোষ্ঠীর সদস্য হওয়ায় বৈষম্য বা অবহেলা

ঙ) সামাজিক অবস্থানগত কারণে বৈষম্য

চ) অন্যান্য ____________

১২.১৯ আপনার ০ থেকে ৩ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা নিশ্চিতকরণের ক্ষেত্রে প্রধান বাধা কোনগুলো? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতা

খ) সচেতনতার অভাব

গ) সেবা প্রদানকারী প্রতিষ্ঠানের অভাব

ঘ) বাড়ি থেকে সেবাদানকারী প্রতিষ্ঠানের দূরত্ব

ঙ) অন্যান্য ____________

১২.২০ প্রাপ্ত সেবাসমূহের পাশাপাশি আরো কী কী সেবা বা সুযোগ-সুবিধা আপনি আপনার ০ থেকে ৩ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে আশা করেন?

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১২.২১ বাড়িতে আপনার ০ থেকে ৩ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনে প্রধানত কে কে সহায়তা করে? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) মা

খ) বাবা

গ) বড় ভাই/ বোন

ঘ) দাদা-দাদী/ নানা-নানী

ঙ) পরিবারের অন্য সদস্যবৃন্দ

চ) প্রতিবেশী

ছ) অন্যান্য __________

১২.২২ বাড়িতে আপনার ০ থেকে ৩ বছর বয়সী শিশুর দেখাশোনায় সাহায্যকারী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে নিম্নোক্ত কোন কোন বিষয়গুলো সম্পর্কে জানেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর পুষ্টি চাহিদা

খ) শিশুর সুস্বাস্থ্য

গ) শিশুর সুরক্ষা ও নিরাপত্তা

ঘ) শিশুর প্রারম্ভিক শিখন সুযোগ

ঙ) শিশুর প্রতি তার চাহিদানুযায়ী যত্ন

চ) কোনোটিই নয়

ছ) অন্যান্য ________

১২.২৩ বাড়িতে আপনার ০ থেকে ৩ বছর বয়সী সন্তানের প্রারম্ভিক শিখনের জন্য আপনারা প্রধানত কী কী করেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর সাথে গান গাওয়া

খ) শিশুর সাথে খেলাধুলা করা

গ) শিশুকে বই পড়ে শোনানো

ঘ) শিশুকে প্রশ্ন করা

ঙ) শিশুর সাথে আঁকিবুঁকি করা

চ) শিশুর পক্ষে করা সম্ভব এমন ছোট ছোট কাজ করতে দেওয়া

ছ) অন্যান্য ________

১২.২৪ ০ থেকে ৩ বছর বয়সী শিশুর মা-বা এবং অন্যান্য যত্নকারীদের শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখন সম্পর্কিত দক্ষতা, জ্ঞান ও সচেতনতা বৃদ্ধির ক্ষেত্রে কোন পদক্ষেপগুলো নেওয়া সবচেয়ে প্রয়োজন বলে মনে করেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) এলাকাভিত্তিক শিশু লালন-পালন বিষয়ক সচেতনতামূলক সভা

খ) হোম ভিজিট

গ) শিশু লালন-পালন বিষয়ক প্রচারণা

ঘ) অভিভাবক ও যত্নকারীদের প্রশিক্ষণ

ঙ) অন্যান্য ________

আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী কোনো সন্তান থেকে থাকলে **১৩.১** থেকে **১৩.১৯** নম্বর প্রশ্নের উত্তর দিন। (বাকিদের জন্য এই প্রশ্নগুলো প্রযোজ্য নয়)

১৩.১ আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন ও বিকাশের ক্ষেত্রে নিম্নোক্ত কোন কোন বিষয়গুলো সম্পর্কে আপনি ভালোভাবে জানেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর সুস্বাস্থ্য ও পুষ্টি চাহিদা

খ) শিশুর প্রতি প্রতিক্রিয়াশীল যত্ন

গ) শিশুর সুরক্ষা ও নিরাপত্তা

ঘ) শিশুর প্রারম্ভিক শিখন সুযোগ

ঙ) শিশুকে প্রাতিষ্ঠানিক প্রাক-প্রাথমিক শিক্ষার জন্য প্রস্তুতকরণ

চ) কোনোটিই নয়

ছ) অন্যান্য ______

১৩.২ আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন ও বিকাশের বিষয়গুলো সম্পর্কে আপনি কীভাবে জেনেছেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) নিজ উদ্যোগে

খ) পরিবারের সদস্যদের কাছ থেকে

গ) অন্য অভিভাবকদের কাছ থেকে

ঘ) গণমাধ্যম থেকে

ঙ) সামাজিক যোগাযোগ মাধ্যম থেকে

চ) এলাকায় আয়োজিত সচেতনতামূলক কার্যক্রমে অংশগ্রহণ করে

ছ) শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা নিশ্চিতকরণে নিয়োজিত প্রতিষ্ঠানসমূহের কার্যক্রমের মাধ্যমে

জ) মাঠকর্মীদের কাছ থেকে

ঝ) অন্যান্য ________

১৩.৩ আপনার এলাকায় ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে প্রাতিষ্ঠানিক সেবা সহজলভ্য কতোটা সহজলভ্য?

ক) একেবারেই সহজলভ্য নয়

খ) কিছুটা সহজলভ্য

গ) মোটামুটি সহজলভ্য

ঘ) অনেকটা সহজলভ্য

ঙ) ধারণা নেই

ক.৪ আপনার এলাকায় ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখন সেবার মান আপনি কেমন মনে করেন?

ক) খারাপ

খ) মাঝারি

গ) ভালো

ঘ) খুব ভালো

ঙ) ধারণা নেই

১৩.৫ আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে কি আপনি কোনো ধরণের প্রতিষ্ঠান বা সংগঠনের সাহায্য নিয়ে থাকেন?

ক) হ্যাঁ

খ) না

১৩.৫ নম্বর প্রশ্নের উত্তর হ্যাঁ হয়ে থাকলে, ১৩.৬ থেকে ১৩.১৯ নম্বর প্রশ্নের উত্তর দিন।

১৩.৬ আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার ক্ষেত্রে আপনি কোন ধরণের প্রতিষ্ঠানের সাহায্য নিয়ে থাকেন? (একাধিক উত্তর গ্রহণযোগ্য)

ক) কমিউনিটি ক্লিনিক

খ) স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র

গ) এনজিও

ঘ) বেসরকারি / ব্যক্তিমালিকানাধীন প্রতিষ্ঠান

ঙ) দিবাযত্ন কেন্দ্র

চ) প্রাথমিক স্কুলের শিশু শ্রেণী

ছ) কিন্ডারগার্টেন/ প্রি-স্কুল

জ) মক্তব

ঝ) মাদ্রাসা

ঞ) মসজিদ বা মন্দির ভিত্তিক শিক্ষা কার্যক্রম

ট) অন্যান্য ________

১৩.৭ আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার ক্ষেত্রে আপনি প্রধানত কোন কোন কারণে প্রাতিষ্ঠানিক সাহায্য নিয়ে থাকেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সন্তানের পুষ্টি ও সুস্বাস্থ্য নিশ্চিত করা

খ) সন্তানের সুরক্ষা ও নিরাপত্তা নিশ্চিত করা

গ) সন্তানের প্রতি তার চাহিদানুযায়ী যত্ন নিশ্চিত করা

ঘ) সন্তানের প্রারম্ভিক শিখন ও বিকাশের জন্য উদ্দীপনা দেওয়া

ঙ) বিলম্বিত বিকাশ (যেমন, স্পিচ ডিলে/ দেরিতে কথা বলা, সামাজিক যোগাযোগে অনীহা) প্রতিরোধ ও প্রতিকার

চ) শিশুর ভাষাগত বিকাশ নিশ্চিত করা

ছ) শিশুর সামাজিকীকরণ

জ) চাকুরি বা অন্যান্য কারণে শিশুকে সময় না দিতে পারা

ঝ) শিশুর মোবাইল বা ডিভাইস ব্যবহার নিয়ন্ত্রণ করা

ঞ) অন্যান্য ________

১৩.৮ উক্ত প্রতিষ্ঠান থেকে আপনি ও আপনার সন্তান কোন ধরনের সেবা পেয়ে থাকেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর পুষ্টি চাহিদা পূরণ

খ) শিশুর স্বাস্থ্যসেবা প্রদান

গ) অভিভাবকের অনুপস্থিতিতে শিশুর প্রতি প্রাত্যহিক প্রতিক্রিয়াশীল যত্ন

ঘ) শিশুর সুরক্ষা ও নিরাপত্তা নিশ্চিতকরণ

ঙ) শিশুর প্রারম্ভিক শিখনের সুযোগ তৈরি

চ) মা ও শিশুর মনোসামাজিক যত্ন

ছ) শিশুর পরিবার ও যত্নকারীদের মধ্যে শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা সম্পর্কে সচেতনতা সৃষ্টি

জ) বাড়িতে শিশুবান্ধব পরিবেশ তৈরি বিষয়ক নির্দেশনা প্রদান

ঝ) কোনোটিই নয়

ঞ) অন্যান্য ________

ক.৯ উক্ত প্রতিষ্ঠান বা সংগঠন থেকে প্রদানকৃত সেবার মান বা কার্যকারিতা সম্পর্কে আপনাদের মতামত গ্রহণ করা হয় কি?

ক) নিয়মিত

খ) মাঝে মাঝে

গ) কখনো কখনো

ঘ) কখনোই না

১৩.১০ হ্যাঁ হলে, কীভাবে মতামত নেওয়া হয়? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সভা আয়োজন করে

খ) মোবাইলে যোগাযোগের মাধ্যমে

গ) সরাসরি সাক্ষাতের মাধ্যমে

ঘ) সার্ভে ফর্মের মাধ্যমে

ঙ) অন্যান্য

১৩.১১ উক্ত প্রতিষ্ঠান থেকে প্রাপ্ত সেবা নিয়ে আপনি কতটুকু সন্তুষ্ট?

ক) পুরোপুরি সন্তুষ্ট

খ) মোটামুটি সন্তুষ্ট

গ) কিছুটা সন্তুষ্ট

ঘ) একেবারেই সন্তুষ্ট নই

১৩.১২. সেবা নিতে গিয়ে আপনি কোনো বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন কি?

ক) হ্যাঁ

খ) না

১৩.১৩ হ্যাঁ হলে, আপনি কী ধরণের বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন? (একাধিক উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতার কারণে সেবা না পাওয়া বা অবহেলা

খ) মেয়ে/ ছেলে শিশুর জন্য ভিন্ন ব্যবহার

গ) প্রতিবন্ধিতা বা বিশেষ চাহিদাসম্পন্ন হওয়ার কারণে উপেক্ষা বা অবহেলা

ঘ) ক্ষুদ্র নৃ-গোষ্ঠীর সদস্য হওয়ায় বৈষম্য বা অবহেলা

ঙ) সামাজিক অবস্থানগত কারণে বৈষম্য

চ) অন্যান্য ____________

১৩.১৪ আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা নিশ্চিতকরণের ক্ষেত্রে প্রধান বাধা কোনগুলো? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতা

খ) সচেতনতার অভাব

গ) সেবা প্রদানকারী প্রতিষ্ঠানের অভাব

ঘ) বাড়ি থেকে সেবাদানকারী প্রতিষ্ঠানের দূরত্ব

ঙ) অন্যান্য ____________

১৩.১৫ প্রাপ্ত সেবাসমূহের পাশাপাশি আরো কী কী সেবা বা সুযোগ-সুবিধা আপনি আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে আশা করেন?

____

১৩.১৬ বাড়িতে আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনে কে কে সহায়তা করে? (একাধিক উত্তর গ্রহণযোগ্য)

ক) মা

খ) বাবা

গ) বড় ভাই/ বোন

ঘ) দাদা-দাদী/ নানা-নানী

ঙ) পরিবারের অন্য সদস্যবৃন্দ

চ) প্রতিবেশী

ছ) অন্যান্য __________

১৩.১৭ বাড়িতে আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী সন্তানের দেখাশোনায় সাহায্যকারী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে নিম্নোক্ত কোন কোন বিষয়গুলো সম্পর্কে জানেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর পুষ্টি চাহিদা

খ) শিশুর সুস্বাস্থ্য

গ) শিশুর সুরক্ষা ও নিরাপত্তা

ঘ) শিশুর প্রারম্ভিক শিখন সুযোগ

ঙ) শিশুর প্রতি তার চাহিদানুযায়ী যত্ন

চ) কোনোটিই নয়

ছ) অন্যান্য _______

১৩.১৮ বাড়িতে আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী সন্তানের প্রারম্ভিক শিখনের জন্য আপনারা প্রধানত কী কী করেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর সাথে গান গাওয়া

খ) শিশুর সাথে খেলাধুলা করা

গ) শিশুকে বই পড়ে শোনানো

ঘ) শিশুকে প্রশ্ন করা

ঙ) শিশুর সাথে আঁকিবুঁকি করা

চ) শিশুর পক্ষে করা সম্ভব এমন ছোট ছোট কাজ করতে দেওয়া

ছ) শিশুর স্কুলের পড়া বা বাড়ির কাজে সাহায্য করা

জ) অন্যান্য ________

১৩.১৯ ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর মা-বা এবং অন্যান্য যত্নকারীদের শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখন সম্পর্কিত দক্ষতা, জ্ঞান ও সচেতনতা বৃদ্ধির ক্ষেত্রে কোন পদক্ষেপগুলো নেওয়া প্রয়োজন বলে মনে করেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) এলাকাভিত্তিক শিশু লালন-পালন বিষয়ক সচেতনতামূলক সভা

খ) হোম ভিজিট

গ) শিশু লালন-পালন বিষয়ক প্রচারণা

ঘ) শিশুর প্রাক-প্রাথমিক শিক্ষার গুরুত্ব বিষয়ক সচেতনতা কার্যক্রম

ঙ) প্রাক প্রাথমিক শিক্ষক ও যত্নকারীদের প্রশিক্ষণ

চ) শিশুর চাহিদা বুঝে বিশেষায়িত কার্যক্রমের সুযোগ তৈরি

ছ) অন্যান্য ________

আপনার ৬ থেকে অনূর্ধ্ব ৮ বছর বয়সী কোনো সন্তান থেকে থাকলে ১৪.১ থেকে ১৪.১৯ নম্বর প্রশ্নের উত্তর দিন। (বাকিদের জন্য এই প্রশ্নগুলো প্রযোজ্য নয়)

১৪.১ আপনার ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন ও বিকাশের ক্ষেত্রে নিম্নোক্ত কোন কোন বিষয়গুলো সম্পর্কে আপনি ভালোভাবে জানেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর সুস্বাস্থ্য ও পুষ্টি চাহিদা

খ) শিশুর প্রতি প্রতিক্রিয়াশীল যত্ন

গ) শিশুর সুরক্ষা ও নিরাপত্তা

ঘ) শিশুর প্রারম্ভিক শিখন সুযোগ

ঙ) শিশুকে আনুষ্ঠানিক ও মানসম্মত প্রাথমিক শিক্ষার জন্য প্রস্তুতকরণ

চ) কোনোটিই নয়

ছ) অন্যান্য ______

১৪.২ উপরিউক্ত বিষয়গুলো সম্পর্কে আপনি কীভাব জেনেছেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) নিজ উদ্যোগে

খ) পরিবারের সদস্যদের কাছ থেকে

গ) অন্য অভিভাবকদের কাছ থেকে

ঘ) গণমাধ্যম থেকে

ঙ) সামাজিক যোগাযোগ মাধ্যম থেকে

চ) এলাকায় আয়োজিত সচেতনতামূলক কার্যক্রমে অংশগ্রহণ করে

ছ) শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা নিশ্চিতকরণে নিয়োজিত প্রতিষ্ঠানসমূহের কার্যক্রমের মাধ্যমে

জ) মাঠকর্মীদের কাছ থেকে

ঝ) শিশুর প্রাক-প্রাথমিক শিক্ষা প্রতিষ্ঠান থেকে

ঞ) অন্যান্য ________

১৪.৩ আপনার এলাকায় ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে প্রাতিষ্ঠানিক সেবা সহজলভ্য কতোটা সহজলভ্য?

ক) একেবারেই সহজলভ্য নয়

খ) কিছুটা সহজলভ্য

গ) মোটামুটি সহজলভ্য

ঘ) অনেকটা সহজলভ্য

ঙ) ধারণা নেই

১৪.৪ আপনার এলাকায় ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখন সেবার মান আপনি কেমন মনে করেন?

ক) খারাপ

খ) মাঝারি

গ) ভালো

ঘ) খুব ভালো

ঙ) ধারণা নেই

১৪.৫ আপনার ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে কি আপনি কোনো ধরণের প্রতিষ্ঠান বা সংগঠনের সাহায্য নিয়ে থাকেন?

ক) হ্যাঁ

খ) না

১৪.৫ নম্বর প্রশ্নের উত্তর হ্যাঁ হয়ে থাকলে, ১৪.৬ থেকে ১৪.১৯ নম্বর প্রশ্নের উত্তর দিন।

১৪.৬ আপনার ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার ক্ষেত্রে আপনি কোন ধরণের প্রতিষ্ঠানের সাহায্য নিয়ে থাকেন? (একাধিক উত্তর গ্রহণযোগ্য)

ক) কমিউনিটি ক্লিনিক

খ) স্বাস্থ্য ও পরিবার কল্যাণ কেন্দ্র

গ) এনজিও

ঘ) বেসরকারি / ব্যক্তিমালিকানাধীন প্রতিষ্ঠান

ঙ) দিবাযত্ন কেন্দ্র

চ) সরকারি প্রাথমিক স্কুল

ছ) বেসরকারি প্রাথমিক স্কুল

জ) কিন্ডারগার্টেন/ প্রি-স্কুল

ঝ) মক্তব

ঞ) মাদ্রাসা

ট) মসজিদ বা মন্দির ভিত্তিক শিক্ষা কার্যক্রম

ঠ) অন্যান্য _______

১৪.৭ আপনার ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষার ক্ষেত্রে আপনি প্রধানত কোন কোন কারণে প্রাতিষ্ঠানিক সাহায্য নিয়ে থাকেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সন্তানের সুরক্ষা ও নিরাপত্তা নিশ্চিত করা

খ) সন্তানের প্রতি তার চাহিদানুযায়ী যত্ন নিশ্চিত করা

গ) সন্তানের প্রারম্ভিক শিখন ও বিকাশের জন্য উদ্দীপনা দেওয়া

ঘ) বিলম্বিত বিকাশ (যেমন, স্পিচ ডিলে/ দেরিতে কথা বলা, সামাজিক যোগাযোগে অনীহা) প্রতিরোধ ও প্রতিকার

ঙ) শিশুর ভাষাগত বিকাশ নিশ্চিত করা

চ) শিশুর সামাজিকীকরণ

ছ) চাকুরি বা অন্যান্য কারণে শিশুকে সময় না দিতে পারা

জ) শিশুর মোবাইল বা ডিভাইস ব্যবহার নিয়ন্ত্রণ করা

ঝ) অন্যান্য ________

১৪.৮ উক্ত প্রতিষ্ঠান থেকে আপনি ও আপনার সন্তান কোন ধরণের সেবা পেয়ে থাকেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) শিশুর পুষ্টি চাহিদা পূরণ

খ) শিশুর স্বাস্থ্যসেবা প্রদান

গ) অভিভাবকের অনুপস্থিতিতে শিশুর প্রতি তার চাহিদানুযায়ী যত্ন

ঘ) শিশুর সুরক্ষা ও নিরাপত্তা নিশ্চিতকরণ

ঙ) শিশুর প্রারম্ভিক শিখনের সুযোগ তৈরি

চ) মা ও শিশুর মনোসামাজিক যত্ন

ছ) শিশুর পরিবার ও যত্নকারীদের মধ্যে শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা সম্পর্কে সচেতনতা সৃষ্টি

জ) বাড়িতে শিশুবান্ধব পরিবেশ তৈরি বিষয়ক নির্দেশনা প্রদান

ঝ) কোনোটিই নয়

ঞ) অন্যান্য ________

১৪.৯ উক্ত প্রতিষ্ঠান বা সংগঠন থেকে প্রদানকৃত সেবার মান বা কার্যকারিতা সম্পর্কে আপনাদের মতামত গ্রহণ করা হয় কি?

ক) নিয়মিত

খ) মাঝে মাঝে

গ) কখনো কখনো

ঘ) কখনোই না

১৪.১০ হ্যাঁ হলে, কীভাবে মতামত নেওয়া হয়? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) সভা আয়োজন করে

খ) মোবাইলে যোগাযোগের মাধ্যমে

গ) সরাসরি সাক্ষাতের মাধ্যমে

ঘ) সার্ভে ফর্মের মাধ্যমে

ঙ) অন্যান্য

১৪.১১ উক্ত প্রতিষ্ঠান থেকে প্রাপ্ত সেবা নিয়ে আপনি কতটুকু সন্তুষ্ট?

ক) পুরোপুরি সন্তুষ্ট

খ) মোটামুটি সন্তুষ্ট

গ) কিছুটা সন্তুষ্ট

ঘ) একেবারেই সন্তুষ্ট নই

১৪.১২ সেবা নিতে গিয়ে আপনি কোনো বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন কি?

ক) হ্যাঁ

খ) না

১৪.১৩ হ্যাঁ হলে, আপনি কী ধরণের বাধা, অবহেলা বা বৈষম্যের শিকার হয়েছেন? ? (একাধিক উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতার কারণে সেবা না পাওয়া বা অবহেলা

খ) মেয়ে/ ছেলে শিশুর জন্য ভিন্ন ব্যবহার

গ) প্রতিবন্ধিতা বা বিশেষ চাহিদাসম্পন্ন হওয়ার কারণে উপেক্ষা বা অবহেলা

ঘ) ক্ষুদ্র নৃ-গোষ্ঠী র সদস্য হওয়ায় বৈষম্য বা অবহেলা

ঙ) সামাজিক অবস্থানগত কারণে বৈষম্য

চ) অন্যান্য ____________

১৪.১৪ আপনার ৩ থেকে অনূর্ধ্ব ৬ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিক্ষা নিশ্চিতকরণের ক্ষেত্রে প্রধান বাধা কোনগুলো? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) আর্থিক অস্বচ্ছলতা

খ) সচেতনতার অভাব

গ) সেবা প্রদানকারী প্রতিষ্ঠানের অভাব

ঘ) বাড়ি থেকে সেবাদানকারী প্রতিষ্ঠানের দূরত্ব

ঙ) অন্যান্য ____________

১৪.১৫ প্রাপ্ত সেবাসমূহের পাশাপাশি আরো কী কী সেবা বা সুযোগ-সুবিধা আপনি আপনার ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে আশা করেন?

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ক.১৬ াড়িতে আপনার ৬ থেকে ৮ বছর বয়সী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনে কে কে সহায়তা করে? (একাধিক উত্তর গ্রহণযোগ্য)

ক) মা

খ) বাবা

গ) বড় ভাই/ বোন

ঘ) দাদা-দাদী/ নানা-নানী

ঙ) পরিবারের অন্য সদস্যবৃন্দ

চ) প্রতিবেশী

ছ) অন্যান্য __________

১৪.১৭ বাড়িতে আপনার সন্তানের দেখাশোনায় সাহায্যকারী শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের ক্ষেত্রে নিম্নোক্ত কোন কোন বিষয়গুলো সম্পর্কে অবহিত? (একাধিক উত্তর গ্রহণযোগ্য)

ক) শিশুর পুষ্টি চাহিদা

খ) শিশুর সুস্বাস্থ্য

গ) শিশুর সুরক্ষা ও নিরাপত্তা

ঘ) শিশুর প্রারম্ভিক শিখন সুযোগ

ঙ) শিশুর প্রতি তার চাহিদানুযায়ী যত্ন

চ) শিশুর প্রাথমিক শিক্ষা কার্যক্রম

ছ) কোনোটিই নয়

জ) অন্যান্য _______

১৪.১৮ বাড়িতে আপনার ৬ থেকে ৮ বছর বয়সী সন্তানের প্রারম্ভিক শিখনের জন্য আপনারা কী কী করেন? একাধিক উত্তর গ্রহণযোগ্য)

ক) শিশুর সাথে গান গাওয়া

খ) শিশুর সাথে খেলাধুলা করা

গ) শিশুকে বই পড়ে শোনানো

ঘ) শিশুকে প্রশ্ন করা

ঙ) শিশুর সাথে আঁকিবুঁকি করা

চ) শিশুকে তার সাধ্যের মধ্যে ছোট ছোট কাজ করতে দেওয়া

ছ) শিশুর স্কুলের পড়া বা বাড়ির কাজে সাহায্য করা

জ) অন্যান্য _______

১৪.১৯ ৬ থেকে ৮ বছর বয়সী শিশুর মা-বা এবং অন্যান্য যত্নকারীদের শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখন সম্পর্কিত দক্ষতা, জ্ঞান ও সচেতনতা বৃদ্ধির ক্ষেত্রে কোন পদক্ষেপগুলো নেওয়া প্রয়োজন বলে মনে করেন? (সর্বাধিক তিনটি উত্তর গ্রহণযোগ্য)

ক) এলাকাভিত্তিক শিশু লালন-পালন বিষয়ক সচেতনতামূলক সভা

খ) হোম ভিজিট

গ) শিশু লালন-পালন বিষয়ক প্রচারণা

ঘ) শিশুর প্রাক-প্রাথমিক শিক্ষার গুরুত্ব বিষয়ক সচেতনতা কার্যক্রম

ঙ) প্রাথমিক শিক্ষক ও যত্নকারীদের প্রশিক্ষণ

চ) শিশুর চাহিদা বুঝে বিশেষায়িত কার্যক্রমের সুযোগ তৈরি

ছ) অন্যান্য _______

নিচের ১৫ থেকে ২০ নং প্রশ্নগুলো সবার জন্য প্রযোজ্য

১৫. আপনার সন্তান শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনে নিয়োজিত সেবায় অংশগ্রহণ করার ফলে তার আচরণ বা শিক্ষায় কোনো পরিবর্তন লক্ষ্য করেছেন কি?

ক) হ্যাঁ, ইতিবাচক

খ) না, নেতিবাচক

গ) তেমন কোনো পরিবর্তন লক্ষ্য করছিনা

১৬. শিশুর প্রারম্ভিক যত্ন, বিকাশ ও শিখনের জন্য পৃথক সেবার খরচ বহন আপনার জন্য কতটা কঠিন?

ক) বেশ কঠিন

খ) কঠিন

গ) সহজ

ঘ) খুব সহজ

১৭. আপনার শিশুর প্রারম্ভিক যত্ন, বিকাশ ও সেবার ক্ষেত্রে সংশ্লিষ্ট প্রতিষ্ঠান ও প্রতিষ্ঠানের কর্মীবৃন্দ (যেমন, পরিবার, স্বাস্থ্যকর্মী, মাঠকর্মী, শিক্ষক, ধর্মীয় নেতা) কি সম্মিলিতভাবে কাজ করে বা নিজেদের মধ্যে তথ্য আদান-প্রদান করে?

ক) নিয়মিত

খ) মাঝে মাঝে

গ) কখনো কখনো

ঘ) কখনোই না

চ) এ বিষয়ে তেমন কোনো ধারণা নেই

১৮. শিশুর প্রারম্ভিক যত্ন ও বিকাশ সংক্রান্ত সেবা প্রদানকারী প্রতিষ্ঠান কর্তৃক, আপনার শিশুর স্বাস্থ্য, বিকাশ বা শিক্ষা সম্পর্কিত তথ্য (যেমন, ওজন, উচ্চতা, শিখনের অগ্রগতি) কি নিয়মিত সংরক্ষণ করা হয়?

ক) হ্যাঁ

খ) না

গ) কোনো ধরণের প্রাতিষ্ঠানিক সেবা নেওয়া হয়না, তাই প্রযোজ্য নয়

১৯. উত্তর হ্যাঁ হলে, কী প্রয়োজনে এই তথ্য সংরক্ষণ করা হয়?

ক) শিশুর স্বাস্থ্য, বিকাশ বা শিক্ষার অগ্রগতি পর্যবেক্ষণের জন্য

খ) শিশুর বিকাশগত কোনো সমস্যা চিহ্নিত করার জন্য

গ) শিশুর স্বাস্থ্য, বিকাশ বা শিক্ষার ক্ষেত্রে যথাযথ পদক্ষেপ নেওয়ার জন্য

ঘ) শিশুর প্রারম্ভিক যত্ন , বিকাশ ও শিক্ষার মান উন্নয়নের জন্য

ঙ) অন্যান্য

২০. শিশুদের প্রারম্ভিক যত্ন, বিকাশ ও শিখন সংক্রান্ত সেবাগুলোকে উন্নত করতে আপনি কী সুপারিশ করবেন?

আপনার মূল্যবান মতামত এবং সময়ের জন্য অসংখ্য ধন্যবাদ।

Annex 6

Observation Protocol for Day Care, PPE, and Primary Classes

দিবাযত্ন কেন্দ্র/ প্রাক-প্রাথমিক শ্রেণি/প্রাথমিক শ্রেণি পর্যবেক্ষণের জন্য ফ্যাসিলিটেটর/শিক্ষকের সম্মতিপত্র (consent form)

গবেষণার নাম: Scoping Study on Status of Pre-natal to Transition to Schooling including Early Primary Education in Bangladesh

গবেষণার উদ্দেশ্য: আসসালামুআলাইকুম/আদাব, আমি---। বাংলাদেশ ইসিডি নেটওয়ার্ক (ইউঘ) বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের সামগ্রিক অবস্থা সম্পর্কে ধারণা পাওয়ার জন্যঊহযধহপবসবহঃ ড়ভ ভধাড়ঁৎধনষব বহারৎড়হসবহঃ ভড়ৎ ঃযব ঢ়ৎড়সড়ঃরড়হ ড়ভ ঊঈঈউ (ঊঋউচ-ঊঈঈউ) প্রকল্পের আওতায় গবেষণাটি পরিচালনা করছে।

পদ্ধতি: এই গবেষণার অংশগ্রহণকারী হিসেবে আপনার প্রতিষ্ঠানকে বেছে নেয়া হয়েছে। তথ্য সংগ্রহের অংশ হিসেবে দিবা যত্ন কেন্দ্র/শ্রেণি পর্যবেক্ষণ এই গবেষণাকে সমৃদ্ধ করবে। শ্রেণি পর্যবেক্ষণের জন্য একটি পর্যবেক্ষণ ছক ব্যবহার করা হবে।

ঝুঁকি এবং সুবিধাদি: এই গবেষণায় অংশগ্রহণের কোন ঝুঁকি বা সুবিধা নেই। এই পর্যবেক্ষণের তথ্য আপনার বা আপনার দিবা যত্ন কেন্দ্র/বিদ্যালয়ের পারদর্শিতা মূল্যায়নের জন্য করা হচ্ছে না; দিবা যত্ন কেন্দ্র/প্রাক-প্রাথমিক বা প্রাথমিক শিশুর জন্য বিদ্যমান সেবা সম্পর্কে সাধারণ ধারণা পাওয়ার জন্য করা হচ্ছে। এই গবেষণা থেকে প্রাপ্ত তথ্য বাংলাদেশের প্রাক-শৈশব যত্ন এবং বিকাশের ক্ষেত্রে কার্যকর নীতি এবং কর্মসূচি নির্ধারনে সহায়ক হতে পারে।

গোপনীয়তা: শ্রেণি পর্যবেক্ষণ থেকে প্রাপ্ত তথ্যের গোপনীয়তা সম্পূর্ণভাবে রক্ষা করা হবে এবং এই তথ্য শুধু গবেষণার কাজে ব্যবহার করা হবে। আপনার দিবা যত্ন কেন্দ্র/শ্রেণি পর্যবেক্ষণ থেকে প্রাপ্ত তথ্য অন্যান্য দিবা যত্ন কেন্দ্র/শ্রেণি পর্যবেক্ষণ থেকে প্রাপ্ত তথ্যের সাথে একত্র করে একটি প্রতিবেদন (রিপোর্ট) আকারে প্রকাশ করা হবে। প্রতিবেদনে কোথাও আপনার বা আপনার প্রতিষ্ঠানের নাম থাকবে না।

স্বেচ্ছায় অংশ অংশগ্রহণ: আপনার অংশগ্রহণ সম্পূর্ণ স্বেচ্ছাপ্রণোদিত। সম্মতি (ঈড়হংবহঃ) প্রদান করার পরও যে কোন সময় আপনি পর্যবেক্ষণের অনুমতি বাতিল করতে পারেন।

অংশগ্রহণকারীর অধিকারঃ এই গবেষণার ব্যাপারে কোন প্রশ্ন থাকলে আপনি গবেষক ড. মুহাম্মদ মাহবুব মোর্শেদ (মোবাইল ০১৭৬৭৯০৩৬২৪)/ গবেষণা সহযোগী সায়েবা বিনতে জহির (মোবাইল ০১৭৭১৫৩৫০৩৮) অথবা বাংলাদেশ ইসিডি নেটওয়ার্ক-এর প্রতিনিধি সৈয়দা সাজিয়া জামান (মোবাইল ০১৭১৬৪১৮২৭৫)/ মাহমুদা আক্তার (মোবাইল ০১৭৫৫৫৯২৯৩৭) কে ফোন করতে পারেন।

এই পর্যবেক্ষণ করতে দেওয়ার ব্যাপারে কি আপনার সম্মতি রয়েছে? (টিক চিহ্ন দিন)

হ্যাঁ	না

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দিবাযত্ন কেন্দ্র/ প্রাক-প্রাথমিক শ্রেণি/প্রাথমিক শ্রেণির ফ্যাসিলিটেটর/শিক্ষকের স্বাক্ষর ও তারিখ

নামঃ

পদবি ও প্রতিষ্ঠানঃ

উপজেলা ও জেলাঃ

আমি এই সম্মতিপত্র অংশগ্রহণকারীকে পড়ে শুনিয়েছি এবং তিনি সম্মতি দিয়েছেন/দেননি।

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পর্যবেক্ষকের স্বাক্ষর ও তারিখ

পর্যবেক্ষকের নামঃ

দিবাযত্ন কেন্দ্র/ প্রাক-প্রাথমিক শ্রেণি/প্রাথমিক শ্রেণি পর্যবেক্ষণ চেকলিস্ট

পর্যবেক্ষণের তারিখঃ

ক. প্রতিষ্ঠানের নামঃ

খ. প্রতিষ্ঠানের ধরণঃ

- ডে কেয়ার
- প্রাক-প্রাথমিক শ্রেণিকক্ষ
- প্রাথমিক শ্রেণিকক্ষ

গ. বিভাগঃ________________ জেলাঃ ____________ উপজেলাঃ _______________

চ. এলাকার ধরনঃ

- ○ শহরাঞ্চল
- ○ গ্রামাঞ্চল
- ○ শহুরে বস্তি এলাকা
- ○ দারিদ্র্যপীড়িত অঞ্চল
- ○ চর/ নদীভাঙন এলাকা
- ○ হাওড় এলাকা
- ○ পার্বত্য অঞ্চল
- ○ দুর্যোগপ্রবণ অঞ্চল

ছ. মোট শিশুর সংখ্যাঃ ______ ছেলে শিশুঃ মেয়ে শিশুঃ

জ. উপস্থিত শিশুর সংখ্যাঃ _________

ঝ. উপস্থিত শিক্ষক/ যত্নকারীর নামঃ _________

ঞ. উপস্থিত শিক্ষক/ যত্নকারীর সংখ্যাঃ _________

বিবৃতি	সম্পূর্ণ বা বেশিরভাগ ক্ষেত্রে সঠিক	মোটামুটি সঠিক	একদমই বা বেশিরভাগ ক্ষেত্রে সঠিক নয়	মন্তব্য/উদাহরণ
১. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলো পরিষ্কার পরিচ্ছন্ন।				
২. ডে কেয়ার সেন্টার ক্লাসরুমগুলো শিশুদের জন্য নিরাপদ।				
৩. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলোতে বসার ব্যবস্থা শিশু উপযোগী (মাদুর/ নিচু বেঞ্চ/ ছোট চেয়ার টেবিল ইত্যাদি)।				
৪. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলোতে শিশুদের সংখ্যার তুলনায় যথেষ্ট জায়গা আছে।				
৫. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলো শিশু উপযোগীভাবে সাজানো আছে।				

৬. ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে শিশুদের জন্য শিশু উপযোগী ওয়াশব্লক রয়েছে।				
৭. ওয়াশব্লকগুলো যথেষ্ট পরিষ্কার পরিচ্ছন্ন এবং পানি, সাবান ইত্যাদি পর্যাপ্ত পরিমাণে রয়েছে।				
৮.ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে শিশুদের জন্য নিরাপদ পানির ব্যবস্থা রয়েছে।				
৯. ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে শিশুদের জন্য পুষ্টিকর নাস্তা/ দুপুরের খাবারের ব্যবস্থা রয়েছে।				
১০. ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে শিশুদের খেলাধুলার জন্য যথেষ্ট জায়গা রয়েছে।				
১১. ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে শিশুদের জন্য পর্যাপ্ত সংখ্যক খেলার সরঞ্জাম রয়েছে।				
১২. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলোতে শিশুর বয়স উপযোগী বিভিন্ন কার্যক্রম করানো হয়/ শিশুকেন্দ্রিক পদ্ধতিতে কার্যক্রম পরিচালনা করা হয়।				
১৩. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলোতে খেলার মাধ্যমে শেখার প্রতি গুরুত্ব দেওয়া হয়।				
১৪. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলোতে শিক্ষক/ যত্নকারীরা শিশুর প্রারম্ভিক শিক্ষার জন্য উদ্দীপনা দেওয়ার ক্ষেত্রে গান, ছড়া, গল্প বলা, খেলা, যৌথ কাজ ইত্যাদি পদ্ধতি ব্যবহার করেন।				
১৫. শিশুরা সক্রিয়ভাবে বিভিন্ন কার্যক্রমে অংশগ্রহণ করে।				

১৬. শিশুদের জন্য সুপরিকল্পিত শিক্ষাক্রম/ পাঠ্যসূচি (কারিকুলাম) এবং পাঠ পরিকল্পনা (লেসন প্ল্যান) ব্যবহার কয়রা হয়।				
১৭. শিশুদের জন্য শিখন-শিক্ষণের জন্য বই, খেলনা, শিখন উপকরণ ইত্যাদি পর্যাপ্ত পরিমাণে আছে।				
১৮. শিখন উপকরণসমূহ শিশুদের জন্য উপযোগী।				
১৯. শিশুদের সাথে এমন কোনো কার্যক্রম করা হয় যা তাদের পরবর্তী পর্যায়ের জন্য প্রস্তুত করে। (যেমন, ডে কেয়ার থেকে প্রাক প্রাথমিক এবং প্রাক প্রাথমিক থেকে প্রাথমিকে উত্তরণ)				
২০. ডে কেয়ার সেন্টার/ ক্লাসরুমগুলোতে শিশুদের মধ্যকার পার্থক্যগুলো বিবেচনা করে সেই অনুযায়ী কার্যক্রম পরিচালনা করা হয় (যেমন, বুদ্ধিমত্তার ধরণের পার্থক্য, আচরণগত পার্থক্য ইত্যাদি)।				
২১. শিক্ষক/ যত্নকারী প্রয়োজন অনুযায়ী ইতিবাচক বলবর্ধক (প্রশংসা, হাসি, স্বীকৃতি ইত্যাদি) ব্যবহার করেন।				
২২. শিশুদের শ্রেণি কাজে খাপ খাওয়াতে, প্রত্যাশা অনুযায়ী আচরণ করতে এবং এক কাজ থেকে আরেক কাজে যেতে শিক্ষক/ যত্নকারী সুনির্দিষ্ট রুটিন বা পদ্ধতি ব্যবহার করেন।				
২৩. শিশুদের সাথে খেলা বা শ্রেণিকাজে শিক্ষক/ যত্নকারী নিজে সক্রিয়ভাবে অংশগ্রহণ করেন।				
২৪. শিশুদের একে অপরের সাথে কথা বলতে, পারস্পরিক সহযোগিতা করতে এবং পরিবেশের সাথে মিথষ্ক্রিয়া করতে শিক্ষক/ যত্নকারী সক্রিয়ভাবে উৎসাহ দেন।				

২৫. ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে বিশেষচাহিদাসম্পন্ন শিশুদের জন্য বিশেষ ব্যবস্থা আছে (র‍্যাম্প, ব্রেইল, সাইন ল্যাঙ্গুয়েজ, এডাপ্টিভ ডিভাইস ইত্যাদি)।				
২৬. ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে সুবিধাবঞ্চিত এবং পিছিয়ে পড়া জনগোষ্ঠীর জন্য নিরাময়মূলক বা বাড়তি সহায়তার ব্যবস্থা আছে।				
২৭. শিশু অস্থির, উদ্বিগ্ন বা অবসন্ন থাকলে শিক্ষক/ যত্নকারী তাকে যত্ন ও ভালোবাসা দিয়ে স্থির ও মনোযোগী করেন।				
২৮. শৃঙ্খলাবিরূদ্ধ আচরণের ক্ষেত্রে শিক্ষক/ যত্নকারী শাস্তি না দিয়ে ইতিবাচক শৃঙ্খলামূলক কৌশল ব্যবহার করেন।				
২৯. ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে শিশুদের জন্য প্রাথমিক চিকিৎসার ব্যবস্থা এবং প্রয়োজনীয় সামগ্রীসমূহ রয়েছে।				
৩০. শিক্ষক/ যত্নকারী শিশুর বিভিন্ন চাহিদার প্রতি সাড়া দেন এবং সহানুভূতিশীল।				
৩১. প্রত্যেক শ্রেণিকক্ষে একজন প্রধান শিক্ষক বা যত্নকারী ছাড়া শিশুদের দেখাশোনা ও সাহায্য করার জন্য অন্য কেউ উপস্থিত আছে (যেমন, আয়া, প্যারা টিচার ইত্যাদি)।				
৩২. শিশুর পরিবারের সদস্যরা ডে কেয়ার সেন্টার/ শিক্ষা প্রতিষ্ঠানে শিশুর প্রাত্যহিক কার্যক্রমের সাথে সম্পৃক্ত থাকে।				

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পর্যবেক্ষকের স্বাক্ষর ও তারিখ

পর্যবেক্ষকের নাম