การพัฒนาและสถานภาพสตรีในบังกลาเทศ

นางสาว อิราม อักตาร

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GENDER DEVELOPMENT AND WOMEN'S STATUS IN BANGLADESH

Miss Iram Akhtar

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By	Ms. Iram Akhtar
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Thesis Advisor	Pavika Sriratanaban, Ph.D.

Accepted by the Faculty of Political Science, Chulalongkorn University in Partial Fulfillment of the Requirements for the Master's Degree

.....Dean of Faculty of Political Science

(Professor Charas Suwanmala, Ph.D.)

THESIS COMMITTEE

.....Chairperson

(Professor Amara Pongsapich, Ph.D.)

.....Thesis Advisor

(Pavika Sriratanaban, Ph.D.)

.....Member

(Surat Horachaikul)

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บังคลาเทศเป็นประเทศที่มีประชากรหนาแน่น โดยประมาณ 140 ล้านคน ซึ่งประชากรส่วนใหญ่เป็นมุสลิม 75 เปอร์เซ็นต์ของประชากรทั้งหมดนั้นอาศัยอยู่ในชนบทและครึ่งหนึ่งของประชากรนั้นเป็นสตรี ที่ถูกละทิ้ง มีฐานะต่ำต้อย ขนบธรรมเนียม ประเพณีก็ได้รับอิทธิพล วิถีชีวิตของสตรีและความยากจนทำให้เกิดความเสียหายต่อการพัฒนาทางด้านเศรษฐกิจและสังคม

จุดเด่นของงานนี้ คือ การให้อำนาจแก่สตรีและอิทธิพลของมันต่อการพัฒนาทางด้านสังคม ในการใช้สุขอนามัยเป็นเครื่องบ่งชี้พร้อมกับเน้นความสำคัญทางการกีดกันทางวัฒนธรรม ทางด้านการศึกษา สุขอนามัย และปัจจัยต่างๆ ทางด้านเศรษฐกิจ-สังคม ข้อมูลนี้ได้ถูกรวบรวมมามากกว่า 8 ปี ตั้งแต่ปี ค.ศ 1995 ถึง ค.ศ 2003 ข้อมูลนี้ได้ถูกจำแนกให้เห็นถึงความเปลี่ยนแปลงในสถานะทางด้านสุขอนามัยและการให้สิทธิ/อำนาจกับสตรีในบังคลาเทศ

ในชนบทสตรีมีส่วนร่วมในงานกรรมกร(ผู้ใช้แรงงาน)และธุรกิจการเกษตรขนาดเล็ก ซึ่งสิ่งเหล่านี้นำไปสู่การเปลี่ยนแปลงในความคิดและทัศนคติของผู้ชายที่มีต่อสตรี การเปลี่ยนแปลงดังกล่าวส่งผลกระทบต่อบทบาทของสตรีนครอบครัวและสังคม องค์กรNGOs หลายองค์กรได้ช่วยเหลือความเป็นอยู่ผู้คนในพื้นที่ เช่นสินเชื่อขนาดเล็ก, การศึกษา, สุขอนามัย, การสุขาภิบาล, โภชนาการ และปัญหาสิ่งแวดล้อม นโยบายของรัฐชี้ให้เห็นถึงการกระทำและทัศนคติที่ดีที่รัฐต่อการให้อำนาจต่อประชาชน สุขอนามัยและการพัฒนา

จะเห็นได้ว่าอัตราประชากรที่รู้หนังสือเพิ่มขึ้น และเด็กผู้หญิงเข้าศึกษาระดับชั้นประถมการศึกษาเพิ่มขึ้นเช่นกัน ในทางสุขอนามัยของสตรีก็มีการเปลี่ยนแปลงเช่นกัน สังเกตได้จากอัตราการตายของแม่ที่ให้กำเนิดบุตรลดลงและภาวะที่มีบุตรมากก็ลดลง ทางด้านเศรษฐกิจบ่งชี้อัตราการเพิ่มขึ้นของคนงานหญิงที่ได้ค่าจ้างและอัตราการลดลงของแรงงานที่ไม่ได้ค่าจ้าง โดยทั่วไปได้มีการพิจารณาการให้อำนาจ/กระจายอำนาจต่อสตรี อย่างไรก็ตามอัตราการพัฒนาของสตรีอย่างคงเป็นไปอย่างช้าๆ การกีดกันทางด้านวัฒนธรรมและความไม่มั่นคงของการเมืองทำให้การพัฒนาของสตรีนั้นช้าไปด้วย ดังนั้นหวังว่าการเปลี่ยนแปลงสภาพความเป็นอยู่ของสตรีจะดำเนินการต่อเนื่องในอนาคตอันใกล้นี้.

สาขาวิชาการพัฒนาระหว่างประเทศ ลายมือชื่อนิสิต Iram Akhtar

ปีการศึกษา 2549 ลายมือชื่ออาจารย์ที่ปรึกษา ภาวิกา ศรีรัตนบัลล์

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Bangladesh is densely populated with a population of approximately 140 million. The majority of its population is Muslim. 75 percent of the population lives in the rural areas and half of the total population are women. Ignorance, low status, traditional inhibitions have influenced the life of women and poverty has been detrimental to socio-economic development.

The focus of this paper is the development of women and their status. Using social development indicators with emphasis on cultural barriers, education, health and socio-economic factors data was collected for a time series trend over a period of 8 years from 1995 to 2003. The data was then analyzed to see the changes in women's development and status in Bangladesh.

Women's participation in the labor sector and small agricultural businesses in the rural areas has brought about a change in behavior and attitude of men towards women. These changes have made an impact on women's role in the family and society. Many NGOs have helped to influence women's lives, socially and economically. Major contributions by them have been in the areas of micro-credit, education, health, sanitation, nutrition and environmental issues. Government policies indicate positive attitude and commitment towards empowerment, health and development.

There has been an increase in literacy rates, and an increase in girls primary school enrollment. Also, improvements in women's health were indicated by the decrease in maternal mortality ratio, and decrease in fertility rate. The economic indicators showed an increase in female paid labor force. In general, there has been considerable development of women. However, the rate of development for women is still very slow. Cultural barriers and political instability has slowed the progress of development for women. Nevertheless, the improvements evident are expected to continue in the near future.

Field of study International Development Studies..... Students signature Iram Akhtar.....
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ABBREVIATIONS

ADB	Asian Development Bank
ANC	Ante-Natal Care
BRAC	Bangladesh Rural Advancement Committee
CARE	Cooperative for American Relief Everywhere
CEDAW	Commission on the Elimination of Discrimination against Women
DFID	Department For International Development
DHS	Demographic Health Survey
EmOC	Emergency Obstetric Care
ESCAP	Economic and Social Commission for Asia and the Pacific
FHI	Family Health International
GDI	Gender Development Index
GOB	Government of Bangladesh
HDR	Human Development Report
ICCPR	International Covenant on Civil and Political Rights
ICDDRB	International Center for Diarrheal Disease Research Bangladesh
ICESCR	International Covenant of Economic, Social , and Cultural Rights
ICPD	International Conference on Population Development
IDRC	International Development Research Center
IFAD	International Fund for Food and Agricultural Development
ILO	International Labor Organization
MDG	Millennium Development Goals
MHFW	Ministry of Health and Family Welfare
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOWCA	Ministry of Women and Children Affairs
NAP	National Action Plan
NGO	Non Governmental Organization
NGOAB	Non Governmental Organization Affairs Bureau
NIPORT	National Institute of Population Research Training
OTOP	One Tambon One Product
PFA	Platform For Action
PPP	Participatory Perspective Plan
TBA	Traditional Birth Attendants
UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations Education Scientific and Cultural Organization
UNICEF	United Nations International
WB	World Bank
WHO	World Health Organization
WID	Women In Development

CHAPTER I

INTRODUCTION

1.1 Statement of the Problem

In Bangladesh, women's status is the root cause of all problems. In this age of globalization, empowerment and health related issues are becoming complex and interrelated. The governments in developing countries are addressing them so that millennium development goals could be achieved. To understand the development of women involves taking into account the needs of social opportunities of education, economic emancipation, cultural barriers, as well as health determinants through policy and legislation, including NGOs that help reinforce quality of life for all people.

Nation's health and development are intimately linked. Morbidity[1] and mortality[2] have resulted in diseases from malnutrition, increase in infectious diseases, environmental degradation, low investment in the health sector and increasing violence in society (WHO, 2006). Women and children are the most affected group from the developmental point of view. 50% of 6.5 billion world's population is women and nearly 3 billion people live below poverty line (WHO, 2006).

As two thirds of the world's poor live in South Asia and the majority of the poor are women living in rural areas. Mostly women are considered as the poorest among the poor. In many rural areas of Asia, more women than men are among the "working poor" than among the poor as a whole. Women are disproportionately concentrated in the lowest remunerated categories of self-employment and casual labor (IFAD, 2002).

[1] The proportion of sickness or of a specific disease in a geographical locality.
[2] The relative frequency of deaths in a specific population; death rate.

Bangladesh is one of the most densely populated countries of the world situated in South Asia. Bangladesh became independent in 1971 and inherited a war ravaged economy. It also inherited age old religious and cultural biases which have hampered women's empowerment, women's health and women's development. The population of Bangladesh is approximately 140 million with a density of 1000 person per square mile. Approximately 40% of the population lives below the poverty line. Women constitute nearly 50% of the population; while two thirds of the country lives in rural areas. Bangladesh has an agricultural and rural based economy.

According to the Bangladesh Bureau of Statistics the number of women in Bangladesh is 68.7 million that is 49.1% and 5 million are adolescents (15-19 years). 50% of these adolescents are married, 30% have become mothers, and 6% are pregnant with first child. Approximately 4 million women become pregnant each year in Bangladesh. From that, 600,000 develop pregnancy related complications and about 28,000 deaths occur annually (UNICEF, 1999). The number of deliveries each year is about 2.9 million. Only 232,000 deliveries; i.e. 8% of the total deliveries occur in health facilities. In Bangladesh, 2.768 million deliveries occur at home that is 92% of all deliveries and these are mainly in the rural areas. Of the home deliveries 64% are assisted by traditional birth attendants (10% by trained birth attendants and 54%by untrained birth attendants). 75% of children born die within the first year (MOWCA, 1997).

In Bangladesh because of its past legacy the position of women remain considerably lower to that of men. Women, through ages because of traditions, customs and practices, have remained subordinate to men in almost all aspects of their lives. Most women's lives remain centered on their traditional roles (Nosaka, 2004). They have limited access to markets, productive services, education, health care, and local government. This lack of opportunity contributes to lower socio economic condition, which diminishes family's well-being, contributing to the malnourishment, generally poor health of women and children, and thereby frustrating health, educational and other

national development goals. In fact, as long as women's access to education, health care, and training facilities remains limited, prospects for improved productivity among the female population will remain poor.

As late as the 1970's, a girl child was not welcomed as much as a boy would be (Jahan, 1975). Even today a girl is considered a burden to the family. From a young age the girls are made to feel inferior to the opposite sex and they are made to feel they are a liability to the family. These are prejudices that stem from the fact that men are assumed to be income earners. Girls are looked upon as help for their mothers, with very little identity of their own. In many areas the girls have to observe purdah (covering with veils or remain in seclusion) (Jahan, 1975). Moreover illiteracy, early marriage, multiple pregnancies, high maternal and infant morbidity and mortality are all common features in rural Bangladesh (Bangladesh Bureau of Statistics, 2000).

Around 70% of the rural women are small cultivators, tenants, and landless households. They work mostly as laborers part time or seasonally, usually in post-harvest activities and receive payment in kind in the form of clothing or food or in meager cash wages. Another 20%, mostly in poor landless households, depend on casual labor, cleaning, begging, and performing other work as a source of income; their joint income is essential for household survival. The remaining 10% of women are professional in trading, landowning categories, and they usually do not work outside the home (Hamid, 1996).

Even though the economic contribution of women is substantial, doing house work, cooking, cleaning, raising children it is mostly unacknowledged. Women in rural areas are responsible for most of the post-harvest work, and for keeping livestock, poultry, and small gardens. Women in cities rely on domestic and traditional jobs. During the 1980s, many export based industries mushroomed thus, increasing jobs in the manufacturing sector, especially in the readymade knitwear and garment industries

(Kibria, 2001). Those with better education work in offices, health care sector, and teaching, but their numbers still remain small (Hamid, 1996). Continuing high rates of population growth and the declining availability of work made more women seek employment outside the home, also increasing migration from the rural to the urban areas (Afsar, 2001). Accordingly, the female labor force participation rate doubled from 9% to 16% between 1980s and 1990s (World Bank, 1997). Female wage rates in the 1980s were low, typically ranging between 20%-30% of male wage rates (Hamid, 1996).

Majority of women living in the rural areas have low level of education and are economically dependant on their families with little say or voice in family matters. This has been perpetuated over ages because of women's subordinate role in the South Asian society. This has resulted in her reduced access to education, job opportunities and proper health care. There is always a gap between availability of health services and access to them by the poor rural women causing an increase in their mortality and morbidity (Afsana, 2001). Lack of care deprives them of a life of quality which they deserve and have a right to demand.

The rate of life expectancy shows the countries development in all sectors because health is related to education, economy, social welfare, environment, commerce, industry and all the other spheres of life directly or indirectly. The sex ratio gives an idea of the equality and equity of care to the population, larger gaps would indicate bias towards boys or girls. The total fertility rate is the number of children born to a woman during her reproductive life. An increase in fertility rates increases the maternal mortality risk, because every time a woman is pregnant her risk of dying increases, especially in a country like Bangladesh. Maternal Mortality Ratio is the number of maternal deaths per 100,000 live births. In Bangladesh the MMR which was 600/100,000 live births in 1995 has been brought down further to 380/100,000 live births in 2003 (HDR, 2005) which though commendable is still rather high and indicates the poor health status of women specially in the rural areas, as compared to maternal mortality ratio's in developed

countries 14/100,000 live births, (WHO-UNICEF, 2000-2005). The major causes of maternal death are due to abortion, hemorrhage, eclampsia, obstructed labor and infection. Child mortality indicates the education level of mother. An educated mother would look after her baby better with nutritional knowledge, the need for immunization and will have good hygienic practices. Contraceptive prevalence rate is the percentage of people in a country using any method of contraception. Bangladesh has a very large population which is affecting the development of the country. Since its independence the government has been trying to control the population growth. Family planning has been the main focus of the health policy. Contraceptive use alone can control the population increase and improve the health of women to a great extent by reducing the number of pregnancies and spacing the number of births.

Lack of educational background decreases the chances of women to compete with her male counterparts in different socio economic situations and this continues to increase the gap and inequalities between the two sexes and reduces her chances of quality health care. The problems affecting economic and social status of women in Bangladesh are vast and complex. Poverty, lack of education, training and job opportunities has forced them to a state of complete dependency and low decision making power. Political reforms in conjunction with international organization policies and platforms, have forced Governments to bring about reforms leading to women's empowerment.

There is no question that education is central to the process of empowerment for both poor men and women. Literacy levels in Bangladesh are improving, however traditionally girls in rural areas were not sent to school because they helped mothers in the home. Socio-economic barriers did not allow them the luxury of getting an education. Education receives the highest allocation of resources in Bangladesh. The importance of education has been emphasized globally through the millennium development goals (MDG, 2000). Bangladesh is also a signatory of the Declaration emphasizing education as a major development strategy for the Bangladesh government.

Economic growth is also necessary for development. Women are the most economically deprived because of their traditional roles which keep them at home, due to their lack of education and lack of opportunities to earn their living independently. Over the last three decades development policies are becoming more people centered, and although poverty concerns have been on the development agenda the implementation of development policies has not always addressed poverty alleviation (Mehra, 1997). Economic factors for empowerment are jobs and business's which give them economic independence. The Bangladeshi rural women are not without work. Although they appear to be unemployed, they are actually overworked. These women are making direct contribution to the economy through their participation in agriculture and non-farming activities and also through their work at home, which is unrecognized. Without economic emancipation women's status will continue to remain low and development will be slow, because women form a major portion of the labor force their full participation is essential. Developing countries like Bangladesh cannot afford to neglect these important issues and they are in reality being addressed in the national policies. What remains to be seen is how effective these policies are in empowering women. Along with development organizations NGOs are closely linked to women's economic emancipation in rural Bangladesh.

In Bangladesh NGOs have been successfully playing a major role in poverty alleviation and facilitating women's empowerment; by making her more self sufficient and more self confident. NGOs and other development organizations can be facilitators in the empowerment process. Their efforts are enabling women to gain individual empowerment by teaching the women skills, increasing their decision making capacity, control over resources by encouraging them to participate in these micro programs. There are over 20,000 NGOs are involved in various development programs in Bangladesh. They range from health related projects, educational projects, empowerment or micro credit projects, nutritional and environmental, maternal and child health, immunization,

safe drinking water, sanitation and hygiene, and many other projects to name only a few. Their contribution over the last three decades has helped the government reach people in the rural areas to improve their quality of life. Effective collaboration between the government and NGOs will strengthen the organizational objectives and make the projects more successful.

Government policies in any country are constantly changing with the time and needs of the people. Many institutional and financial constraints are drawbacks that make it difficult to meet the set goals; however the country policy shows the commitment of a country towards overcoming a particular issue or problem. The reality is that the health status of women in a country is intimately related to empowerment of women. The health policy of the government is a reflection of the health status of the people and position or status of the people specially the women and children.

In 1995, women's development issues were first addressed. Subsequently, with the government's commitment and involvement to the MDGs and Beijing declaration, policy changes have been made. Women's development is a process of change and new and appropriate adjustments have to be made with the passage of time. Bangladesh has come a long way since independence; this research should give a picture of where women stand today.

1.2 Objectives of the Study

The objectives of this study are:

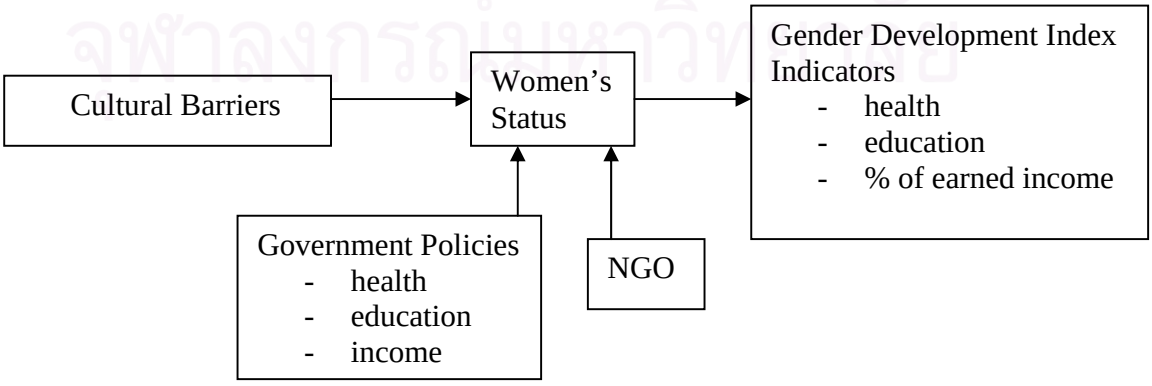
1. To understand the trend of women's development in Bangladesh for the years 1995, 2000 and 2003.
2. To interpret the changes during these 8 years in the context of women's development and their status.

1.3 Hypothesis

The development of women improves women's status.

1.4 Conceptual Framework

The conceptual framework below has taken into account cultural barrier, government policies relating to health, education and income, as well as the role of NGOs in women's development and status. All these factors not only affect lives of individuals but in a third world country like Bangladesh, it has influenced women the most. Government policies play a major role in improving the development of women. Several health policies and programs have been developed and implemented. NGOs alongside, they have tremendously aided in the process of women's development, some also in collaboration with the government. Government and NGOs have emphasized that every person get an education enabling them to have more opportunities, opening up their chances for a job and improving her status. It gives a person a better chance of earning a livelihood and becoming financially independent, and for women this is important because when her earning capacity increases she gains not only independence but also gains some measure of position and higher status in the family that enables her to have a say in the family affairs. The increase of the social and economic indicators allows women to improve their status. As a result, when translated in figures, the GDI will show a trend in women's development.



1.5 Scope and Limitation

The research will only take into consideration the years 1995, 2000 and 2003 due to the insufficiency and unavailability of data. For the data to be consistent and much more accurate, the human development report and world development indicators were used as much as possible. Figures for the year 2005 in these reports were unavailable as they only had their most recent data recorded from two years previously – this was consistent with the data gathered from earlier human development reports. Therefore, the latest available data used was for 2003. Also, statistics from 1990 were inadequate as most data, especially in the human development reports, was not recorded under the specifications that they had been in recent years.

The limitations for a study of this type is that had it been possible it would have been best if primary source data were available for analysis. Secondary source studies have to be researched intensively and there is always a possibility of bias being present of the author. In addition, the authenticity of the article has to be ensured as well.

CHAPTER II

LITERATURE REVIEW

2.1 Human Development Indicators

How do we develop our attitudes, values, and stereotypes about what is proper and expected behavior for men and women when barriers exist in this age against women's development?

In Bangladesh, rural women live and work in the confines of the extended family home and compound. Many women have no independent sources of income, little or no education, and few marketable skills. Reproductive decision-making has been influenced by traditional female role expectations and women's dependence on men.

The composite indices Human Development Index (HDI), Gender Development Index (GDI) and Gender Empowerment Measure (GEM) are used to measure human development and gender inequality. HDI measures the average achievements of the country in terms of the extent to which people lead a long and healthy life, are educated and knowledgeable, and enjoy a decent standard of living. GDI is HDI adjusted for gender inequality. It measures achievements in the same basic dimensions as HDI but in addition captures inequalities between women and men. The GEM is concerned with the opportunities available to women vis-à-vis men as regards participation in the economic and political life of a country. Together these three indices attempt to capture the level of human development, the level of development of women and the extent to which women are free from discrimination in building their capabilities and in gaining access to resources and opportunities. This thesis however, will only take into account GDI.

In 2003, South Asia had a regional HDI of 0.628, which positions it below the HDI of both the average of developing countries as well as for the world. Within the South Asian region there are notable disparities. India has been ranked as 127 out of 177 countries at the lower end of the medium human development group. Pakistan, Nepal, Bhutan and Bangladesh are all ranked below India. Sri Lanka and Maldives both have HDI rankings above that of the average for developing countries and the world, and much higher than the rest of the South Asian region.

2.2 Attitudes, Values, and Stereotypes

Ratna Kapur, Director for the Centre for Feminist Legal Research in New Delhi, at a public forum held at the headquarters of the IDRC spoke on addressing barriers to empower women in South Asia, “First, there is the absence of a rights discourse, and second there is a troubling focus on culture when it comes to women’s rights in Asia-Pacific.” (IDRC, 2005). This thesis is based on such studied, tested and tried assumptions that cultural barriers are a big impediment in women’s development in Asia Pacific.

A study in 1999 by the International Centre for Diarrheal Disease Research in Bangladesh on maternal and child mortality/morbidity in found relatively high rates. The study was based on the fact that social and cultural beliefs and practices regarding motherhood and childrearing have significant influence on maternal/child health. Also, utilization of available health care resources by women is relatively low. The situation is most severe in rural areas where women are largely illiterate and suffer from structural as well as socio-cultural barriers to accessing health services.

The project was aimed to take an anthropological approach and use a variety of qualitative and quantitative methods to identify the socio-cultural as well as structural barriers to better health for women and children in rural Bangladesh. Set in Matlab, a

rural area sixty miles south of the capital Dhaka, the study would attempt to identify change agents that may be used to bring about behavioral changes among women and children, and the community at large. The ultimate goal was to help design culturally sensitive policies and intervention programs to increase rural Bangladeshi women's participation in and utilization of health care resources.

One of the most important women's groups in Bangladesh is Women for Women: A Research and Study Group, located in Dhaka. It is a pioneer non government, non-profit, voluntary women's organization, engaged in research and public education programs on gender issues with a view to enhancing the status of women. It was established in 1973 by a group of committed woman professionals, representing a variety of academic disciplines. The Group strongly felt the need for developing a sound information base for identifying the issues relating to the disadvantaged status of women in Bangladesh and for creating public awareness with a view to ameliorating the existing situation. Since then, Women for Women have been engaged in research, information, dissemination, advocacy awareness and motivational programs (Abdullah, 1981). United Nations Capital Development Fund cited Bangladesh in the context of microfinance in South Asia that although many institutions said that women were still seen primarily as housewives and enjoyed limited control over their income, respondents also reported signs of change. One Indian institution said that some of its older credit groups were now emerging as the first role models for female entrepreneurs in the area. An institution in Bangladesh highlighted the crucial role that women play in household management, noting that "Women are expected to be the household bank." Perhaps as a result of this role, another respondent from Bangladesh was able to report that women's access to loans had produced a positive change in gender relations among its client base, by obliging the men to depend on women for credit.

Jejebhoy and Sathar found in 2001 on women's autonomy and the influence of religion and region; lives of women explored dimensions of their autonomy in different regions of South Asia—Punjab in Pakistan, and Uttar Pradesh in north India and Tamil

Nadu in south India. It explored the contextual factors underlying observed differences and assesses the extent to which these differences could be attributed to religion, nationality, or north–south cultural distinctions. Findings suggested that while women's autonomy – in terms of decision-making, mobility, freedom from threatening relations with husband, and access to and control over economic resources – is constrained in all three settings, women in Tamil Nadu fare considerably better than other women, irrespective of religion. Findings were of little support to the suggestion that women in Pakistan have less autonomy or control over their lives than do Indian women (Abdullah, 1981). Nor do Muslim women – be they Indian or Pakistani – exercise less autonomy in their own lives than do Hindu women in the subcontinent. Rather, findings suggested that in the patriarchal and gender-stratified structures governing the northern portion of the subcontinent, women's control over their lives is more constrained than in the southern region (Jejebhoy, 2001).

Endangered Daughter: Discrimination and Development in Asia by E. Croll examines the reasons why large numbers of women seem to be "missing" from the populations of countries across Asia. Bringing together demographic data and anthropological field studies to paint a vivid picture of the social costs of daughter discrimination across Asia today, Croll reveals the multiple ways in which girls are disadvantaged, from excessive child mortality to the withholding of health care and education on the basis of gender, It argues that the increasing availability of sex-identification technologies will serve to supplement older forms of infanticide and neglect (Croll, 2000). Focusing especially on China and India, this compelling account reveals the surprising coincidence of increasing daughter discrimination with rising economic development, declining fertility and the generally improved status of women in East and South Asia.

Nussbaum, author of *Women and Human Development*, one of the most innovative and influential philosophical voices of the time, proposes a new kind of feminism and argues for an ethical underpinning to all thought about development

planning and dramatically moved beyond the abstractions of economists and philosophers to embed thought about justice in reality of struggles of poor women.

Some of the South Asian Women's Networks surveyed during researching this thesis:

- Adhunika is dedicated to the promotion of technology usage for women in Bangladesh.
- Ain o Salish Kendro (ASK). A human rights and legal resource centre. ASK provides free legal aid, mediation and counseling services, monitors, documents and campaigns on human rights and women's rights issues, and undertakes public interest litigation. It has litigated a number of cases on women's human rights, including challenges to the practice of "safe custody". It also publishes an annual report on human rights in Bangladesh. Address: 26/3 Purana Paltan Line, Dhaka 1000, Bangladesh. Tel: 8802 831 5851; email: ask@citechco.net.
- Dhaka American Women's Club is an organization for US citizens and their wives who provide community within their group as well as assistance to less fortunate people in Bangladesh. They sponsor social and charitable activities through the year.
- Grameen Bank in Bangladesh provides credit to the very poor in their villages. The Grameen dialogue, a newsletter published by the Grameen Trust, has more information about the current status of Grameen.
- A feminist bookstore in Bangladesh is Narigrantha Prabartana, 2/8 Sir Syed Road (Above Sari and Handicraft Shop), Mohammadpur, Dhaka.
- Nari Pokhho, Road 9-A, House 51, P.O. Box 35, Sylhet, Dhanmandi, Dhaka. Consciousness-raising and lobbying on women's issues, research and publication.
- Center for Social Studies works with rural women. Room 1107, Ark Building, Dhaka University, Dhaka.
- Women for Women. Research and publication, seminars and video films on women's issues. 1/2 Sukrabad, Dhaka 12077.

- Bangladesh Rural Advancement Committee (BRAC) has development activities for rural women. 66, Mahakali Commercial Area, Dhaka-12.
- Gonoshasthaya Kendra has development activities for rural women. P.O. Nayarhat, Savar Distt., Dhaka.
- Nari Shonghoti works with rural women. Center for Social Studies, Room 1107, Ark Building, Dhaka University, Dhaka.
- Nijera Kori has action programs for landless peasant women and men. P.O. Box 5015, New Market, Dhaka-5.

2.3 Islamic Law

Taslima Nasreen, a Bangladeshi writer, gained international attention when Islamic leaders issued a fatwa calling for her death. Nasreen is one of the few women in her country who have dared to call for more freedom for the women of Bangladesh.

The Islamic Law often creates a huge debate when talking about women and equality. Majority of the people in Bangladesh are Muslims and follow Sharia Law. Sharia is the body of Islamic law. The term means “way” or “path”. It is the legal framework within which public and some private aspects of life are regulated for those living in a legal system based on Muslim principles of jurisprudence (Wikipedia, 2007).

Sharia deals with many aspects of day-to-day life, including politics, economics, banking, business law, contract law, sexuality, and social issues. Some Islamic scholars accept Sharia as the body of precedent and legal theory established before the 19th century. Other scholars view Sharia as a changing body and include Islamic legal theory from the contemporary period (Wikipedia, 2007).

There is not a strictly codified uniform set of laws pertaining to Sharia. It is more like a system of devising laws, based on the Quran, Hadith and centuries of debate and

interpretation. Before the 19th century, legal theory was considered the domain of the traditional legal schools of thought.

During the 19th century the history of Islamic law took a turn due to new challenges the Muslim world faced. The West had risen to a global power and colonized a large part of the world, including Muslim territories. Societies changed from agricultural to the industrial and new social and political ideas emerged as social models slowly shifted from hierarchical towards egalitarian (Wikipedia, 2007). The Ottoman Empire and the rest of the Muslim world were in decline, and calls for reform became louder. In Muslim countries, codified state law started replacing the role of scholarly legal opinion. Western countries inspired, sometimes pressured, and sometimes forced Muslim states to change their laws. Secularist movements pushed for laws deviating from the opinions of the Islamic legal scholars. Islamic legal scholarship remained the sole authority for guidance in matters of rituals, worship, and spirituality, while they lost authority to the state in other areas (Wikipedia, 2007).

- **Secularists** believe the law of the state should be based on secular principles, not on Islamic legal theory.
- **Traditionalists** believe that the law of the state should be based on the traditional legal schools. However, traditional legal views are considered unacceptable by most modern Muslims, especially in areas like women's rights or slavery.
- **Reformers** believe that new Islamic legal theories can produce modernized Islamic law and lead to acceptable opinions in areas such as women's rights.
- **Salafis** believe that the traditional schools were wrong, and therefore failed, and strive to follow the generation of early Muslims.

Contemporary practice of Sharia law illustrates that there is tremendous variance in the interpretation and implementation of Islamic law in Muslim societies today. Liberal movements within Islam have questioned the relevance and applicability of

Sharia from a variety of perspectives. Several of the countries with the largest Muslim populations, including Indonesia, Bangladesh and Pakistan, have largely secular constitutions and laws, with only a few Islamic provisions in family law. Turkey has a constitution that is officially strongly secular, but where the state systematically favors Sunni Islam. India is the only country in the world which has separate Muslim civil laws, framed by Muslim Personal Law board, and wholly based on Sharia. However, the criminal laws are uniform. Some controversial Sharia laws favor Muslim men, including rejection of alimony and polygamy (Wikipedia, 2007). Therefore, issues that still persist today regarding women as a consequence of religion, it is something that has been a part of the Muslim faith since the time Islam was born. To completely change the ideologies of a 600 year old religion – the words of God – is not something that can be altered hastily. Thus, in the context of Islamic Law, women's concerns remain a sore topic in the development agenda.

United Nations development agenda measures women's development in terms of women's participation in decision making policies. Mainstreaming women into decision-making positions is no easy task. It involves multi-pronged interventions that generate enabling policy, institutional and social environments. These include awareness raising challenging discriminatory social stereotypes that relegate women to the privacy of domesticity, and thrust men into highly valued public leadership roles; encouraging women, families and communities to believe in and support women as resourceful leaders, decision-makers and managers; developing a culture of shared domestic responsibility between men and women in the family, and/or providing adequate child care and household services to free women to participate politically; training women on political structures and processes, and the mechanics of contesting elections successfully; transforming the culture of political parties to provide quotas, ensure women's representation at decision-making levels in parties and place women high on party lists in winnable seats; providing adequate funds to women candidates to contest elections.

But women’s participation in decision-making per se, does not necessarily guarantee a transformational agenda for women. Consciousness raising for elected officials – men and women – on gender responsive good governance is critical. This includes instilling clarity on a gender sensitive rights perspective; operationalizing this through policies, plans and programs to address women’s concerns; training to govern in a transparent, inclusive, honest, participatory manner. Finally, we need to build enlightened constituencies, catalyze institutional mechanisms to ensure public support to women leaders with a transformational agenda and to hold to account duty bearers who renege on their commitments to gender equality and women's empowerment (Heyzer, 2006).

CHAPTER III

METHODOLOGY

3.1 Instruments

This is a study based on the analysis of secondary source material, of development of women in Bangladesh and their status over a period of 8 years (1995-2003), mostly using data from the UNDP HDR. It is a longitudinal study and any further data required were found in reviews, articles from well known and reputed journals, research studies, country fact sheets, country reports, country papers presented at international seminars and conferences like International Conference of Population Development (ICPD) 1994 in Cairo, Beijing Conference in 1995 and Beijing +10 in 2005 in Bangkok. Online research of published reports from website of international organizations like WHO, World Bank, UNDP, UNICEF, ESCAP, UNESCO, etc. were studied. Reports of NGOs like CARE, FHI were also researched.

Extensive literature search was carried out on information regarding women's development and status in Bangladesh. Data and statistics were derived from reading articles, reports and studies carried out in Bangladesh. Most of the data used were from human development reports, i.e. HDI and GDI, due to limitation of time. These statistics will then be compared to assess the trend in women's development and their status using a set of social indicators. The gender development indicators were socio-demographic indicators, educational indicators, indicators showing economic development and health indicators.

The need for women's empowerment to be achieved calls for ways of measuring or evaluating existing policies and programs. There are a few ways that indicators of empowerment can be assessed, the most commonly used and well developed among

these are, for example, GDI. It is important to bear in mind that empowerment is a very complex concept. It is difficult to say that any one way is the best way to measure empowerment. But, some method has to be used to investigate the success or failure of a program.

The adjusted human development indicators are similar to those of Moghadam and Senftova stating that these set of indicators show a high or low female status (Moghadam, 2005). They can be referred to basic capabilities of women. The indicators in this group are life expectancy at birth (female/male in years), sex ratio (female/male), average female age at first marriage, adolescent marriage (% of female in age group 15-19 years), number of births to 1,000 women (15-19 years) and total fertility rate (births per woman).

This set of indicators show the concern women have about women's control or say about their body. These are the critical issues considered in women's movements since 1993's World Conference on Human Rights in Vienna and in the ICPD in Cairo in 1994. These indicators refer to the protection of women's right to life, physical integrity, privacy and dignity or constituent elements of women's civil rights.

Health indicators are maternal mortality ratio (per 100,000 live births), child mortality rate (% age 0-5, female/male), contraceptive prevalence (% married women) and people infected with HIV (% female among adults).

Literacy and education have been recognized as a necessary condition for economic development and growth, citizen's rights and women's life options. These are of course very much in keeping with the MDG. However there has been a lot of discussion about whether primary enrollment can be considered enough to assess girl's life options. Therefore secondary school enrollment has been included in addition to

mean years of schooling. The higher the values in these categories the higher will be the level of empowerment of women.

The indicators used here are: youth literacy (% of ages 15-24, female/male), adult literacy rates (% ages 15+ and over, female/male), net secondary school enrollment (% female/male) and tertiary enrollment rates, gross enrollment ratio (% female/male).

The importance of this category of indicators is to show women's autonomy and empowerment. Salaried employment with maternity leave is a concern. Studies show that women with jobs have fewer children. Also, the statistics of increased labor force does not indicate positive connotations always. It could be the result of rising economic pressures, inequalities, or poverty in a given time and place. Although the discrepancy in the statistics is that it undercounts household labor, the urban informal sector, and women's agricultural labor.

The economic indicators will consider adult labor force participation rate (female/male), female share of paid labor force, unemployment rate (% female/male), estimated earned income (PPP US $) and female professional and technical workers (as % of total).

3.2 Analysis

The first part of the analysis will comprise of tables with data on the above indicators shown over a period of 8 years to see the trend over a period of time. While the second part of the analysis will comprise of the interpretation of what these changes signify in the context women's development and status.

It is hoped that that through these indicators it will be possible to understand to what extent women's empowerment has been achieved in Bangladesh and its effect on

health. It will also highlight the extent to which gender inequalities are being addressed. However, for countries like Bangladesh it will take some time for all the data to be available from one source. But with the increase in demand for these data sets, the government and other agencies will become more aware of the need to make sufficient and relevant data available

3.3 Ethical consideration

The ethical consideration has been an important aspect of the research. All the facts and figures of Government documents analyzed will not be wrongly interpreted and in no way findings of the documents negated. At the same time materials and text of various studies used in this study will not be quoted out of context.

Keeping in mind all information ethical considerations will be to constructively and positively used. Moreover issues where more information or more government reinforcement is required so that improvements can be made. Use of authentic and verifiable data and to minimize bias as much as possible.

CHAPTER IV

SOCIO-CULTURAL CONDITIONS OF WOMEN

The aim of this study is to study the development of women and their status in Bangladesh over the last decade. This will include cultural barriers, health, education, socio-economic independence, and government and NGO commitment.

The concept of the GDI was first mentioned in the 1992 HDR as the adjusted HDI, which took into account a set of disaggregated data by race, gender or region. The HDI itself comprises of the three basic components: longevity, knowledge and standard of living. In 1994, only a few selected countries had the adjusted HDI calculated as the data for the rest of the countries had not been available yet. In was in 1995 that the disaggregated GDI data was used to assess a country based on gender. This is because even though a country may have a high HDI, the GDI can be low thus, illustrating the disparity between men and women.

It has been observed that that by and large the role of women in South Asia is more or less traditional, she is a home maker, a wife, a mother, an agricultural helper to her family or husband and remains unremunerated. As she remains overworked her health suffers because of lack of finance and inability to have access to medical care, all these are the results of years of cultural norms and traditions. There is denying the fact that culture and tradition influence the life of people in rural Bangladesh. The women in the rural areas are thus trapped in the vicious cycle. Moreover the lack of education has led to increased poverty lowering the status of women. *The Fifty Percent* by Salma Khan reiterates the same philosophy of low status of rural women. Females have never been more advantaged than men in any known society. In many societies around the world women are discriminated against by law and by custom making them the most vulnerable and disadvantaged group (Hamid, 1996). Hamid's statement 20 years later maintains that

women are still in the same low status in Bangladesh, in addition Islamic laws depriving women equal rights for example equal right to property have not been enacted by government legislation (Islamic law entitles women to one fourth share of the husbands or fathers property as compared to the male who gets double the share of the sister) the Islamic law of property rights prevail even today.

In Bangladesh life of women is highly dependant on her status within the family as a daughter, wife or mother. In other words, sexual inequality is established through socioeconomic inequality, and distribution of authority and asset between the sexes as determined by the family organization and stratification of society (Khan, 1988). It is therefore necessary to give greater emphasis to improve the status of women in society in order to increase their capacity to control their lives, including their sexual and reproductive health (Dey, 1998). When the poor become poorer, there is less scope for improving maternal health only by reorganizing cosmopolitan obstetric care, which is equally inefficient in improving maternal health (Afsana, 2005).

Even in the affluent and developed countries, people who are financially constrained have substantially shorter life expectancies as they are subject to more illnesses than the rich. Not only are these differences in health an important social injustice, they have also drawn scientific attention to some of the most powerful determinants of health standards in modern societies. They have led in particular to a growing understanding of the remarkable sensitivity of health to the social environment and to what are known as the social determinants of health (WHO, 2003).

In developed countries, maternal mortality is reduced not simply due to better access to obstetric care, but to better education, better nutrition, improvements in housing and working conditions, and wider availability of effective, birth control (Doyal, 1995). While the causes of maternal mortality and morbidity are debated, the significance of

socio-economic contexts is ignored with little effort undertaken to address the issues in Bangladesh (Afsana, 2005).

Despite the slow income growth and efforts to diminish poverty there have been improvement in the demographic and health indicators, especially in terms of infant and child mortality. However, more than 20,000 maternal deaths occur every year. Maternal morbidity is estimated to be 30 times higher (Begum, 1997).

In Bangladesh, most poor people living in rural areas rely on traditional healing practices or self-care. Lack of health education and awareness prevent many people from seeking modern health care, even when these are available free. Moreover rural residents asked about common health seeking practices, all reported to use a home remedy. When diseases persisted and symptoms increased in severity, they would then visit traditional healers. Only in extreme cases would they visit hospitals (Roy, 2000).

It is estimated that approximately 585,000 maternal deaths occur every year globally and 99% of these occur in the developing countries (WHO, 1996). For the vast majority of the poor countries it is a ‘neglected tragedy’ because effective interventions are available to deal with this persistent crisis (BRAC, 2001).

The majority of women are in rural areas these women are involved in multiple roles in the agricultural sector, 50% of paid labor opportunities for women is from crop processing for other households. Some of the rural industrial work for women are in handloom weaving, jute handicrafts, coir rope making, mat making, pottery, oil pressing and lime making, paper bag making, and fish net making but their pay is one taka per hour or US 7cents per hour compared to US 35cents for males ((Hamid, 1996).This shows inequality in labor pay even in rural areas. The women are exposed to miseries such as frequent pregnancies, low nutritional status due to inadequate food intake causing increased mortality. Early adolescent marriage, which is a reflection of low status of women and their low educational attainment, also causes high mortality (Ahsanullah,

2003). Ahsanullah's study indicates the difficulty in getting out of old traditions which favor early marriage especially in the rural areas where people are more conservative.

Early marriage is very common in rural areas even in these modern times. Schuler's study is based on the hypothesis that if mothers or mother-in-laws are empowered they can influence the daughters and daughter-in-laws to stand up to their reproductive health rights. This has a direct effect on the maternal health because marriage can be delayed if the older mother so desires, and pregnancy can be delayed and therefore there is decrease in the number of mortalities (Schuler, 2003). Taking steps to enhance the status of women through education and economic empowerment in society will be more effective to reduce maternal mortality (Dey, 1998).

Women have since the very beginning had a very low position in Bangladeshi society, more so in the rural areas. With women's development, changes are taking place globally and women in Bangladesh have benefited from the change in attitude towards the female sex and gender equity (Jahan, 2001). There is however a very strong influence of culture and norms still prevalent in rural areas especially among women. The dominant roles of mother's in-laws and husbands inhibit the young, uneducated, jobless wife. And she takes a subservient place in the household. But though their status is low, when she reaches middle age she has a more powerful status, at the time of child birth the mother in law and older family members and husbands decide if she should get a skilled attendant for delivery (Haider et al, 2000)).

Social beliefs influence the health seeking behavior of rural mothers to be, younger, educated ones, were able to demand skilled birth attendants (Hlady et al, 1993). Some social changes are taking place even in Bangladesh as a result of the effect of education, economic independence, but their decision making ability in the rural areas is restricted to asking for a TBA but not hospital care for child birth, this is due to the

economic constraints of the majority of families, and rural women are economically and socially dependant on their husbands (Afsana and Rashid, 2001).

Reproductive decision making has been influenced by traditional female role expectations and women's dependence on men. Women are encouraged to take initiative in the family planning domain; however, in general, reproductive empowerment has not translated into better opportunities for women's control of other areas of their lives (FHI, 1996). By gradually encouraging women to leave their homes and seek information and services at fixed facilities, will broaden women's horizon and may give them the courage to seek social and economic empowerment (FHI, 2000).

Within the household structure, the decision to select the birth attendant has been found to rest predominantly with husbands and guardians (in 70 percent cases). For treatment of female diseases or gynecological problems other than pregnancy, a vast majority of women (65%) usually do not seek any medical care, with husbands bringing medicine in a reported 7.7% of cases (Haider et al., 2000).

In efforts to reduce gender and socio-economic disparities in the health of populations, the provision of medical services alone is clearly inadequate. While socio-economic development is assumed important in rectifying gender and socio-economic inequities in health care access, service use and ultimately, outcomes but studies showing empirical evidence of its impact is limited (Masud, 2000). In Masud's study he finds women suffering illness tend to report significantly less often than men. It is their nature to be less concerned about the seriousness of their illness.

The Government budget needs to be increased, as it is only 5.6% of the total budget (MOF, 2004). An important sector like health deserves more government funding. However there is two and a half times more money spent on the education and defense

budget as compared to the health budget. This could partly explain the higher increase in values of the indicators of literacy and educational data set.

Table 1: Health infrastructure and Personnel

	1994	2004
Medical College Hospital (Government)	8	13
Post Graduate Hospital	4	6
Specialized Hospital	12	25
Number of Government dispensaries	1362	1362
Number of beds in Hospitals & dispensaries	27544	40773
Number of Doctors	23805	36576
Doctor: Population (ratio)		1:4719
Number of Nurses	13000	19500
Nurse: Population (ratio)		1:8226
Number of Midwives	11000	17622
EmOC (emergency obstetric care)	1	64

Source: Ministry of Health and Family Welfare (2004)

The Government of Bangladesh updated report from the Ministry of Health in 2004 showing that within the last 10 years many improvements have taken place in the context of the health infrastructure of Bangladesh. These increases can very easily be assumed to be the reason for the declining MMR. The increase in number of hospital beds, and numbers of doctors and nurses implies more health personnel attending the patients, also increase in number of midwives and traditional birth attendants who

actually give direct care to the women at the time of birth are also contributing to the decrease.

The availability of EmOC, a joint collaboration project of Bangladesh Government and UNFPA in 1993 has helped strengthen the reproductive health sector by increasing skills and services of EmOC in all Maternal and Child Welfare Centers of Bangladesh. This is more so because the majority of complications leading to maternal deaths occur because of lack of medical skills and facilities at the time of child birth. However statistics show utilization, but very poor utilization at that of the EmOC. Therefore, it is probable that the other socio-economic factors influenced the decline of MMR from 600 to 380/100,000 live births.

Low literacy rate is an indicator of lower status of women; female literacy is lower in the rural areas of Bangladesh. Though poverty has been seen to be the cause of inability to send children to school, in one study the researchers felt that the culture of poverty was the major reason of illiteracy rather than poverty per se, (Khan, 1988).

As boys are perceived ultimately to take care of parents, sending them to school and investing in their education is preferred over investing in girls. Also girls are married of as a teenager, have a baby before the age of 19 years, and expose her to the possibility of becoming a statistic in the maternal mortality ratio.

Education has been inaccessible to rural women for centuries. A part of the reason lies in the fact that there was a clear lack of adequate and sensitive educational efforts to mobilize rural women, involve them in the educational process and help them reflect critically on their lives (Batliwala, 1993). Alternatively, on the other hand, the problem lies with the women themselves in the inability and lack of will to assert and demand education.

Maternal education is one of the most important determinants of the use of health care services and one of the strongest factors associated with the likely hood of receiving antenatal care and formal assistance at delivery in developing countries. Various studies have found that women with higher educational attainment are more likely to use formal pregnancy related care than the less educated. Increased autonomy enables women to take advantage of the services that health care institutions and providers have to offer (Hossain, 1996). Also by delaying the age of marriage, it increases the scope of additional number of years of schooling and improve the rural women's mortality ratio because most women who married early have become mothers by the age of 15 (MOHFW, 2000).

Women have lower mortality in rural Bangladesh if they get formal education (Hurt, Ronsmans, Saha, 2004). This is because she understands more about health and well being with education. She would also practices better family planning methods and protects herself from early pregnancy and risks of mortality. Simultaneously it also showed that, women in rural Bangladesh own very few assets and their movement are restricted outside the home. When they marry they move in with their husband's family and apart from the dowry they bring from their own family, they receive little financial support from their own family (Fauveau and Matlab, 1994) and in this setting her low primary level education is unlikely to increase her prospects of income or employment. Maternal education will however effect preventive health behaviors including use of preventive health services, or encourage greater cooperation with curative health services (Caldwell, 1994). While domestic hygiene and eating practices have been shown to improve with education, the use of formal health care remains restricted (Guldan, 1993). In rural settings however, where men often consult healthcare practitioners on behalf of their wives, the effect of education may have limited impact (Alam, 2000).

The socio-economic limitations affect the well being of an individual, family, community and society as a whole. Everything in today's world revolves around

economics. Women have the extra burden of caring for the whole family, specially a woman living in rural Bangladesh. However with the emergence of the micro credit programs poor women have found a way out of this dire state. NGO's with micro credit programs have not only economically emancipated these women but they have been able to improve their quality of life. However, within the spectrum of poverty alleviation programs, it enables the beneficiaries to acquire means of production and forces them out of the dependency that may be created with other programs such as food for work or food supplementation (Nanda, 1998).

Many NGOs in Bangladesh are involved in socio-economic development work. They are mainly involved in the areas of education, employment and empowerment of women. Their main focus is on helping the rural poor both men, women and children to improve their quality of life. Cottage industries have been setup to train and teach a trade to these rural people. There products are then marketed at home and abroad through their marketing chain. Many other similar smaller organizations have also developed, which are also providing services to the rural people.

In recent times, change in attitude is occurring due to increased hardship which is making many from the rural population leave their homes in search of jobs outside the villages. Insufficient mechanisms at all levels to promote the advancement of women is prevalent because women in the working arena was not very common even a couple of years ago, but in the last few years women are coming out to work because of need and an increase in the realization that they are capable of earning a living and contributing to the family economically (Afsar, 2001).

No country in the world seems to be immune to health inequalities, but the increasing concern is that the health gaps between different social groups are widening worldwide (Karim, 2004). His study claims that inequities of different levels were found among extreme poor, moderate poor and non poor but, the extreme poor women were

found to be least likely to use the health services. This was mainly due to lack of money and it was also noticed that those services which were easily accessible are being equitably used by the poor, and for this the NGOs are performing social mobilization and educating people to use these services.

These programs improve the status of women because of their ability to earn money, they have value and position in the family, they have some control over the resources earned for making small purchases of clothes (Nanda, 1998). They are also able to ask for medical care and this will affect the maternal mortality ratio. As women realize the value of ANC and go to more ANC check ups, also demanding skilled birth attendants at delivery, the mortality of women at child birth will decrease considerably (Nanda, 1998).

Also, women who are educated, older and associated with a micro credit program, have more capacity and ability to chose a form of contraceptive and/or make decisions in the family. This is also a resultant of her being financially solvent (Islam, 2000). Within the last decade the women participants in the micro credit programs have become not only economically independent but there is more freedom for them. They have more mobility and they are an active part of the paid labor force of the country. They have some degree of education and their decision making power has increased (Hossain, 2000). They are able to demand and afford better health care which will help reduce the maternal mortality. In addition, economic segregation due to non-accessibility to resources keeps her away from income earning opportunities, thus, strengthening her subordination to male authority which denies her access to health services.

4.1 Role of Micro-credit

Micro-credit is also linked to empowerment and health. A contrast of health and utilization of health facilities by a micro-credit users and non-credit group in Bangladesh

shows that, with economic independence and with its associated education more awareness to counter diseases. Thus, individuals become more confident to deal with some diseases by self care. Women irrespective of economic status show under reporting of diseases and negligence of their health (Ahmed, 2000).

The poor in Bangladesh have been addressed by NGOs where millions are covered by the NGO's reproductive health program (about 7% of the total population, 1992-1996). Many studies indicate that participation in the micro credit increases women's empowerment. Their participation increases mobility, their ability to make purchases and take major household decision, their ownership of productive assets, their legal and political awareness and participation in public campaign and protests (Hashemi, 1996). Hashemi's study shows that although the husbands take away the money earned by their spouse, the status of the women and their bargaining power improves in a manner that the family realizes she is an important income earner for them. There was some decrease of violence at home. It is true that the exposure to the credit program improves her empowerment status because of her interaction with the outside community increases and takes her out of her sheltered existence. The credit programs are able to reach large numbers of poor women and they are effective to an extent to empower women but these programs cannot be the means to change age old patriarchal traditions, effort at state levels may start the process of change by gender mainstreaming.

Within the spectrum of poverty alleviation programs, credit is outstanding in that it enables the beneficiaries to acquire means of production and forces them out of the dependency that may be created with other programs such as food for work or food supplementation (Nanda, 1998). Results point toward economic power being instrumental in making women's position better, especially in Bangladesh. Credit programs such as the one mentioned above provide both access to credit for the purchase of productive capital as well as non-credit services such as skill training, health services and education (Pitt and Khandker, 1997).

There is a positive impact of women's participation in credit programs on their demand for quality health care, which operates through their control over resources. It is also stated that those women who are making their own decisions will probably demand skilled attendants for delivery irrespective of whether they have control over resources or not (Nanda, 1992). It is the woman's behavior and enhanced capabilities that will allow her demand better care for herself. A passive woman may not be able to demand anything even with economic independence.

To understand women's position in the country it is imperative to take note of the steps being taken by the government also. In efforts to reduce gender and socioeconomic disparities in the health of populations, the provision of medical services alone is clearly inadequate (Ahmed, 2000). Education, health equity and social status, and empowerment are all interlinked and factors that are affecting women's lives. There is reinforcement in the conclusion that credit participation leads to women taking a greater role in household decision making, having greater access to financial and economic resources, having greater social networks, having greater bargaining power vis-à-vis their husbands, and having greater freedom of mobility, also increase spousal communication in general about planning and parenting concerns (Pitt, 2003). Participation in NGOs is bringing this positive change.

However, although the majority agrees of the positive impact of NGOs, there are arguments against NGOs that their interventions contributed only a very small percentage to alter gender relations in favor of female but in fact may contribute to reinforcing existing gender imbalances (Ahsanullah, 2003). Even after three decades of NGO involvement to help rural women, findings do suggest that despite the positive results of the social indicators, inequalities still prevail, more research has to be done to understand how else to approach the poor women's low status.

Several studies propose that statistical indicators by themselves do not reveal the actual status of women or measure the developments achieved. It suggests that a framework for analysis of women's status takes both statistical indicators and the ideological dimension of gender equality into consideration. Developmental achievements must be considered with gender mainstreaming to enable equality of opportunity for all members of society irrespective of gender. Therefore, this study is focused on the changes that are brought about in health of women through empowerment.

4.2 Gender Mainstreaming

While men and women are physically and physiologically different the differences between them are natural and unavoidable and should not translate into status and power inequalities. Nonetheless, social justice requires that men and women be treated differently (in terms of kinds of services provided for men and women) in order to achieve equality in the opportunity for an outcome such as health (Vlassoff, 2002).

The key to placing gender values firmly in place in 'Health for All' renewal is a change in philosophy at all levels of the health sector. This change requires firstly recognition that gender is not synonymous with women or sex; it is a concept that sees men and women within the context of their culturally defined roles, constraints and potentialities (Vlassof, 2002). A study by Karim showed health disparities among different poverty groups, the poorest, moderately poor and non poor in Bangladesh, lower levels of inequities were found between the poor and non-poor in the utilization of health facilities and services which were easily accessible and free of charge. The extreme poor were less likely to use health services than the moderately poor or non-poor, suggesting the need for a more appropriate program to address their pressing health need (Karim, 2005).

Gender inequality in access to health care is reflected in women's unwillingness to go to hospital to deliver because it will disrupt household organization (Okojie, 1994). The key factor for success of health reforms was the participation of civil society, which enabled a large number of women, particularly poor women, to engage with the design of reforms (Jahan, 2003). Addressing factors like increasing the age of marriage, increasing education, financial security and access to doctors will improve their lives.

Inequality in economic structures and policies, in all forms of productive activities and in access to resources influence the social status and health of the women. The micro credit programs are responsible for some of the developmental changes in developing countries. Work being done by these NGOs is focused on rural development through poverty alleviation of women. These organizations are incorporating new projects which are addressing improvement in women's access to health, education and employment opportunities. A study compares the attitudes and experiences of both men and women development workers in some micro-credit programs and shows that interestingly women development workers are often more critical than their male counterparts on the gender relations and engage with the women on subjects of domestic violence, reproductive health, child care asset holdings, etc. It shows women are more sympathetic to their own kind. So activities to help women would be best done by using women volunteers.

With an increase in awareness regarding women and their special needs, there is a global emphasis on gender and health, which is also reflected in GOB programs. Maternal health is specially addressed, due to the MDGs and ICPD in Cairo in 1994, the Beijing platform for Action or the Beijing +10 Conference held in 2005, there has been an overall awareness in raising concern amongst the governments including the Bangladesh Government to take necessary measures and steps to achieve goals in line with the policies set by these International Declarations. The Health Policy formulated by GOB, amply reflects concerns for women and children's health in the national interest.

4.3 Accessibility and Utilization of Health Facilities

The Bangladesh Demographic Health Survey (DHS, 1999-2000) collected information from women about their perceived problems in accessing health care. 80% of women felt that not having a health facility near their home was an obstacle in accessing health care. 54% women mentioned lack of confidence in the service. Other problems often mentioned included: 71.4% difficulty getting money for treatment; 44% inability to get family permission; 49.2% difficulty to get someone to accompany them; 63.2% not knowing where to go. We can say it would seem that the high cost and the long distances create a delay and barrier to accessing health facilities.

Less than 40% of the population has access to basic health care, and 67% of pregnant women do not receive antenatal care. The proportion of women seeking postnatal care from a “medically competent person” is very low both in rural and urban areas. On the whole, only 2% of women delivered at home sought postnatal care from medically component persons (MOWCA, 2002).

The bad reputation of health facilities and poor behavior of providers is another factor affecting low utilization of facilities. The Government themselves acknowledge the deficiencies in the health system. It suffers critically from a large number of problems, such as shortage of medical equipment, dearth of doctors/nurses/technicians, unhygienic physical environment, scarcity of power and water, pilferage of drugs and medicines and irregularities in the management system (MHFW, 2000).

In many cases distance is also a major deterrent for utilization of facilities even for getting midwives. In rural areas referrals for complicated health conditions to hospitals are also made by family members and by traditional birth attendants most of whom are uneducated and wait too long before they send the patients to hospitals (Goodburn *et al.*, 1995).

At times, decisions to choose the type of birthing care are taken by uneducated husbands and elderly relation who delay the referral. The most frequent reasons cited for not using a modern health facility were: lack of information and education about services, superstition, fear of losing family prestige, financial crisis, negligence of service providers, insufficiency of logistics in facilities (lack of adequate drugs or medicine), shortage of skilled doctors, and predominance of service by male doctors in the government hospitals (Haider *et al*., 2000).

Many believe that hospitals are for sick people and child birth is not a disease, therefore, mothers refuse to go to health centers. Bangladeshi women prefer traditional birth attendants but most have poor hygienic practices, making the mothers susceptible to infection (Claquin, *et al*., 1982). UNICEF found harmful practices of traditional birth attendants causing more harm than good. There has been a conscious decision not to rely too much on the services of trained traditional birth attendants or to invest further in training this category of provider (MHFW, 2001). In general it was observed that rapid care seeking (less than 6 hours) occurred more often when complications were seen as life threatening (NIPORT *et. al,* 2002). Overcoming the barriers that lead to delays to seek care in the first place is clearly a priority for improving Bangladeshi maternal health.

Moreover, inequalities and inadequacies in and unequal access to health care and related services also affect the woman and the development process of the country. An ailing woman cannot fulfill all her obligations to the family and society, the result is a burden to society. A WHO survey showed that among the outpatients coming to clinic, 32% were female, 20% were children and 48%were male (WHO survey). This is probably due to a lack of health awareness, access and ability to demand better health care among the women, compared to the men, and less availability of health services in the rural areas.

Although it is difficult for poor villagers to access health facilities during complications of birth, they actually manage to borrow money for transportation to hospitals (BRAC, 2001). Poor service delivery systems in the health care facilities also made women hesitant to go to hospitals as no one, including nurses, pays attention to the needs of patients (Juncker and Khanum, 1997). The extreme poor are less likely to use health services than the moderate or non-poor (Karim, 2005).

As money is so scarce for the poor to spend it on health is considered a waste. This is due to lack of education and ignorance about the value of good health. Micro credit members have better health seeking capacity and enhanced capacity to function effectively on their own behalf in health promotion and decision making (Ahmed, 2000). The women in the credit programs develop some confidence which enables them to seek health care.

4.4 Governments Role

Since independence Bangladesh government has been trying to improve and increase the number of facilities and personnel in the health system. In Bangladesh, 90 percent if births take place at home, only 5.33% take place at Government hospitals, and 2.93% take place at private clinics (Afsana, 2005).

State policy is geared towards modern obstetric care allocating the total budgetary resources by organizing different programs in health care hierarchies. Yet the resources used for obstetric care are not at all adequate for the women for whom it is intended. The under resourcing of hospitals occurs not just because of lack of resources, but, who has control over those resources (Navarro, 2000). Maldistribution of resources and corrupt practices give rise to poor quality services in Bangladeshi hospitals. Whereas defense budget is three times the health budget (Afsana, 2005).

It is essential for governments and development agencies to realize that increase in empowerment requires not only an economic dimension but also administrative and political dimensions. Democratic political institutions, effective and transparent institutions of governance and increased women's participation and gender mainstreaming in all sectors of government will promote empowerment and pro poor outcomes (Chowdhury, 2005).

No matter how poverty is experienced by people whether inherited or created, unless critical corrective institutional factors are addressed the status of the poor will not improve (Chowdhury, 2005). A change in attitude is necessary for different institutions and development agencies in the country to act at administrative and political levels to enable empowerment of women. The question of how to work towards it is a debatable issue. Development inputs, including micro credit, have not led to questioning gender hierarchies, but have broadened the space for women, enabling her to make choices, but she may not overstep the boundary, that is accommodation with existing intra household gender hierarchies with enhanced bargaining capacity (Chowhury, 2005).

Inequality between men and women in the sharing of power and decision-making at all levels has to be addressed at all levels, at home; in the work environment; at the government level; and at the policy making level. By enhancing the status of women, her decision making power will increase. A study by BRAC showed that the poor heath system was the result of inadequate implementation of the government policies and there was difference of views among advocacy groups (BRAC, 2001).

CHAPTER V

ANALYSIS

5.1 Cultural Barriers

For women in Bangladesh, cultural barriers still exist today. Over the last three decades however, there have been some improvements. Even so, had these barriers been removed and not held on so strongly, the country would not have remained in a state it is today. The benefits of progress for the society would have been far more rewarding. Culture very often is deeply rooted in a society. Therefore, it is extremely difficult to put aside ones culture and adopt another. Culture is a part of ones history and not easily forgotten. As is the case in Bangladesh, certain cultural aspects can also be harmful in a global modern progressive world.

Often, it is women who have to bear the burden of these cultural barriers. Firstly, from a health perspective, in rural areas there are still women/girls getting married at a very young age and is then expected to do all the housework, including looking after the children (Dey, 1998). This setting carries a heavy toll on the woman's life and wellbeing. Being married at such a young age and then having to bear children as well, she is unable to understand the consequences this has on her health. Also, most women when giving birth are not taken to the hospital resulting in maternal deaths and/or severe complications. Sometimes it is the mother-in-law who insists that the daughter-in-law give birth at home as she had done so in the past. Women also tend not to go to the hospitals as there will be male doctors which would not be appropriate.

Secondly, when it comes to schooling, the boys will be the ones to get an education because it is thought that girls would not have any use for it (Hamid, 1996). Plus, a girl would also not need it as once she is married she will be doing the housework

and looking after the children. However, school enrollment among women has increased and there is a lot of pressure for girls today to get an education. The state realizes the importance of two extra hands in the betterment of the country.

Thirdly, women continue to play a marginal role in the visible non-domestic economy relative to men. It is commonly believed that Bangladeshi women are trapped by cultural traditions that confine them to their homes and keep them more involved in household work, child care, care of the family, health care and agricultural work like food processing, rice pounding, home gardening (Jahan, 2001). Even with a job and income, the money that is brought home is taken away by the husband. Men are still not accustomed to the idea that women can be an income earner for the family. This concept however is slowly changing and thousands of women are now economically emancipated.

Fourthly, the Islamic Law, one that applies to Muslims. The only discrepancy with this law against women would be the inheritance law which claims women only get two-thirds or half the inheritance as opposed to her brothers. Therefore, this notion is conflicting with equal rights. But to state this as a cultural barrier that is affecting a woman's livelihood in the long run would be incorrect. This is because even though she is only entitled to a certain percentage according to the Islamic Law, she also has full support from her family if they wish to give it to her. The problem arises if/when her parents/siblings wash their hands off and let their daughter/sister fend for themselves. Her family always has the capability and choice to look after her. However, what is most often seen in Bangladesh is that these laws have been manipulated to become rigid rules, and if her family does not have enough money to adequately take care of her, thus marginalizing her from society.

It is thus, these cultural barriers that hamper women's development. The progress that women are making though is gradual; better than no progress at all. It is also perhaps

the best way to move forward from a backward cultural society only gradually, as it is really the only way. There is no harm in holding onto cultural practices that will not harm others, but the ones that do, it is only be natural that they be put behind in a continuing steady manner.

With the passage of time gender mainstreaming is gaining ground in Bangladesh and gradually changing the attitude of people. For example, attitudes of many doctors and nurses often constitute particular obstacles to women seeking informed decisions concerning their own health. Therefore, it is necessary that capacity building should be to inculcate in all health workers a respect for the dignity and human rights of all service users, including the right to full information about their health condition and possible treatments. This should be expressed and reflected in simple language as charters of rights practiced in developed countries.

Gender mainstreaming is reaching wide attention and recognition by the policy makers. Many proponents are disillusioned with the way it has moved so far and are beginning to feel that it has not achieved the objective. From a developmental perspective, certain critical element of mainstreaming has not yet been seriously addressed.

Implementation has focused solely on internal organizational dimensions, such as staffing, policies, developing indicators, and training, which is often interpreted as preconditions or precursors to interventions at the operational level. Government and development organizations are already attempting to implement gender mainstreaming with varying degrees of success. Most importantly, such attempts have shown useful lessons that must be used to move ahead to enable making gender main streaming to be more successful in the coming decade.

However, we must be optimistic that the vast body of experience and knowledge gained over the past three decades as to what works and what doesn't in development interventions across different sectors could be applied to make greater and more rapid progress on mainstreaming gender and bringing it to fruition.

The basic lesson from the above, however, is that it is necessary to go beyond instrumentalism. This does not just mean considering the empowerment of women in order to benefit their families and communities, but also paying attention to the benefits of enhancing women's agency for the well-being and self-esteem of women themselves. For instance, one of the impacts we need to consider is whether there is an increase in women's self-esteem and their perceived contribution to the basic necessities of life in terms of food, clothing, shelter, education and health in the household. In other words, there is need to first address questions of the empowerment of women and then well-being of their families and communities.

5.2 Government Policies

Gender and development have evolved dramatically over the last three decades with various planning frameworks stressing the needs of women within. The process of changes of gender planning started in 1975, with the Declaration of the UN Decade for Women gender and development coming to the fore front. Prior to that the declaration on Women's Issues were more focused on reproductive health concentrating on family planning, and associated health care. Subsequently in 1995 gender mainstreaming was adopted as a major strategy for promoting gender equality at the Fourth World Conference of Women in 1995, at Beijing. It called for mainstreaming in all 12 Critical Areas of Concern at the conference which included amongst others poverty, human rights, economy, violence against women and armed conflict. In addition, the Beijing Platform of Action established that gender analysis should be undertaken on the respective situation and contributions of both women and men before undertaking

development policies and programs. The inclusion of a goal on gender equality and the empowerment of women in the MDG re-established the commitment voiced in Beijing. Bangladesh too committed itself to the Beijing Platform for Action.

Over the last two decades, women's issues have moved rapidly up the policy agenda of national governments and international organizations. During the 1980s there was a major increase in policies designed to prevent women from being marginalized from the mainstream of economic, political and social life. Though these policies did lead to significant improvements in women's lives, their overall status in society remained very much the same. In recognition of this continuing discrimination the focus on women alone has shifted towards a broader concern with gender relations. In health care and in other areas of public policy, the emphasis is on identifying and removing the gender inequalities that prevent women, and sometimes men, from realizing their potential.

The promoters of WID school of thought came about after much frustration and disappointment with the welfare approach. It was expected that with this new approach of WID everyone would benefit and women no longer be marginalized if they were brought into the development process along with a concurrent change in policy from Welfare to Equality. It was an equity approach that recognized women's active role in the development process with a change in policy from welfare to equality (Baruah, 2000).

As the concept of gender mainstreaming entered the sphere of international public policy in 1995 with the inclusion in the Declaration and in the Platform for Action of the Fourth World Conference on Women in Beijing, it defined the concept broadly and dedicated the institutions of the United Nations to the systematic incorporation of a gender perspective into policy making. This subsequently became a subject of interest for researchers, organizations working in the human rights field, and of people and institutions involved in policies.

Gender mainstreaming involves not restricting efforts to promote equality to the implementation of specific measures to help women, but mobilizing all general policies and measures specifically for the purpose of achieving equality by actively and openly taking into account at the planning stage their possible effects on the respective situation of men and women (DFID, 2004). Policies and necessary measure need to be systematically examined taking into account possible effects when defining and implementing them.

Bangladesh after independence in 1971, inherited a poor economy and multitude of social, economic and political problems. As such solutions to the problems were through more noticeable approaches of addressing women by poverty alleviation and income generating projects. In many developing countries this is a common strategy for development. However, the negative side being that women are merely instrumental to accomplish grander goals of family welfare, poverty relief and economic growth (Moser, 1993), by enabling women to get work through developmental programs and being paid in cash or kind that is the welfare approach. Women were the earners but the husbands or fathers, brothers took away the money. The family image was that they were financially better off, with food, clothing, shelter and women were also involved in the economic sector. In reality women's status was not improving, her contribution to the family gave them a false sense of grandeur and importance.

5.2.1 Welfare Approach

Bangladesh with the problems of past legacy, damaged infrastructure and economy having more than its share of natural calamities be that cyclone, floods, tornados, draughts and the burden of poverty. The welfare approach initiated by the government and donor agencies were all comprehensive as they gave assistance in cash and kind, food, clothing and house building materials etc. Moreover, many development agencies after the Independence of Bangladesh, considered women as passive recipients of relief services, as opposed to recipients of tools, techniques and resources aimed at

enhancing their self-reliance in economic sector. Although, situation improved after introduction of the micro-finance programs, by the noble laureate Dr.Yunus, but women's access to formal economy remained very limited. Also, development agencies did not consider the social constraints and opportunities women encounter in Bangladeshi societies. In fact, agencies took an easier approach to meet the need of poor women, as opposed to promoting social and economic rights of women.

The welfare approach has different meanings in different countries. In Bangladesh it refers to multitude of services provided by the Government, NGOs and Donor bodies in mitigating sufferings of the poor and needy.

Although both men and women contribute to the economic need of the family, but men generally in Bangladesh have always been considered to be the bread earner and the women folk by and large are recipients of the Welfare for themselves and their family's sustenance. As men are considered the head of the household, all resources are channeled through them. This prevented the women in the household, who play the major role in household's development and protection, without access to those resources. Women thus have to remain dependent on their fathers, husbands, or brothers for accessing resources and supports that came through relief or welfare work.

In Bangladesh a number of programs since its independence were formulated with the sole purpose of helping the poor and needy specially the women, mostly in the form of food for work etc. These programs though well intentioned however marginalized women because it gives a stigma that women are incapable of earning at par with the men and they are also not in a position to do laborious jobs like men. So the work they do gives women less wages as compared to the same work done by men. In Bangladesh women constitute 50% of the population and they are managing the household, and raising children and assisting men folk in the agricultural sectors. If translated in economic terms, contribution of women could easily be shown to be much higher than

that of men. However, those remain unrecognized. This legacy of work has passed through generations and is accepted as the tradition and culture of Bangladesh. This form of work is not recognized as formal work. The women have thus been pushed to the sidelines as insignificant as far as breadwinners are concerned in comparison to the men. Men traditionally are the income earners in the eyes of family and women the vulnerable unproductive marginalized group both within and outside the home.

The World Food Program came up with the novel idea and started the, food- for-work program, which has helped thousands of women and also benefited the family in terms of feeding. On the other hand, the Feminists argue that this Welfare Approach is beneath the dignity of the women and she must be considered to be capable of being an equal partner with the men as far as earnings are concerned. Therefore, programs should be formulated with the intention to recognize equality for both the sexes and with equal wages provided for women. The government was not complacent of the real need of women. As they are vulnerable the government allowed these programs with safety nets in the form of free food and free health services. Unless women are held at par with men and given equal status in the economic and social arena, women would continue to remain weaker, inferior and subordinate to men. Men and women through generations are compared at different levels in different contexts of life.

Bangladesh with a large density of population and damaged infrastructure, the government had to formulate development plans keeping in mind the needy and vulnerable groups and specially the women. This brought about the concept of the welfare approach where the capacity or ability of men at the family level was considered to be that of the bread earner, while the women were the obvious recipients of the food brought to the household by the men. The women were also considered to be unproductive as their output was unrecognized and they were marginalized inside the family and outside in the society.

In addition, the feminist activists in Bangladesh were critical to this approach of the Government, on the ground that women were being marginalized, by accepting relief and assistance under welfare programs women are becoming weaker and dependant on welfare from the government, NGOs and donors. This made the women psychologically inferior and marginalized class in Bangladesh. After all, unless women are considered as equal and given equal opportunity and rights they would always be considered as inferior and subordinate and weaker to the male. These feminists promoted the cause of equality and equity for women and opposed the welfare approach. Their opinion of the welfare approach was, it against the dignity of women. They also promoted that women should be treated equally at par with the men as they contributed just as much as men if not more, the only difference being that women's work consisted of long hours without proper recognition and remuneration made women marginalized. Moreover, women were marginalized with the Food for Work Programs and government doles and handouts. It was not fair for the women to remain inferior as it was also the right of women not to be dependant and remain below men for their survival. Though the new approach of the WID has rightly claimed equal rights for women to be an equal partner in the family and society even though it is rhetorical to some extent, but in Bangladesh for educated women there is light at the end of the tunnel and in today's world they are starting to hold high positions and high offices in politics, and business. So far, many policy changes have taken place and it is an ongoing process of keeping with the concern of women's development objectives.

In the First Five Year Plan of the Government (1973-1978), there was no specific inclusion of women in the National Policy to improve her life economically or other wise. Moreover women's issues were not addressed in the health policy. The health policy was in fact welfare oriented concentrating on health for all, primary health care and family planning. In the Second Five Year Plan (1980-1985), women's development was recognized as a special category but no specific strategies were devised. In the Third Five Year Plan (1985-1990), there were hardly any changes in the policy neither for

health nor for women's empowerment or development. However, in the Fourth Five Year Plan (1990-1995) improvements were made to the existing policies on health and women's issues. Women were given due recognition in the policy and strategies of the Government. For empowerment of women, a Women in Development (WID) Policy was made (1990-1995) the following issues were targeted increasing women's participation in public decision making; raising productivity and income; improving health and nutrition; reducing population increase; reducing infant and maternal mortality; decreasing the male-female literacy gap; ensuring participation of the women in development. In the Fifth Five Year Plan (1998-2003) the Government launched the Health, Nutrition and Population Sector Program. The Bangladesh Population Policy aims to improve the status of family planning and maternal and child health, including reproductive services. In addition, the government has also stated its commitment to ensuring and supporting gender equity and empowering women. One of the main objectives of the policy is to actively support programs for elimination of gender disparity in education, health and nutrition.

5.2.2 Health

While gender affects the health of men and women, special emphasis on the health consequences of discrimination against women exist in nearly every culture. Powerful barriers including poverty, unequal power relationships between men and women, and lack of education prevent millions of women around the world from having access to health care and from attaining and maintaining the best possible health (WHO, 2002).

During the 1980s there was a major increase in policies designed to prevent women from being marginalized from the mainstream of economic, political and social life. Though these policies did lead to significant improvements in women's lives, their overall status in society remained very much the same. In recognition of this continuing discrimination the focus on women alone is now shifting towards a broader concern with

gender relations. In health care and in other areas of public policy, the emphasis is now on identifying and removing the gender inequalities that prevent women, and sometimes men, from realizing their potential.

Women and men are differentiated by social and biological characteristics. This means that gender issues are not just of concern to women. Men's health too is affected by gender divisions in both positive and negative ways. These differences in "femaleness" and "maleness" are reflected in the patterns of health and illness found among women and men around the world.

Women and children are the main targets as they are the most marginalized groups. Low self-esteem limits women's ability to make demands. Lack of education contributes to this lack of self worth while also denying women the opportunity to understand their own bodies or to make an accurate assessment of their need for health care (Afsana, 2005). Culture and traditions have always victimized women and children of being neglected as they are weak and incapable of standing up for themselves. In certain regions of the world, many households spend less on health care for women and girls (UNICEF, 1990). Discrimination in rights and legislation has also made women more vulnerable.

The Government in Bangladesh has made a significant expenditure and given priority to the health sector and many policy changes have been made. In the last ten years immunization has been a success story, family planning can also be said to have made a positive impact by increasing the contraceptive usage with a simultaneous decrease in fertility rate. Education has a direct social impact on health and gender equality. There has been a visible increase in the literacy rates, including the numbers of enrollment of female students, which has helped raise their awareness of health concerns and their capability of taking corrective measures. The gender gap in male-female student enrolment has decreased and has become almost the same. The education sector has

benefited more financially and results are encouraging. The government expenditure on education is 12% of the annual budget (GOB, 2004).

Nonetheless, many grave gender–related health problems still persist. Nearly half of the mothers do not receive antenatal care, and 90% of births take place at home in the rural areas. If any help is required during delivery it is through the traditional birth attendants. In 2004, only 13% of the pregnant women used skilled birth attendants (Bangladesh Demographic Health Statistics, 2004). The government expenditure on health is only 5% of the annual budget (GOB, 2004). The problem is recognized by the government and special projects have been made in the 2001 Health Policy to increase the ante natal utilization, increased use of skilled birth attendants during delivery and more utilization of emergency obstetric care services. This is part of the Poverty Reduction Strategy for the health sector taken by the government.

Another health problem faced is pregnancy due to early teenage marriage. This affects both mother and child's wellbeing. Both are under nourished in most cases due to poverty and low educational background. It increases the risk of infant mortality while at the same time depriving the young mother of the opportunity to continue her studies and prepare her for a better life by restricting her career choices and earning capabilities. So, to achieve gender equality of capability and opportunity the government has tried to increase the average age of marriage. Results have shown that the average age of marriage has increased and the success can be credited to the government initiatives that have been implemented.

Poor nutrition is another major concern especially for children and women in Bangladesh. Most mothers are anemic, giving birth to low birth weight babies whose survival is at stake. Approximately 9 million women are anemic (Helen Keller International Health and Nutritional Surveillance for Development, 2005). An additional 23 million pre-school children was also suffering from anemia, therefore nutritional

status has to be improved for all children. The high child mortality rate of boys in comparison to girls stresses the fact that nutritional improvement is essential; the number of male deaths was 62 per 1000 in 1994 and 38 per 1000 in 2000, and for females, 47 per 1000 in 1994 and 28 per 1000 in 2000 (World Bank, 2005). Linked with poor nutrition is child malnutrition which is causing stunting in 43% of children aged less than 5 years, 13% from wasting and 48 percent being under weight. The significant gender gaps in child mortality rates with female rate in the 1-4 year age group one third higher than males raises concern about possible gendered patterns of nutrition and health care at the household level. To address these issues, the government has started health and nutrition programs in 2003, and has initiated the National Food and Nutrition Policy.

The nature of female labor itself may affect women's health. Household work and child care can be exhausting and debilitating especially if they are done with inadequate resources and combined, as they are for many women, with pregnancy and subsistence agriculture. It can also damage mental health when they are given little recognition and carried out in isolation. The time consumed by caring for others leads to neglect by women of their own health.

For women, domestic life and labor also carry the threat of violence since the home is the arena in which they are most likely to be abused. The emphasis on their domestic roles also means that women suffer more severe consequences than men when a family member is a substance user or if they use substances themselves. Even in the context of paid work, "female" jobs often pose particular hazards that receive little attention. Gender-based violence is a risk factor for many women. Not only is it a violation of their human rights but it has wide ranging consequences for their physical and mental health and the health system. Women are victims of assault as a result of inequalities in society, and are most at risk of abuse from their partners and close relatives.

Also, social institutions are addressing gender mainstreaming by encouraging more women doctors and health personnel to work at the rural hospitals, and also ensuring longer maternity leave, providing day care facilities for working mothers. We can say that health is an outcome of social decisions-making, which is reflected in decreasing maternal mortality ratio and infant mortality.

5.2.3 Education

In the last decade, efforts to make the development 'mainstream' work for women have resulted in impressive gains as well as staggering failures (Rao, 2005). In the wake of Beijing +10, a number of documents have been reviewed and the strategic partnerships forged between the women's movement and policy reformers in the process of putting equity and women's rights at the heart of development debates (UNRISD, 2005). Women have made striking gains in getting elected to local and national governance bodies, and entering public institutions; girls' access to primary education has improved sharply; and women are entering the labor force in increasing numbers. Under the banner of gender mainstreaming in institutional practice, there are numerous examples of positive outcome (Rao, 2005).

Human resource development is at the core of Bangladesh's development efforts and access to quality education is critical to poverty reduction and economic development. To maintain a modern, scientific and effective education system, the Bangladesh Government attaches the highest priority to improvement of the education sector. With this end in view, after achieving independence in 1971, the Bangladesh Government formed the following Education Commissions, (1) Qudrat-e-Khuda Education Commission-1972; (2) Mofiz Uddin Education Commision-1988; (3) Shamsul Haque Education Committee-1997; (4) National Education Policy-2000.

The Government of Bangladesh started the Universal Primary Education (full enrollment of all children in the primary school age-group) in 1981, and introduced Compulsory Primary Education in 1993. The Government also fixed a target of Education for All by 2010 to eradicate illiteracy from the country.

Education is a prerequisite for realization of the goal of equality and development. Primary education is education of children aged 6-10 years in grades 1-5. The first step towards this is ensuring that both girls and boys are being sent to school. To ensure this the Government has taken certain steps to increase the enrollment of students at the primary level.

Stipends for female students of grades 6-10 are being given in the 460 sub-districts since 1993 to promote female education, empower women and ensure participation of women in development activities. Governments are also reaching out to school children through their families by giving the families a stipend of Taka 100 and Taka 125 for sending one and more than one child.

Tuition fees for female students have been exempted up to grade 12. In addition financial assistance for purchasing books and for examination fees are also being given. Teachers Training program to motivate, train and employ and increase female teachers by 30% are being addressed, as many parents in rural areas are inhibited to send their daughters to co-education schools. Opportunities are being created for involving the poor female students in education sector through these projects. Vocational training in the form of three polytechnic institutes for ensuring women's empowerment is being implemented.

Development effectiveness through gender mainstreaming signifies performance in bringing about change in increased productivity, improved social development and enhanced gender equality in rights, resources and political voice that generally

disadvantage women (Kelkar, 2005). The most noticeable improvement occurred in policies related to gender and efficiency of resource mobilization for poverty reduction (World Bank, 2004).

At an institutional level, gender mainstreaming is a strategy for promoting gender equality through ensuring that gender difference is taken into account in all aspects of an organization, including policy making, planning, implementation, service delivery, human resource management and resource allocation. At policy level, mainstreaming gender does not mean including women in a predetermined development agenda: it means revising that agenda to ensure that development interventions benefit women equally with men (DFID, 2005).

5.2.4 Income

Social and economic inequalities mean that in many countries women have difficulties in acquiring the basic necessities for a healthy life. Of course the degree of their deprivation will vary depending on the community in which they live but the "feminization" of poverty remains a constant theme. "Cultural devaluation" is also important though it is difficult to measure or even to define. Because they belong to a group that is seen by society to be less worthwhile, many women find it difficult to develop positive mental health. This process begins in childhood with girls in many cultures being less valued than boys and continues into later life where "caring work" is given lower status and less rewards. These gender inequalities are further reinforced by women's lack of power and the obstacles they face in trying to effect social change.

In Bangladesh there has been the development of the export-based readymade garments industry, which now absorbs about two million women as factory workers. In India, the movement out of family workers into income earners has been mainly into casual, home-based workers or "own account workers" in the above classification

(Horton, 1996).

Throughout South Asia, the informal workers have grown both in absolute and relative terms, to the formal sector workers (ILO, 2003). This growth can also be seen in terms of growing workforce. In Bangladesh between 1983-84 and 1995-96, the number of women among the informal workers increased from 44% to 75% (Mahmud, 2000). Economic impacts are visible when we look at the increase in numbers in the women labor force, showing increase in economic opportunities.

Table 2: Labor force by sex

	National		Urban		Rural	
	Women	Men	Women	Men	Women	Men
1990-91	4.9	31.0	0.9	6.6	4.0	24.4
1995-96	7.6	34.1	2.0	7.3	5.6	26.8
1999-2000	10.0	35.0	2.6	7.7	7.5	27.3

Source: Bangladesh Bureau of Statistics 1981-2000

Recognizing women's needs paid maternity leave was also increased from 3 to 4 months, day care facilities are also being included in the policies.

Over the last decade, there has been a slow, partial and even fitful change in women's education, their representation in governance and their status as independent income earners in their own right. But the question is there an advancement women's status, have women's capability improved, has there been an increase in their own well-being, and in their freedom of choice? Have they been able to come out of the patriarchal domination, or are traditional relations and culture and norms restricting them?

It cannot be said that changes have not occurred, but the question is to what extent. Because of mainstreaming many social changes are in motion for women and those which were prevalent are continuing. Gender mainstreaming affects the outlook of

people, society and country's in a slow but steady process, with effects in socio-political development of which some are good and some bad.

For example, women as wage workers in the garment industry in Bangladesh and also, the presence of women as own-account producers in the informal economy, it has to be accepted as a move in the positive direction. In both cases, whether as wage workers or own account producers, there is the role of women as income earners, one which is different from their former and traditional status as dependent family workers. There is the increase in dignity that goes along with being a wage earner, often even the major income provider in the family. This is different from women's work in family agriculture; women's contribution would have been subsumed in the general household labor and not even acknowledged as productive labor, given that men are generally the owners of land in south Asia. Women's earnings from wage labor in garment manufacture, although low, were still twice of what they could have earned in the informal economy or in rural areas (World Bank, 1995).

It was further found that 57% of women garment workers determined how their own wages are spent and also that their husbands contributed 1.3 to 3.7 hours of household work per day (World Bank, 1995). With both wage labor and own-account production, women have greater prestige in the family and also have a greater control over how their income is spent, which is what Amartya Sen's theory of household bargaining as cooperative conflict would predict. Women are able to direct more of the household income towards their own and their children's well-being (Nathan, Kelkar 2004).

Studies by Dreze and Sen in 2002 and Deolalikar in 2005 show a clear correlation between women's educational status and infant and child mortality. This probably works in two ways. On the one hand, women are able to use the knowledge they acquire from education (and mobility, we should add). On the other hand, women's education is likely

to increase their role in household decision-making. Both of these routes together lead to an improvement in infant and child nutrition status. Many empirical studies suggest that the gender disparities in health, schooling and nutritional outcomes of children tend to narrow with mother's schooling, as mothers (relative to fathers) tend to invest more in their female children (Deolalikar, 2005).

Thus, new deal for women in agriculture, along with necessary inputs and credit support could increase the efficiency of resource use and thus contribute to increasing production. This is borne out by an ongoing IFAD project in Bangladesh, the Aquaculture Development Project.

Studies on micro-credit in Bangladesh have shown that this does happen when women become income earners; they are able to use more of household income to improve their own wellbeing, thus reducing poverty within households. It further improves women's mobility, social visibility, dignity and self esteem (Kelkar, Nathan, Jahan, 2004). The basis of this strategy lies in the recognition of some crucial interrelations between reducing gender inequality and reducing poverty.

Since women experience greater poverty than men, it is necessary that women be enabled to improve their own well-being. There is substantial evidence to show that women's empowerment, or agency enhancement, can benefit not only women themselves but also children and men. Women's education, economic independence, increase in remunerative employment, political mobilization and so on, altogether have a substantial effect in reducing the number of births, and also reduce child mortality rates for both girls and boys. Women's active participation in community management and control over productive assets can increase the efficiency with which households and communities can use their human, natural and other resources. Environmental regeneration requires both the active participation of women as community managers, and their increased economic

participation in order to transform natural resource use patterns. Women's agency can have an impact on society as a whole through raising issues of social transformation.

Major advances in women's livelihood condition have been through the institution of microfinance and their participation in the local markets. Starting in Bangladesh, through the innovations of Grameen Bank and BRAC, microfinance institutions, as in the form of NGO-run credit groups have now become a standard feature of women's livelihood programs.

Rural women in significant numbers have bought or based agricultural land in their independent names in four districts in Bangladesh. The Aquaculture Development Project in Bangladesh is now trying to formulate measures to transfer effective control of household ponds to women. Women in these projects are more independent, and said "men no longer order us to do things and where to go and not to go. Now we have acquired a social visibility and self-respect as women" (Nathan and Kelkar 2004). Women are under represented as policy makers, decision-makers and educators in many developing countries as such there is inequality in access to training and education. This translates into reduced access to resources and a lack of attention to women's needs and priorities.

In Bangladesh gender mainstreaming is being addressed in different foras to suit the needs of the experts. The objectives for gender mainstreaming in Bangladesh are as follow: To enable women to achieve or make choices in line with their aspirations which can be fulfilled, for example to obtain a higher education; To improve the quality of interaction between men and women as equal partners with ability to show respect, dignity and value at every level, be that inside the home, in society and at the regional level by enjoying equal economic opportunity; At the macro level, in relation to, social, cultural, political, and economic fields, and also institutional levels by giving support to development of both men and women enabling changes through the legal framework, as

changes in norms and traditions (a very slow and tedious process), and through policy changes which will support development of men and women with especial emphasis on empowerment of women.

5.3 NGOs

Even though the issue of gender and health are intrinsically bound, when coalesced with health of the under privileged, the consequences are more far reaching. South Asia has had more women heads of government than any other region. Ironically for the country and the gender issue this happens to be an indicator of measuring the empowerment of women. Bangladesh is unique, in that women head both political parties. However, unique as it may be, simply following the broader South Asian pattern whereby female political leadership inherits its position from a dead male relative. So, although it may appear as if the situation for women is changing, that is not the case. The paradox for women in South Asia is that some women-those born into privileged circumstances with access to education and economic and family support do rise to high positions in public life, in politics, commerce, the executive, education, medicine, etc. But largely, representation of women in positions of decision-making in the social and economic scenario remains extremely low in proportion to their population (WB, 2005).

Where there has been notable success is at the local level of participation, NGOs, grassroots organizations, and women activists have played the greatest role. There has been a significant change in the political, social and economic awareness among women in Bangladesh (WB, 2005). This is attributed to the visionary leadership of the NGOs. In collaboration with the government, NGOs have been working in urban and rural Bangladesh to alleviate the miseries of the poor and deprived. There are over 20,000 NGOs registered in Bangladesh. Their work is concentrated in the rural areas to improve and increase level of education, both formal and non-formal, health, nutrition, safe drinking water, sanitation and hygiene, immunization, maternal and child health

knowledge, family planning concepts and most importantly micro-credit which gives them the financial autonomy which is essential for both health and empowerment.

The representation of women in all aspects of life is a question of democracy. The lack of adequate women's equality in health education and gender therefore raises serious doubt about the legitimacy and validity of the decision-making process in our countries.

The region's women leaders have had little if any positive impact on the women of their countries. Millions of South Asian women live in sub-human conditions and are so far from participating in public life they are almost beyond reach of any form of governance structure. Grameen Bank as an example, 2.4 million women have borrowed Taka 15 billion, repaid Taka 14 billion, and saved Taka 9 billion. Their children are attending primary school (2.5 million), secondary school (200,000), and university (1,500) (WB, 2005). The success of Grameen's programs has been proven to be due to the involvement of women rather than men.

5.3.1 Key activities and their Impact: An Assessment of NGO Performance

NGOs provide a strikingly homogenous set of services, with credit dominating. A World Bank survey of three hundred NGO branches in 2003 shows that while the total range of NGO interventions is wide, the typical NGO branch provides between three to four services. Around 90% of all NGO branch offices provide credit services, followed by health (56%), sanitation (52%) and education (45%). A parallel community survey conducted as part of the 2003 NGO survey shows that the service delivery priorities identified by communities match closely with what is provided by NGOs (WB, 2005). Advocacy and public awareness work are also common areas of NGO work: 93% reported awareness-raising activities, usually relating to sanitation, health and social issues, while 42% of NGO branches reported having lobbied local or national

Government over the previous year. Following are the assessment of three key services; micro-credit, health and education, as well as advocacy activities.

One of the main reasons for the growing presence of NGO programs is due to the expansion in micro-finance. Micro-credit now reaches as many as 37% of all Bangladeshi households and around 60% of poor households. The sector is dominated by the Grameen Bank, BRAC and Proshika, who between them lend to 76% of all borrowers (WB, 2005). Micro-credit generally succeeds in reaching the poor, though there are several geographical pockets of poverty where micro-credit coverage is relatively low.

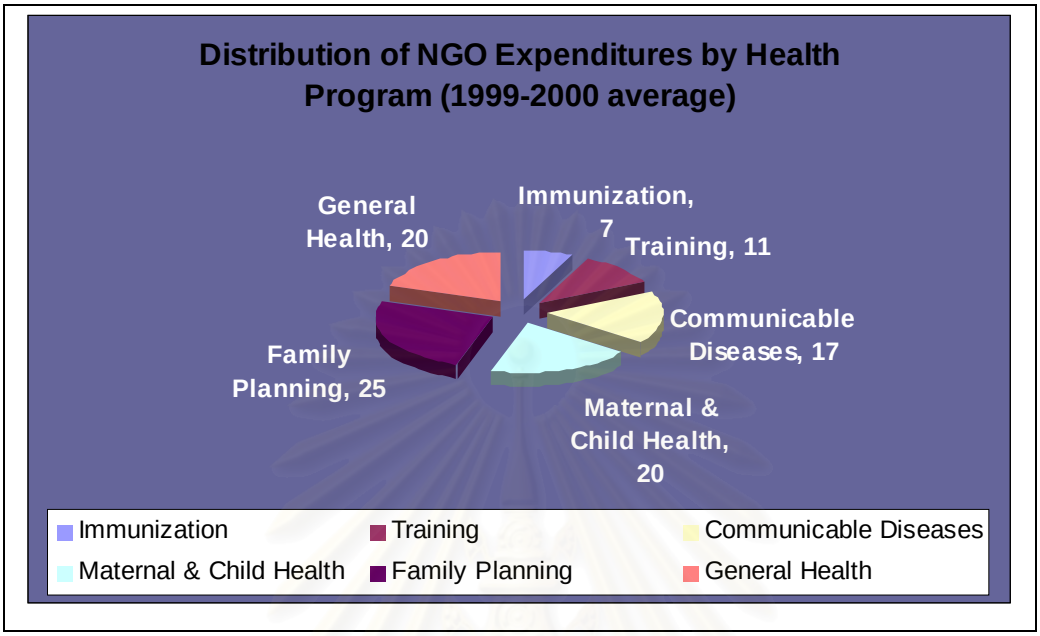
Improvements in key social indicators of wellbeing are also associated with micro-credit borrowing most notably measures of female empowerment, children's schooling and health status (WB, 2005). These social gains are also associated with the complementary social mobilization, training and awareness raising activities that typically go hand in hand with micro-credit.

NGOs use village based community health workers to provide door to door health services, mainly focusing on preventative care and simple curative care targeted at women and children. While a nationwide network of these NGO para-professionals succeed in extending health care to large numbers of poor households, NGO facility based care is relatively sparse. Hence, while expenditures by NGOs on health grew significantly since the mid-nineties they constitute about one-third of public sector expenditures and less than 10% of total health expenditures (that includes household spending on private care) (WB, 2005). NGOs also contribute to health outcomes by providing water and sanitation services, with notable successes in community-based programs involving behavioral change. Achievements in health include programs on child nutrition and tuberculosis treatment, in partnership with Government.

The impact of NGO interventions on a range of health and nutritional indicators is striking. Cure rates averaged 85% in the tuberculosis program, malnutrition rates dropped by around 20% among the poor due to the presence of NGOs in the community and neo-natal mortality among NGO clients has been found to be significantly lower when compared with a control group of households (WB, 2005).

Larger NGOs are becoming increasingly dominant in health. A survey of 149 NGOs involved in health and nutrition sector activities highlighted the growing dominance of the five largest NGOs in the sector, whose spending almost doubled between 1999 and 2002, reaching 73% of total NGO health sector spending. In contrast, spending by small NGOs declined in absolute terms, from Tk 819 million (16 per cent of NGO health spending) in 1999 to Tk 486 million (6 per cent of NGO health spending) in 2002 (WB, 2005).

The high burden on poor households of medical expenses in Bangladesh makes a strong case for NGO provision of health services. Illness within poor families is a major feature of impoverishment and downward mobility. While NGO facility-based curative health services are a small proportion of such services in total, the community based health delivery approach contributes to reducing inequities by improving access for poor rural women for whom distance to health facilities is a major determinant of their use. Spending by NGO health facilities is more progressive than in public or private facilities with the rural poor in general successfully exempted from fee payments.



Source: World Bank

NGO involvement in the health sector has to date been principally financed by donors, although growing recognition of the potential importance of NGO involvement in the sector has led to greater linkages with Government. While direct donor support to NGOs rose in absolute terms between 1999 and 2002, the share as a proportion of the total declined from 78% to 67%. This declining share reflects the sharp growth in resources channeled through Government to NGOs, which rose from 12% to 26% of total funding between 1999 and 2002. The policy context is strongly supportive of NGO involvement, in recognition of the scale of the need and the shortfall in present provision, as well as of NGO capacities to stimulate behavioral change and to target and supply credit to poor rural women. The two major policies on water and sanitation, the National Safe Water Supply and Sanitation Policy (1998) and the National Water Policy (1999) both encourage and support a role for NGOs. The target group approach and practices of beneficiary training and community-based group meetings have been vital for transmitting messages to rural populations about arsenic contamination, open defecation, the use of safe water, and hygiene. Another key intervention is the provision of micro-credit for sanitary latrines and shallow tubewells.

About 1.5 million children - around 8% of primary enrolment - are in NGO schools, most in non-formal primary schools for which the sector is best known. The NGO education sector is highly skewed with one large NGO, BRAC, receiving around three-fourths of donor resources with a similar share of primary enrolment. BRAC also franchises its model by subcontracting two hundred small NGOs to deliver non-formal education programs. Incidence analysis comparing different providers of primary schooling show that NGO education programs are effectively targeted to the poor, and to poor girls, in particular. NGO schools impact positively on school enrolment and achievement, particularly of girls, and record higher attendance and completion rates than formal schools.

5.3.2 Financing NGOs: Trends and Prospects

Exposure to NGO schools has a greater impact on female enrolment relative to Government schools. There is clear evidence that NGOs set up schools in villages where there are a higher proportion of children with no schooling – these are also villages where typically adults have lower average schooling. After controlling for a range of individual and household level characteristics and village level fixed effects, exposure to a NGO school in a village has a greater impact on girl enrollment than for boys, while there is no gender difference for government schools. This impact is greater for girls from poor households residing in rural areas.

Bangladesh is unusually well-endowed with a dense and sophisticated network of development-oriented NGOs. While other countries may have comparably-sized nonprofit or ‘third’ sectors, few, if any, combine the qualities of scale with secular, innovative development orientation and focus on the poor as is found in Bangladesh. Institutional and definitional variety makes direct data-based comparison with other developing countries difficult. However, by 2000, more than 90% of rural communities

had some NGO presence[8]. Around 13 million mainly poor women are now reached through micro-finance programs, some 8% of primary enrolment is provided by NGO schools, and there are nationwide health and sanitation programs that involve NGOs. Around 1882 NGOs were registered with NGOAB in 2004 as potential recipients of foreign funds, and we estimate there are around 2000 development NGOs currently operating in Bangladesh.

5.3.3 Cross-cutting Themes

The main key services provided by NGOs are micro-finance, health and education and NGO advocacy activities. Empirical evidence show that these services are by and large successfully targeted to poor households, though there is some room for improvement particularly in terms of geographical concentration of NGO activity. The impact of these services is also clearly positive. However while the impact on their clients has been largely positive, the wider "macro" impact has been limited by the fact that the services are still relatively "micro" in certain aspects. For instance while micro-credit has a 'macro' reach, which has resulted in important benefits for borrowers, the 'micro' loan size has limited the extent of employment that it has generated. Similarly, while non-formal primary education programs have contributed to reducing gender disparities in access to schooling and students have better educational outcomes, the impact on national educational quality is limited by the fact that only eight percent of primary school students are in NGO schools.

The Gonoshasthaya Kendra NGO experience shows that in areas where NGO health interventions are intensive there has been clear improvements in outcomes. Nevertheless quantifying the NGOs contribution in improvements in national health indicators is difficult, particularly as a significant part of NGO work is in awareness-raising of various kinds such as simple cures (e.g. diarrhea), sanitary practices, family planning and facilitating linkages with the public sector (e.g. tuberculosis program) all of

which are hard to measure. Moreover, tackling the emerging priorities in the health sector, such as curbing neo-natal mortality, will require more facility based care an area where NGOs are still relatively 'micro'. Hence a key issue is the mechanisms by which NGOs can scale up further, or shift directions, to enhance their impact. One issue that is central to the discussion in this chapter is the issue of joint and separate provision of NGO programs.

There are NGOs that focus on one core activity, e.g. Transparency International focuses entirely on advocacy on anti-corruption. Most NGOs though are multi-purpose. Our overall support for joint provision of social services by NGOs, such as health and education, stems from the economies of scale in senior management oversight when both functions are provided by one NGO. The important part is to keep accounts for different programs separate and all forms of cross-subsidies transparent. In the case of micro-finance, there may be greater opportunities in the future for a few large NGOs to spin-off their micro-credit operations into a specialized financial entity such as micro-credit banks (WB, 2005). However, for the majority of NGOs, joint provision of the various services is the most practical arrangement given the synergies between programs.

5.4 Gender Development Indicators

It is expected that the data from these indicators will show the changes that has occurred in the life of the women in Bangladesh indicated by life expectancy, age of first marriage, number of births, total fertility rate, the level of education, economic activity in terms of labor force, mortality rates.

All these data give an overview of the social development changes taking place in the country and shows what improvements are taking place and also what is lacking and in which specific sectors.

Time is the most important factor to look at social changes in attitude, behavior, and government commitment. In this study analysis was done over a period of 8 years, with data collected at gaps of 3 to 5 years, because by using this time trend series it give a picture of what changes are taking place in areas of socio-demographic indicators, education sector and health sector, at intervals of 3 and 5 years.

5.4.1 Table: Socio-demographic

Socio-demographic Indicators	1995	2000	2003
Gender Development Index	-	0.468[a]	0.514[a]
Life expectancy at birth (years, female/male)	57.0/56.8[a]	59.5/59.4[a]	63.7/62.1[a]
Sex ratio (female/male)	0.961[a]	0.961[a]	0.961[a]
Average female age at first marriage	15[c]	16[c]	16[c]
Adolescent marriage (% of female in age group 15-19 ever married)	50.2[c]	48.1[c]	48.7[c]
Number of births to 1,000 women (age 15-19)	147[c]	144[c]	135[c]
Total fertility rate (births per woman)	3.3[a]	3.2[a]	3.0[a]

Source: Human Development Report and World Development Indicators

[a] Human Development Reports.
[b] World Development Indicators.
[c] Bangladesh Health Statistics.
[d] United Nations Development Program. Department of Economic Affairs and Statistics.
[f] Bangladesh Bureau of Statistics. (2002).

The GDI is a good indicator of a countries status in terms of gender. In table 5.4.1 it is evident that from 1995 to 2003 the GDI has increased, implying the gender disparity is slowly growing narrower.

Life expectancy is the average number of years a person is expected to live or survive in a particular country. The life expectancy of people in a country indicates the socio-economic level of the country. The higher the life expectancy the more developed the country, for example life expectancy is highest in Japan, over 80 years for both male and female, indicating that they enjoy good health and longevity is higher because they have improved economy, good nutrition, healthier environment and good health facilities and experienced medical practitioners.

In Table 5.4.1, the socio-demographic indicators show that there has been an increase in life expectancy. Female life expectancy has risen from 67 in 1995 to 63.7 in 2003. The male life expectancy at birth has risen by 56.8 in 1995 to 62.1 in 2003. There may be a number of factors that are causing the female growth rate to exceed the male growth rate. Possible reasons are (1) the government has taken various measures since independence to increase the health infrastructure and to improve the health of the nation. But the health of women have also benefited by the increased availability of health facilities and increased number of doctors and nurses which were not accessible before. The numbers of maternal mortalities are decreasing because of utilization of the health facilities (health infrastructure is shown in a table earlier); (2) More women have better access to education. As a result, they are more educated they are more aware of the health risks, how to live better, practice good hygiene, knowledge of nutrition have all helped to increase the life expectancy; (3) NGOs are also working at the grass roots level to improve women's life, for example, more than 20,000 NGOs are working in Bangladesh, amongst many issues, there main focus of work is in areas of health and family planning, empowerment through micro finance e.g. BRAC, Grameen, education, environment,

water and sanitation; e.g. CARE, Aquaculture and Fisheries; e.g. DIFID, etc. All of these programs have gender as part of there approach.

The sex ratio in table 5.4.1 shows if there is any discrimination against the sexes. Sex ratio of female to male has been constant through 1995 to 2003. One possible reason for this may be the number of female births and deaths occurring in a year are similar. But life expectancy is increasing for women at a much faster rate as opposed to men.

Age at first marriage is an important health indicator; this reflects traditions of the country and its effect on the health of women is seen. Earlier marriage indicates earlier first born; that is a very young mother who is physically not ready to bear the burden of motherhood and bound to have an ill effect on her health. In addition if the mother is young, education level is probably low, so she will have poor knowledge of nutrition, hygiene, sanitation so the child is at risk. Her health is in jeopardy because she has poor knowledge family planning and she may have to deal with multiple pregnancies from an early age.

The data in table 5.4.1 shows there has been a slight increase of the average female age at first marriage from 15 years to 16 years. This could be due to, (1) the government legislation was passed on setting the minimum legal age of marriage to be 19 years (GOB, 1991). It is possible that the legislation has not been able to reach the community in the rural areas where cultural barriers still exist. Therefore, the data only shows a slight increase in the age of marriage; (2) due to the increase in education, the women become more aware of the advantages of late marriage. First the girl when she is studying the is a delay in her getting married, because the government is giving money to families for sending the girls to school, therefore there is no urgency of the family to get the daughter married off. She is also receiving more information about food, nutrition, hygiene, sanitation which improves her chances of living in a healthier environment. These educational programs are being offered by the schools and NGOs; (3) an increase

in the female work force the studies mentioned previously have shown there is a tendency to marry later with more jobs and thus more economic empowerment. The numbers of women are increasing in e.g. the garment industry, where wages are better than those offered as domestic helpers, also there is personal independence, so the women garments workers are marrying late. Therefore with more money earned from their jobs they are eating better, and they have money to get better medical treatment if necessary, which effects their health. In addition the guardians are also interested that she brings the income back to their home and are therefore not rushing their marriage so much.

As mentioned above the adolescent mother has a high mortality risk for both mother and child. Adolescent marriage in table 5.4.1 has decreased from 50.2 in 1995 to 48.7 in 2003. This implies that the number of females between the ages of 15-19 who are getting married has gone down. This can be explained by the fact that, (1) primarily it reflects the success of the awareness building programs of both the NGOs as well as the Governments efforts through community awareness projects. The Government‘s special School Health Program is focusing on the adolescent girl’s health campaign. The Information, Education, and Communication Service has been developed which aims at making the adolescents aware of reproductive health care; (2) education level has increased among the female population; therefore they are probably getting some increased understanding of the problems associated with adolescent marriage. The Government has initiated the development and introduction of suitable curriculum/text book for grade 5 to12 students. Counseling arrangements are being made for these adolescents. All these are contributing to the decrease in number of adolescent marriages; (3) women are pursuing more jobs or migrating to urban areas for better job opportunities and therefore marrying at a later age.

Number of births to 1,000 women (age 15-19) reflects the health of mother and child, and effect on women’s empowerment. The numbers of births in table 5.4.1 have gone down from 147 in 1995 to 135 in 2003. The reasons for could be, (1) the government has been emphasizing on family planning from the birth of the nation; and

this policy has continued for the different governments and their health policies as seen from the First Five Year Plan till the Fifth Five Year Plan continuing now in 2006. Encouraging increase in contraceptive use and more emphasis on family planning programs by the government has increased the awareness of women of the benefits of reducing family size and the benefit to maternal health because of longer birth spacing. All these have contributed to the decrease in number of births; (2) increase in education levels which have increased the knowledge of the women about the benefits of less number of children. Therefore, the numbers of births are decreasing automatically there is a simultaneous decrease in maternal deaths.

Total fertility rate (births per woman) in table 5.4.1 is the most important indicator for population growth. Total fertility rate has gone down, which is a result of, (1) the success of family planning programs, with increase in use of contraceptives is responsible for the decrease in fertility rate. The proof that the government is satisfied with family planning programs is the undertaking of several initiatives to address the population's health needs, particularly of the rural people. The government has approved the Health, Nutrition, and Population Sector Program (HNPSP) for 2003-2006, and it is hoped this will continue to sustain the fertility decline; (2) education also, is responsible for them to be able to take decisions about their personal family life and decrease the number of children they have; (3) due to the increase in the number of women participating in the labor force. As more women work outside the home studies show that their marriage is delayed and with it the number of children also decreases; (4) women have moved to the city to earn a living then the husbands are away and the family pressure to have children is also reduced.

5.4.2 Table: Educational Attainment

Educational Attainment	1995	2000	2003
Youth literacy rates (% ages 15-24, female/male)	33/51[a]	39.8/61.23[a]	41.1/57.89[a]

Adult literacy rates (% ages 15+ and over, female/male)	26.1/49.3[a]	29.9/52.3[a]	31.4/50.3[a]
Net secondary school enrolment (% female)	15.6[d]	44[a]	47[a]
Tertiary enrolment rates, gross enrolment ratio (% female)	-	3[a]	4[a]

Source: Human Development Report and World Development Indicators

The female youth literacy rate in table 5.4.2 has grown from 33 in 1995 to 41.1 in 2003 whereas the male youth literacy rate has only risen from 51 in 1995 to 57.89 in 2003. Some of the reasons for this are, (1) commitment by the government to address female education as per MDG goals, by adding in its policy incentives to increase the literacy rate of the country; (2) the GOB has taken steps in enhancing the literacy level and making education free for all children with special focus on girl child. This is evident by the increase in literacy levels from 1995 to 2003.

Adult literacy rates for females in table 5.4.2 has increased from 26.1 in 1995 to 31.4 in 2003, where as for males it has increased from 49.3 in 1995 to 50.3 in 2003. The female rate has gone up faster than the male rate which may be attributed to, (1) government initiatives to increase literacy level by providing stipends from 1993 have encouraged more students to remain in school and these young students have become the adults of today. Showing increase in statistics for adult literacy especially for girls, as the governments projects were targeted at girls. In 1995, the Government initiated the program entitled 'Program to Motivate, Train and Employ Female Teachers in Rural Secondary Schools', this has also had an impact because in rural areas parents prefer to send their daughters to girls schools, so more girls went to school; (2) the government development project established 3 Women's Polytechnic Institutes, at three Divisional Headquarters for Women's adult education and consequent empowerment.

Female net secondary enrolment ratio in table 5.4.2 has increased from 15.6 in 1995 to 47 in 2003, because, (1) major effort has been put by the Government from 1993 by giving incentives to the family to send the girls to school by giving scholarships, stipends, money for books and uniforms if the girls continue studying; (2) food for education program was implemented. The food for education program is a government initiative for the family's encouragement for female enrolment in school. This could be a reason why cultural barriers, such as girls do not need education, are seemingly decreasing; (3) the stipend program was undertaken in lieu of food for education; around 6 million students from all over the country are now receiving Tk.100 and Tk.125 per month for sending one and more than one child respectively; (4) education sector receives the highest allocation from the National budget of the Government.

Female enrollment in tertiary in table 5.4.2 has increased because, (1) government policies which are encouraging them to go on studying to tertiary levels; (2) because of increased access to secondary school levels, it is giving them opportunity to go to the next level of higher studies.

5.4.3 Table: Economic Participation

Economic Participation	1995	2000	2003
Adult labor force participation rate (female/male)	29.1/47.9[b]	28.2/46.9[b]	28.3/46.6[b]
Female share of paid labor force	-	19.2[b]	38[a]
Unemployment rate (% female/male)	2/3[b]	3/3[b]	5/4[b]
Estimated earned income (PPP US $)	-	1151/2026[a]	1,245/2289[a]
Female professional and technical workers (as	34.7[a]	34.7[a]	25[a]

% of total)			

Source: Human Development Report and World Development Indicators

Adult labor force in table 5.4.3 includes those within the age group of 15-64 years, who have a job, or are looking for a job, or are not looking for a job. This shows there has been a slight decrease in the adult labor force participation rate. This may be due to, (1) there has been an increase in the youth population so a corresponding decrease in adult labor force rate is seen; (2) the level of education, increased needs, increased industrialization is creating a need for more people but the numbers in that age group are less, as the elderly geriatric group is also increasing. This is seen in the 2003 population pyramid; (3) as the numbers of enrollment levels are going up in secondary schools, result is a decrease in the number of women not joining the labor force.

Paid labor force in table 5.4.3 is defined as those people within the age group of 15-64 years, who have a job, or are looking for a job. There has been a major increase in number of women in the paid labor force. The government is the biggest employer in the country. The GOB is policy pledged to ensure equal opportunity for recruitment of men and women. The increase may be due to, (1) women are being recruited for active service in armed forces. Women are being given more opportunity because of a recruitment quota of 10% in the first class officer's rank and 15% in other classes of jobs in the government is being enforced in the public sector employment; (2) the MOWCA, for the convenience of working women, have implemented and are continuing to implement projects for building hostels for women in urban centers; (3) recognizing women's practical gender needs, the government has recently increased paid maternity leave to four months from its previous provision of three months. Simultaneously, day care facilities have been created in office premises, and the MOWCA is implementing a program to further improve working conditions for women. All these factors are probably creating the changes in labor force participation, as more women are getting the

opportunity and advantages in service; (4) since 1995-2003, export oriented industries have encouraged employment of women in garment industries, tea and frozen fish industries to name a few. An estimated 1.8 million women work in the garment industry alone (MOWCA, 2005); (5) previously the method of recording statistics was rather poor. In recent times it has improved to some extent, and there has been inclusion of the number of women working in the agricultural sector. Therefore an increase is seen in the number of women in the paid labor force.

The unemployment rate in table 5.4.3 is defined as the percentage of the total labor force. The rise in female unemployment rates from 2 in 1995 to 5 in 2003 may be a result of, (1) the improvement in development sector of the country has resulted in more industrialization and consequent empowerment of women. More women are available for work, their education level is improving. However the unemployment level is seen to be rising because the number of previously uninterested women is now interested to work and they are becoming part of the work force. But there are not enough jobs available. There is a gap between supply and demand of jobs. Hence the result is a large number of unemployed women; (2) there is a rise in literacy rates. Women who become literate are not joining the labor force where as earlier, when literacy rates were lower there were more women in the female labor force (Hamid, 1996).

There is an increase in the estimated earned income in table 5.4.3 over the past 8 years, which we could assume to be the result of, (1) increase in literacy rates in women, with increased demand in the family for two incomes, also empowerment of women is all responsible for the increase in estimated earned income; (2) women's opportunities and capabilities are both increasing because of actions taken by the Government in policies and programs.

In table 4.4.3 there has been a reduction in female professional and technical workers from 34.7 in 1995 to 25 in 2003. This decrease in female professional and

technical workers may be attributed to, (1) there are increasing numbers of females entering other profession such as working for NGOs, starting their own business, moving into the private sector; (2) this could be because the financial benefits are more in those sectors; (3) self employed women may have more status, although whether are benefiting in the long run is debatable.

5.4.4 Table: Health Condition

Health Condition	1995	2000	2003
Maternal mortality ratio (per 100,000 live births)	6[a]	3.8[a]	3.8[a]
Child mortality rate (% age 0-5, female)	116[c]	94[c]	88[c]
Contraceptive prevalence (% married women)	54[a]	54[a]	58[a]
People HIV infected (% female among adults)	-	23.8[a]	<0.2[a]

Source: Human Development Report and World Development Indicators

In table 5.4.4 the MMR has decreased. The causes are due to, (1) Bangladesh Government has taken especial steps to reduce maternal mortality by developing the health infrastructure, increasing health facilities and personnel and through new health policies e.g. like the Health, Nutrition and Population Sector Program (HNPSP) in 1997, which aims to reduce MMR from 3 to 2.75 by 2015. Included in the HNPSP is the Essential Services Package which includes basic and comprehensive services like, ante natal care, pre natal and post natal care, reduction of unsafe abortion, safe delivery, increase in use of contraception services and increase in use of EmOC; (2) increase in education and economic empowerment is enabling women to have more decision making power and increasing her ability to demand quality health care. All these programs are

under the National Strategy for Economic Growth, Poverty reduction and Social Development which hopes to achieve most of these goals by 2015.

In table 5.4.4 there is a decrease in child mortality, which is due to, (1) government policies to address immunization. The immunization program in Bangladesh has been called a success story. It is a program which has been made possible by joint collaboration efforts with the government and donor agencies; (2) increasing awareness and knowledge on nutrition, hygiene and sanitation which are programs being offered to the rural people by different NGOs have enabled women to look after their babies better and therefore decreasing the child mortality; (3) the Government policy to increase girl's education is helping, because many are young mothers in rural areas and when they are more educated the rate of child mortality decreases; (4) the general decrease in total fertility rate due to god family planning initiatives, are all contributing to the decrease in child mortality.

Contraceptive prevalence in table 5.4.4 is a very good indicator to show the success of family planning programs in a country helps to reduce population growth and be responsible for the decrease in infant and maternal mortality. Since independence the national health policy has focused on family planning as one of its major components. The government has been making special efforts since independence to promote contraceptive use and continuing to do so even now. The reason is, (1) Bangladesh's population is a major concern and also one of the main deterrents for the country's development, therefore the government has gone all out to reduce the population by increasing the use of contraceptives especially in the rural areas where the majority of the population live. Family planning programs and different ways to make contraception easily available to the people are being enforced by the government; (2) NGOs are also involved with projects to increase usage of contraceptive by increasing knowledge of the rural people about the benefits of contraceptive use. Information, education and communication materials are being distributed to the adolescents and the rural poor.

The number of females infected with HIV is increasing globally. In Bangladesh, it is fortunate the numbers of HIV infected people are still very low compared to neighboring countries like India and Myanmar. The female HIV infected population is mostly the commercial sex workers. HIV infection is transmitted by men who are bringing the infection from neighboring countries who have got the infection in large numbers. They are e.g. truckers or migrants returning home. The infection is passed on to the commercial sex workers and they then spread the infection to other men because of unprotected sex. These men then transmit the infection to their innocent wives. In table 5.4.4 there has been a decrease, as (1) the GOB has taken steps to keep HIV under control by spreading the knowledge of HIV/AIDS through media, TV, radio; (2) Bangladesh being a Muslim majority country, with traditional culture of purdah for women has limitation in spread of the disease because women's movements are restricted, and promiscuity in the society is also looked down upon. These are responsible for the low prevalence of HIV/AIDS in Bangladesh.

From the tables it is noted that there have been some changes in Bangladesh regarding the development of women and children and their status. The government is trying hard to integrate the womenfolk of the country into the mainstream of the development process, which is one of the main strategies for overall socio-economic development. Poverty, malnutrition, hunger, illiteracy are largely centered on women, and as such women can act as uniquely suitable agents for elimination of these socio-economic maladies. Attainment of reasonable growth rate, alleviation of poverty through generation of productive employment opportunities and increased self-reliance are inextricably linked with increased participation of women in development efforts. The main goal of the National Policy for Women's Advancement is to ensure equality of men and women in all sphere's of life, improve the lot of the neglected women in the country, ensure their security and empowerment, groom them up as educate and skilled workforce, eliminate discriminations and repression on women and girl-child, establish human rights

of women, alleviate their poverty and ensure their participation in the socio-economic development process. Strategies have been devised to realize these goals.

The National budget shows the highest allocations for education in recent years, which emphasizes the Governments prioritization to human resource development through education. The goal of 'Education for All' is being vigorously pursued. Compulsory primary education, free education for girls up to grade ten, stipends for female students, food for education, total literacy movement and Nation wide integrated non formal education are some of the major programs being implemented by the Government in the education sector.

Bangladesh has undergone a major shift in its economic philosophy and management in recent years. Since the mid seventies, the country undertook a major restructuring towards establishing a market economy with emphasis on private sector led economic growth. The government at present has attached top priority to rapid economic growth alongside reduction poverty in the country through employment generation, human resource development and revitalization of the rural economy. The government is aware that sustainability of poverty alleviation efforts employment generation for the poor alongside targeted programs for raising their income and savings.

The overall health sector in Bangladesh considerable progress has been achieved n the fields of Health and Family Welfare. The immunization program, which has been acclaimed world wide, now covers 80% of children compared to 55% in 1990-1991. Primary Health care facilities have been expanded throughout the country. Infant and maternal mortality rates have come down dramatically. Contraceptive prevalence rate has increased, as a result of which population growth rate has decreased. The health policy of the Government aims to expand healthcare programs and improve service quality.

From the above analysis it is apparent that Bangladesh has been successful in bringing women to the forefront through the micro-finance programs, increased access to education and positive government policies. Changes are slow and steady and many deterrents are present, but they need to be acknowledged and addressed. Also, women's literacy is going up, their numbers in the work force show more economically independent women. Women are present in mid level jobs of the Government indicating increase in education level, women are also seen in politics, and Women Ministers in the Government are present.

CHAPTER VI

CONCLUSION

In Bangladesh women continue to play a marginal role in the visible non-domestic economy relative to men. It is commonly believed that Bangladeshi women are trapped by cultural traditions that confine them to their homes and keep them more involved in household work, child care, care of the family, health care and agricultural work like food processing, rice pounding, home gardening. For women, more than men, allocation of labor between home and market production is also shaped in response to existing local opportunities for female employment, including the demand for female wage labor which is usually more limited than the demand for male wage labor. Therefore it can be said that women place in the labor force is dependent also on the existing supply and demand forces.

The tables have shown that improvement in the education sector has occurred, and studies have also proven that the empowerment of women increases with education. The female literacy rate has increased from 38.1% in 1995 to 56.9% as stated by the Government of Bangladesh in 2002. There is also a direct relation between education and social justice meaning that women who are literate have a strong voice and are able to speak up more and they are listened to. It has also been noticed that legal actions are being taken regarding violence against women with growing awareness in the society and the media is also informing of any injustices upon women.

Also from the tables, almost all the data show a positive trend in women's development. However, if these were to be plotted on a graph, the results would not be as sufficient because the improvements made are very small. Nevertheless, after calculations, there are about a million women out of the whole population who are actually benefiting from the little progress that is made. Some can argue that relying

solely on these numbers do no say much at all, but even that first step forward is better than no step at all.

There has been a big transformation in government sectors. The government has initiated gender sensitive training programs in the government training curricula in Administration, Finance, Judiciary, Police and Health, Public Administration Training Center, Civil Service Training Academy, Academy for Planning and Development, Local Government Institute and Government Training Institutions that run training programs for different categories of personnel.

Moreover, Bangladesh Government has enacted Dowry Prohibition Act, Marriage and Divorce act, Women and Children Act which protects against Trafficking etc. There has been an increase in the number of women lawyers and even NGOs are actively disseminating legal information for assistance to women as a whole. There has also been visible budgetary increase in various departments of Women and Children's Affairs. There has been special allocation of funds for education for girls and for improved health for women and children. These are some success stories of gender mainstreaming by the government. What ever policies the governments formulates unless there is adequate financial allocation there cannot be any successful implementation of the program or any evidence of impact of the programs.

With the introduction of compulsory and free education of girls up to grade 12 this has a direct bearing on overcoming early marriage, improving the mother and her infant's health proven by the decrease in maternal and infant mortality. Studies have shown infant's survival is improved if the mother is educated with better knowledge of food and nutrition, hygiene and sanitation (World Bank, 2005).

In Bangladesh, there has been visible increase in political awareness noticeable by increase in representation of women in the political process, at the grass root level, the

union level (sub-district level) and also at the parliamentary level. However there are many set backs in spite of new policies being made. For example, policy design can be positively influenced by a small group of advocates if they gain entry into the inside track and play the politics right (Jahan, 2003), she mentions the problems faced by governments to implement gender based reforms when change of Governments occur, even though intentions to improve women's social and political position is there. Political conspiracies do not allow such reforms to be implemented in countries like Bangladesh.

The most serious problem in South Asia poverty can only be addressed successfully through the direct involvement of women. However, it was noted that while micro-credit had been an enormous success in Bangladesh, by comparison, small scale enterprise and similar initiatives for women have failed in India. The next step for these women, who have proven their credit-worthiness as institutional borrowers, is to move up-market from micro-credit to the macro-market.

The economic, education and health sector has been a slow success during the last ten years. The Government with its commitment to the MDG and the Beijing Platform for action has given special attention and importance to education, as women constitute 49% of the population. The special projects to encourage enrollment into primary schools and secondary schools with incentives of food, and scholarships have definitely increased the family interest to send the girl child to school with resultant increase in primary school enrolment.

However, though it is said that the literacy rate has gone up, and the numbers of girls in primary school are more than boys in reality the majority of girls are just literate enough to read, write and sign. We can say these rural women are empowered to a certain extent because of the education, but the question remains whether this level of education (primary school level and enabling) is enabling her to have enough empowerment

through education to be able to make her demand better health care and a better life for her and the family.

A difference however has been seen in the economic sector, because of the increase of women in the paid labor force, with a simultaneous increase in unemployment and one of the main reason for this has been the contribution of the joint effort of the Government, NGO's and Private Sectors which have given these poorest of poor women an opportunity to bring themselves out of this darkness into economic independence. The women have got economic independence for the first time because they are able to handle money which they got for small business enterprises. Their economic autonomy has improved her status to a certain extent. They are making small decisions in the household, and they can demand assistance from medical personnel and at health facilities. NGO's are also providing different health related projects which are enabling them to increase their knowledge on water and sanitation, nutrition, immunization, reproductive methods, skills of the cottage industries, to name a few. This is improving the women's and their family's quality of life. But simultaneously there are those controversial issues which are being noticed in present times, for example their status in the family, studies show that importance is being given to them as long as they bring home the money. The majority of these women are not getting the best health care because they cannot spare the money. So they too are empowered but perhaps not enough.

Women's participation in the labor force has increased because of poverty and better wages in employment and services. This is forcing them to look for jobs therefore even though they may not have a job because of scarcity of jobs, technically the fact that they are looking for jobs makes them a part of the labor force participation rate. The positive side to this is that with more jobs being looked for both at the individual level and at the national level something will have to be done about the scarcity of jobs. This

can increase the number of women entrepreneurs and also make the government realize that jobs have to be made available; a solution for the unemployed is needed.

As we look at women's health in the country, all the indicators for health show a trend for improvement, some areas more than others. The health status has improved in Bangladesh over the last 8 years; this could be attributed to the increased and improved health infrastructure, secondly the numbers of health personnel have been increased, third, the Governments commitment to address gender mainstreaming and maternal health issues in a big way and efforts of NGOs, (more/better education facilities) have all contributed to this improvement.

There has been decline of total fertility, increase in contraceptive use with increase in life expectancy; these could be explained as due to the government's keen interest in family planning projects since the independence of the country. All the health policies over the years have consistently addressed population control as its main priority but this is understandable in the context of a country like Bangladesh because the countries most important concern is its high growth of population. Increasing the age of marriage by the government has improved the numbers of women getting married at a later date but this has been slow, as traditional and cultural influences are still strong and prevalent in rural Bangladesh. Increased numbers of girls in schools also make less eligible girls for marriage with consequent decrease in births, child and maternal mortality. As these girls are getting an education their economic opportunities are increasing along with the countries socio-economic development of the country which is reflected in the labor force participation.

The Government of Bangladesh has been making policy adjustments in accordance with its commitment to the ICPD, Nairobi Conference, and Beijing platform for Action and has addressed maternal health as is seen from the National Health Policy of the last decade. This commitment to international human development is the first step

towards intentions to bring about change, and intentions to change will lead to behavioral and institutional change for the better.

However, critics have raised questions as to why this is not enough in Bangladesh with such an enormous population, we see the numbers of health personnel have increased but it is not sufficient. The number of people accessing these facilities is still very low, supplies of drugs deficient. The Government budget is only 5% of the total budget; as such government budget has to be increased. Institutional mismanagement is being considered a hindrance and absence of transparency shows that what ever little budget has been allocated it is not being utilized properly. It is for the government to decide to what extent and at what pace they should move to reduce gender inequalities in accessing social services, opportunities for government employment and to have control over financial and non financial resources to move forwards the cause of women's empowerment.

The low status of women is intertwined in the culture of the Bangladeshi women that though improvements have occurred, and differences in attitudes and behaviors towards women are changing it is a very slow process. It will take few more decades before the Bangladeshi women could be empowered as in the western and developed countries. It is essential that the attitude of people change. It is expected that with the continuation of the present scenario there will be continuation of empowerment of women if the policies for development of women are implemented and the health of the country will continue to increase and improve with growing government commitment. Long term strategic plans for the women in decision making will reduce the resistance and indifference at institutional levels. The resistance and indifference which is due to a deep rooted threat of men losing power and importance as result of ignorance and misapprehensions about being just and equitable partners of resources and rights of men and women. Hopefully, these insecurities of society will change for the betterment of

women's position and status in Bangladesh will definitely lead the country to change for a better future.

Gender inequalities undermine the effectiveness of development policies in fundamental ways. Yet this is an issue that often lies only at the periphery of policy dialogue and decision making, both in national and international arenas. Part of them neglect comes from policymakers reluctance to deal with topics that they deem inextricably associated with societal norms, religion, or cultural traditions. Part comes from a belief that gender gaps should be addressed by advocacy, not policy. And part comes from real (or feigned) ignorance about the nature of gender disparities and the costs of those disparities to people's well-being and countries prospects for development. However, as this thesis shows, the costs of this reluctance, apathy, or ignorance are high.

In conclusion, there is definitely room for improvement in the development of women and their status. The tables have really only shown very minimal improvements which would only, when observed against a graph, be constant. It is very likely that the development process would bear drastic results if certain cultural barriers did not exist. Alongside these barriers, governments also need to make their agendas of development much more concrete for the country to appreciate its successful results. Women should not and are not a threat to a country. They are only two extra helping hands that if given a chance, in collaboration with men, could make this world a better place. A life is a life and should be treated with equality and care; gender hails no disparity.

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BIOGRAPHY

Miss Iram Akhtar, completed her O'levels in Kuala Lumpur Malaysia, and then completed her A'levels in Dhaka, Bangladesh. Her undergraduate BA degree was completed in 2004 from Clark University in Worcester, Massachusetts, majoring in International Development with a minor in Sociology.