RESEARCH PAPER
ON
"GENDER DISCRIMINATION IN HEALTHCARE SPENDING IN THE HOUSEHOLD AND WOMEN'S ACCESS TO RESOURCES: PERSPECTIVE OF BANGLADESH"

By
Khandaker, Mu. Mizanur Rahman
Student ID: 51-118218 (MPP/IP)
The University of Tokyo

Prepared for :
Professor Hiwatari Nobuhiro
GraSPP, The University of Tokyo

July 22, 2013

			Contents	Page no.
	Abstract			3
1.0	Introduction			4
	1.1	Conceptualization of some terminologies on gender issue		4
	1.2	Background issues and research motivation		5
	1.3	Aim and Objectives of the research		8
	1.4	Hypothesis and Key research question		11
2.0		Literature review		12
3.0	Data and Research Methodology			
	3.1	Data		14
		(a)	Source of the data,	14
		(b)	Sampling methodology,	
		(c)	Period of the data collection.	
	3.2	Research Methodology		15
4.0	Empirical Findings			16
	4.1	Discussion on summary statistics and average health care spending		16
	4.2	Discussion on regression results		17
	4.3	Table and charts		19
5.0	Cause analysis of gender gap			23
	5.1	Socio-economic and cultural factors that cause gender disparity		24
6.0		Conclusion and policy implications		30

GENDER DISCRIMINATION IN HEALTHCARE SPENDING IN THE HOUSEHOLD AND WOMEN'S ACCESS TO RESOURCES: PERSPECTIVE OF BANGLADESH"

Abstract :

This paper aims to estimate whether there is gender biasness in health care spending for children within the household of Bangladesh. The prime subject matter of the research is gender discrimination. It is a multidimensional issue which is deeply embedded in the improvised and traditional cultural settings in Bangladesh, and it is considered as a major constraint towards the development process in the country. We, therefore, also have made an attempt to determine the root causes of pervasive gender gap persists in the society in Bangladesh. Data from the Household Income and Expenditure Survey (HIES)-2010 of Bangladesh has been used in order to estimate gender biasness in health care spending for children of age ten and below ten years of old (age<=10) at household level. To conduct the research, linear regression model has been chosen as model specification where the expenditure on healthcare for individual children is considered as dependent variable and the variable of interest is gender. The study reveal that the health care spending for female is significantly lower than that of male children. It is evidenced that socio-cultural norms, religious beliefs, patriarchal family setting and dominance of male counterparts of women contribute to the regular forms of discrimination against women. The study highlights some basic causes of gender disparity against women includes patriarchal family settings, ignorance of female children at birth, lacking of opportunities for education, poverty among women, less investment for women's health care in the household and so forth. Promotion of gender, women's empowerment, and women's integration in the mainstream economic activities along with men are given top most priority by the government and the policy makers as well. We, therefore, have provided some policy implications for further improvement of the gender situation in the country.

1.0 Introduction:

1.1 Conceptualization of some terminologies on gender issue:

(a) Sex:

Sex refers to the biological differences between men and women, boys and girls. It is defined as the property by which organisms are classified as males or females based on reproductive organs and functions (www.thefreedictionary.com). Biological and physiological differences between males and females are represented by sex such as reproductive organs, chromosomes and hormones etc. distinguish men and women, boys and girls (WHO, 2010).

(b) Gender :

Gender describes socially constructed differences between men and women, boys and girls etc. Gender is defined on the basis of social norms, behaviors, activities, relationship, responsibilities which are assigned by the society as appropriate for male and female (WHO, 2010). Understanding of gender varies in different races, nations, castes, ethnic groups, religions.

(c) Gender equality :

The gender equality means that both men and women, as human being, have equal rights and opportunities irrespective of gender. It also refers that all people (men and women) must have equal right to develop their personal abilities and free to make personal choices. State or society will not discriminate between men and women on the basis of gender. Moreover, gender equality emphasis that natural or biological difference between men and women will not lead to difference in status and rights in all sphere of life between men and women (www. http://global.finland.fi). According to World Bank (2012), "Gender refers to the social, behavioral, and cultural attributes, expectations and norms that distinguish men and women. Gender equality refers to the extent to which men's and women's opportunities and outcomes are constrained—or enhanced—solely on the basis of their gender".

1.2 Background issues and research motivation :

Gender discrimination is the consequence of persistent inequality between men and women in all spheres of life. The dimension and degree of discrimination against women manifests itself in different culture, politics, race, region, countries, and economies differently. However, gender discrimination is considered as a tremendous constraint towards the development process and it is found as a causal factor of violence against women. (Jannatul Ferdaush, K. M. Mustafizur Rahman, 2011). Gender equality, therefore, is the current subject of concern among the policy makers of the world because of enhancing economic growth and maintaining continuity of the development process as well (cpd-unfpa, 2002). The present concerns for gender equality, in order to forward the development process is established on a long historical background. Gender issue, in particularly, bringing equality between men and women, has been become a common goal for the International Community since it had been set out in the preamble to the Charter of the United Nations (UN) in 1945. Later, in 1948, gender issue and non-discrimination on the basis of sex was included in the Universal Declaration of Human Rights. Moreover, the Convention on elimination of all forms of discrimination against women (CEDAW) was adopted by General Assembly of United Nations in 1979 which is considered as a great success towards the struggle for equal rights for women of the world. CEDAW is a key international document on the rights of women and it creates tremendous moral as well as legal pressure on the UN member countries to take necessary steps in order to ensure equal rights for women. It also emphasis the civil rights, legal rights of women, reproductive roles and rights, impact of cultural factors on gender relations and barriers on advancement of women (World Bank, 2012). In addition, the Fourth World Conference on Women: Equality, Development and Peace was held in Beijing in 1995. The governments of the UN member states committed themselves to taking a number of measures in order to promote women's economic rights and eliminate discrimination against women in the

Beijing Platform for Action, adopted at that World Conference, (OECD, 2002). Moreover, the Millennium Development Goals (MDGs) which were adopted in the Millennium Summit of the United Nations in 2000 and endorsed by 189 United Nations member states also emphasize on gender issue. "Promote gender equality and empower women" is the third goal of MDGs. The vision of the Millennium Declaration and the eight Millennium Development Goals (MDGs) is to create a more just and equal world where equal access for women along with men is essential to the achievement of all MDGs.

However, different approaches or strategies had been adopted in the past few decades with a view to promoting the advancement of women and gender equality as a whole but in course of time, it was found that the successive approaches failed to address gender issue in a proper manner and could not improve the status of women as it was expected. Thus, at present time, some significant changes have been noticed in the efforts to promote gender issue at national and international level. Until the late 1960s, it was assumed that the overall economic development and modernization process in the developing world would improve the status of women by benefiting both male and female with equal pace (CPD-UNFPA, 2002). During that time, attention was given on women's reproductive health, especially women's access to food, contraceptives, nutrition and health care. However, by the early 1970s different feminist groups, social workers, policy makers and networks had created tremendous pressure on their governments for policy reform and pursuing better strategies to address the gender issue (Farida Faisal, 2011). Consequently, we found that 1975 was declared as the International Women's Year and UN Decade for women (1976-85) which sensitized the gender issue in the global level and International Donor Agencies like International Labor Organization (ILO) , World Bank , World Health Organization (WHO) etc extended their co-operation to improve gender related action plan. During this time, a new paradigm was introduced to address the gender issue namely "Women in Development (WID)" which aims to include women

in development projects in order to make them more efficient. According to Moser (1993) WID paradigm had three phases such as -"Equity approach", second "Anti-poverty" phase, the third "Efficiency" phase. Later, there were found some drawbacks in this development model. In the mid 1980s a new paradigm called "Gender and Development (GAD)" emerged as an alternative effort of WID. "Gender and Development (GAD)" was developed to address inequalities in women's and men's social roles in relation to development. Gender Mainstreaming is the most recent and seems to be the most promising of all the various gender reform paradigms for reforming public policy (Farida Faisal, 2011). Gender Mainstreaming is considered as the modified version of GAD. It emphasizes on the full participation of women for the attainment of sustainable development. The approach Gender Mainstreaming was endorsed by 189 countries while the UN member countries adopted, by consensus, the Beijing Declaration and Platform for Action, at the UN Fourth World Conference on Women in Beijing in 1995. Some affirmative approaches of Gender Mainstreaming are : (i) it considers men and women as a complementary forces and not as opposing forces, (ii) it is an umbrella approach targets gender equality policies, (iii) It has a wide scope to address all kinds of development settings from poverty alleviation to environmental protection, (iii) It aims at institutional restructuring for sustainable development on gender equality, (iv) It tries to determine the root causes of gender discrimination and institutional reform to achieve sustainable development in all spheres of the nation (Farida Faisal, 2011).

In the recent decades, some significant progress has been made towards the gender issue. For instance, literacy rate among the women are increasing gradually, gender gap in primary and secondary level enrollment rate reduced remarkably, and women participation in labor force higher than ever before over the world. Despite of considerable progress in reducing gender gap, there still exists huge discrimination against women in different sectors such as women have less access than men to resources and economic opportunity. Furthermore, they have limited access

to a wide range of services and the movement of women is still restricted in many societies (World Bank, 2012). It is evident that the status of women has changed a little , in particular they have achieved a little gain in economic well being due to traditional social structure (Shahnaj Parveen, 2008; Tamale, S. ,2004). Thus, evaluation of gender situation and monitoring the effect of some approaches adopted in reducing gender disparity is essential for further social and economic development as a whole. It is stated in "Gender Equality in Sector Wide Approaches (June, 2002)" that gender differences and inequalities in resources, access, needs and potential contributions should be assessed to form a gender responsive policy frame work. Necessarily, the economy and society as a whole (macro level), the sector and its key institutions (meso level), and households and their individual members (micro level) should be covered by the assessment to conceptualize how societal, sectoral and household-level conditions shape the relative opportunities and resources of males and females (OECD, 2002). A research on gender discrimination, therefore, has significant importance to the policy makers, social workers, even for the politicians, in the present national and international context.

1.3 Aim and Objectives of the research:

Gender situation in Bangladesh has been changing over last two decades due to considerable economic transition and social change. Although progress has been made in many spheres of social life of women, they still receive less investment for health care, education and intellectual development (unicef, 2010). Low literacy rate among the women of age group (15-49) enhance the ratio of child marriage and adolescent motherhood. In the long run, it is found that high maternal mortality ratio in the country is attributed to early marriage, women's malnutrition, lacking of access to and use of medical services and lacking of knowledge and information.

There is a huge impact of socio-cultural settings of Bangladesh on gender disparity. Bangladesh is a densely populated country of the world. According to the housing and population

census 2001, the size of the population is still quite high, it is approximately 142 million and the natural growth rate is 1.4 percent. Approximately 90 percent of the total population is Muslims, 9 percent are Hindus and the others constitute about one percent. It is, therefore, mention worthy that multi dimensional religious norms exist in the society of Bangladesh which affects the gender relation in different way. Moreover, the half of the population consists of women as the sex ratio is 103.8. Another important finding of the census-2001 is that the life expectancy for female is 64.5 and for male it is 64.0. Statistical evidence shows that women's opportunity and public involvement, particularly in labor force and in economic activities, has been gradually increasing in the recent decades. A significant progress is found in reducing gender gap in school enrollment for some effective public interventions in the education sector. Moreover, due to increasing pattern of foreign direct investment and advancement in industrialization process in Bangladesh offer a potential job market for women.

Bangladesh is a signatory to the convention on the Elimination of all forms of Discrimination against Women (CEDAW),to which of committed to meet the rights of women and eliminate gender inequality. There are a wide range of laws have been enacted in Bangladesh such as the Dowry Prohibition Act of 1980, the Child Marriage Restraint Act (amended in 1984) and the Family Courts Ordinance of 1985. Though it would take time to get the total impact of these interventions at the national level, it might be a positive initiative towards the improvement of gender situation. Moreover, the Article 28(1), 28(2), 28(3), 28(4) of the constitution of the people's Republic of Bangladesh ensure the equal rights for both men and women. It also (Article 65(3)) provides reserved seats for women in the Parliament and it promotes (Article 9) special representation for women in local government. Besides this, government has initiated some encouraging programs (micro credit programs, incentives for female students in secondary level,

various training programs etc.) to increase women's participation in governance. Furthermore, National Council for Women's Development (NCWD) headed by the Prime Minister has been working with a view to eliminating all for forms of discrimination against women and integrating them in mainstream economic activities as well (CEDAW report, Bangladesh, 2009)

Despite of afore said policy intervention of the government and progress of gender situation in some cases, a high degree of gender discrimination exists pervasively in the community because of patriarchal social structure and cultural as well as religious norms (Shahnaj Parveen ,2007). In addition, different studies (BBS-2006, BBS-2005) show that Gender discrimination against girls and women, subordination and deprivation persist, as evidenced by key indicators including high mortality rate and a lower literacy rate, high unemployment rate, lower average wage rate. The nutritional status of children and women continues to be a major concern in Bangladesh. Sexual abuse of children and adolescent girls is a significant problem in the country. The situation of children and women of marginalized groups, vulnerable and disadvantaged groups, including urban slum dwellers, refugees, tribal groups, river gypsies and those living in remote and inaccessible areas deserve special attention. However, issues of gender equality, equity, and the empowerment of women are increasingly recognized as essential to the process of sustainable development. Gender issues today are not merely special concerns but are considered crucial elements in policies, plans and strategies. Women's and men's contributions to society, their partnership and full participation, their different needs and different access to resources are essential components towards the development process. Some empirical evidences show that while equality between men and women exists in the society, the economies grow faster, poverty reduction strategies work effectively, and it becomes easier to achieve sustainable development (World Bank, 2012). It also enhances the possibilities of achieving the targets of Millennium Development Goals

(MDGs). Thus, it is a dire need to address the gender issues properly and effectively. This paper, therefore, would be an effective endeavor towards addressing the gender issues of Bangladesh.

The present study analysis the healthcare spending for the children of age below ten years at household level as the healthcare spending for children of the this age group totally depends on the resources of the parents comparing with the teenagers or adolescents children. We also try to find the overall causal factors of gender discrimination by discussing socio-economic status (access to resources, participation in labor force, literacy & school enrollment) of women in Bangladesh. To address the aforesaid issues, the study has the following specific objectives:

(i) To estimate gender biasness in healthcare spending for the children (age <=10) within the household;
(ii) To find the determinants that cause gender gap in the household as well as in the society, and
(iii) To recommend some policy implications.

1.4 Hypothesis and Key Research Questions :

The prime subject matter of this research is to determine the causes of gender discrimination. It is a multidimensional issue which is deeply embedded in the improvised and traditional cultural settings in Bangladesh, and it is considered as a major constraint towards the development process in the country. This paper examines whether there is gender biasness in the healthcare spending for the children of under ten years of age within household and it also attempts to find the root causes of gender disparity that exists in the society. In this regard, I would search for the answers of the questions mentioned below through regression analysis.

(i) Is there any gender biasness in healthcare spending for the children within the household in Bangladesh ?
(ii) Do the socio-cultural norms influence gender gap against women in the society?

2.0 Literature review:

A wide range of empirical studies are available on investment in healthcare spending at household level. Most of the studies of this kind have been conducted with a view to determining gender biasness in healthcare expenditure and suggested some policy implications how to reduce gender gap from the health sector. It also provided with some valuable recommendations how to improve women's health status and integrate them into the mainstreaming economic activities in order to empower women as a whole. I have reviewed some of the research papers which focused on women's health situation and determined the factors that cause gender discrimination against women. Abay Asfaw, Stephen Klasen, Francesca, Lamanna (2007) have investigated whether there is gender discriminations in the health care financing behavior of household for the infants and children of age below nine years old, in India. The findings of the study reveal that no discrimination among boys and girls is found, while the households use current income to finance inpatient health care expenses. However, significant gender discrimination is found in health care spending for children while the households face resources scarcity. The study has been conducted using data from the 52nd round Indian National Sample Survey and the bivariate probit model has taken to investigate the afore said issue. It has been proven by the stydy that the probability of households to sell assets, borrow money to cover the inpatient costs of girls is respectively 1.4,3.2, and 4.3 percent less than that of boys. The study suggests two specific ways to reduce gander gap in healthcare spending such as (i) To ease household budget constraints, and (ii) To introduce some specific healthcare insurance.

Shahnaj Parveen (2007) has focused on gender awareness among women in rural Bangladesh and the authoress has also highlighted the social status of women in the rural part of Bangladesh which are thought to be the root causes of gender discrimination against women. The research has been conducted taking a sample of 156 women from three villages under an old district

"Mymenshing". The major argument of the authoress is that personal income and physical beauty of women determine a relatively higher status of women in the household and community as well comparing with the women who are distressed, mentally and physically disabled, illiterate, infertile and very young. The Likert scale method has been used to find the women's social status and gender awareness. The study suggested that it is a dire need to improve women's gender awareness in terms of their literacy levels, access to information and productive resources, participation in social activities by establishing women's organizations in the locality.

In the case of Sri Lanka, Rozana Himaz (2008) found that intrahousehold allocation of education expenditure differs between boys and girls in rural Sri Lanka. It has been proved that Sri Lankan rural households seem to be allocating more educational resources towards girls in 1990/91 for age groups 5-9 and 17-19 and in 1995/6 for age groups 5-9 and 14-16. The research was conducted using the data comes from three cross-section Household Income and Expenditure Surveys (HIES) for 1990/91, 1995/6 and 2000/01 carried out by the Department of Census and Statistics (DCS), Sri Lanka. "The Working-Lesser Engel form for demand analysis with a linear relationship" model was used to make a better estimation of the research work. The researcher admitted that the finding is to some extend is different from the gender situation of other South Asian countries. However, he argued that wage returns to junior and senior secondary education have been higher for females than for males through the 1980s and 1990s, thus the household level decisions might be reasonable and it represented the real phenomenon of the society in rural Sri Lanka.

Fariyal F Fikree, Omrana Pasha (2004) argued that the life advantages which women from developed countries enjoyed is not seen clearly in the society where gender gap against women persists pervasively. The study showed that sex selective abortions, neglect of girl children, reproductive mortality, and poor access to health care for girls and women are some basic reasons in

perpetuating gender discrimination in developing countries, in South Asia. This a study based on qualitative analysis approach which would help to reduce gender related barriers towards social development, in particularly improve the life of people as a whole. The authors urged the policy makers and social workers to pay attention to the detrimental health effects that gender plays throughout the life cycle because they have shown that women in south Asia are mostly disadvantaged in terms of healthcare, education, dignity, even to some extent, they are the victim of violation of human rights.

3.0 Data and methodology :

3.1 Data :

The research on "gender discrimination in healthcare spending within the household" has been conducted using data from the Household Income and Expenditure Survey (HIES)-2010 of Bangladesh. Household Income and Expenditure Survey (HIES)-2010 is a national level survey conducted by Bangladesh Bureau of Statistics in collaboration with the World Bank in 2010. It is a household based sample survey. A two stage stratified random sampling technique was followed in drawing sample of HIES-2010. The primary sampling unit, PSU (PSU is basically an enumeration area for HIES-2010) was defined by taking contiguous two or more enumeration areas (EAs) used in Population and Housing Census 2001. Each PSU comprised of around 200 households. Integrated Multipurpose Sample (IMPS) sample design consists of 1000 PSUs where 640 rural and 360 urban PSUs, was developed on the basis of the sampling frame based on the Population and Housing Census 2001.

Stage-1: A sub sample consists of 612 PSUs was drawn for HIES-2010 from Integrated Multipurpose Sample (IMPS) sample design which consists of 1000 PSUs. These PSUs were selected from 16 different strata. There were 6 rural, 6 urban and 4 Statistical Metropolitan Area (SMA) strata.

Stage-2: Using random sampling method, 20 households were selected from each of the rural, urban and SMAs primary sampling unit (PSU). Thus, the sample of HIES is a sub-set of IMPS. In HIES-2010, 12240 households were selected where 7840 from rural area and 4400 from urban area. According to the sample design, the survey had been completed in one complete year (1st February, 2010 to 31st January, 2011) and the data was collected through the year round by 18 terms.

3.2 Research methodology:

In this study, we investigate how the health care spending for children within the household differs by gender in Bangladesh. We focus on health care spending for infants (age less than one year) and the children of age group (1to 10 years old) because the spending of medical care for the children of this age group totally depends on the decisions of the parents comparing with the teenagers or above. Through this mechanism, we would be able to see the intra-household gender biasness in health care spending more correctly. Our hypothesis in this research is that there is more likely gender biasness in health care spending for children within the household. To estimate the gender biasness in the health care spending among the children in the household, we adopt the linear regression model where the expenditure on health care *(healthcare_cost)* for individual children is considered as dependent variable and the variable of interest is gender. The coefficient of gender in the regression function estimates the variation of health care spending between male and female children within the household. The model specification is as follows:

$$\begin{aligned} Ln_healthcare_cost_i = \beta_0 + \beta_1 Gender_i + \beta_2 Age_i + \beta_3 Rural_i + \beta_4 What_Class_i + \\ \beta_5 Immunization_i + \beta_6 Hhsize_i + \beta_7 Parent_edu_i + \\ \beta_8 Highest_passed + \beta_9 Hhwealth_i + \beta_{10} Region_i + \varepsilon_i \end{aligned}$$

Where,

$Healtcare_cost_i$ = Spending on healthcare for individual children,

$Gender_i$ = A dummy variable where, gender =1 for female and otherwise = 0

$What_class_i$ = What class/grade currently attending by individual $children_i$,

$Highest_passed_i$ = Individual level of education,

$Immunization_i$ = Whether the children are given some basic vaccinations (these are also dummy Variable where $Immunization_i$ =1 if $Immunization_i$ is given and other wise 0)

$Hhsize_i$ = Household size,

$Parent_edu_i$ = Level of education of fathers and mothers of $individual_i$,

$Hhwealth_i$ = Land asset and non-land asset of the household,

$Rural_i$ = A dummy variable where rural =1 and otherwise =0

$Region_i$ = Regional dummy(s) which are geographical locations of seven administrative divisions of Bangladesh (Borisal, Chittagonj, Dhaka , Khulna, Rajshahi , Rangpur and Sylhet),

ε_i = Error terms

4.0 : Empirical findings :

4.1 Discussion on summary statistics and average health care spending :

In order to check the validation of the regression, we have estimated the summary statistics of the variables taken in the regression. Our sample size is 2491 and we have included the infants (children of age less than one year) and children of age from one (1) to ten (10) years in the sample (age<=10). From the summary statistics (Table:I) we find the total observations for all variables (dependent and independent) are 2491 which implies that the regression does not suffer from the problem of missing variables. The table for summary statistics (Table:I) also contents the minimum values and maximum values of all variables which reveals that there is no inconsistency among the values of the variables.

We have also estimated the average yearly spending on healthcare (Table: III) for children within household by sex for the children of four age groups. We find that the average yearly spending on healthcare for female children is lower than that of male children for all age groups. Moreover, the difference of average yearly spending on healthcare between male and female children is statistically significant for all groups except the age group (9-10) which reveals that there exists gender biasness in yearly spending on healthcare for children within household.

4.2 Discussion on regression results:

(a) Our principal target is to estimate the gender biasness in health care spending for children in the household. We, therefore, have run regression of several specifications in order to get unbiased estimation of health care spending of children. The regression specification (1) in Table (IV) is the primary regression where we have regressed *healthcare_cost* on several factors such as (i) *individual characteristics, (ii) family background, and (iii) regional variation.* Where individual characteristics includes gender, age , chronic diseases and so on; family background includes educational level of parents, household's resources, household size etc and rural, urban, and seven administrative regions are taken to control the regional and societal variation in health care spending for children in the household.

(b) We have chosen the regression specification (2) in Table: IV, as the base specification where *healthcare_cost* is the dependent variable, *gender* is considered as the variable of interest, and others independent variables such as *age, what_class, chronic diseases, hhsize* etc are taken as control variables. The Table: IV is prepared based on the regression results for pulled sample (**individual level Standard Error).** It is found that the coefficient of gender is negative and significant at 1% level of significance which implies that the health care spending for female children in the household is significantly lower than that of male children holding all other things constant. We also find that the coefficients of the independent variables age, chronic_dis, hhsize,

nonland_asset, fathereducation, and mothereducation are significant at either 1% or 5% level of significance which imply that these are very important variables in determining the health care spending for the children irrespective of gender. From the regression result we also find that an in crease in age of the children is associated with decrease in health care spending of the children holding other variables constant. Another important finding is that the coefficient of the variable *chronic diseases* is significant at 1% level of significance which implies that the health care spending for the children who have been suffering from chronic diseases is higher than that of children who have not been suffering from this kind of diseases keeping all other variables unchanged. It also reveals that an increase in educational level attained by the parents is associated with increase in the health care spending for the children irrespective of gender while taking all other variables unchanged as the coefficients of the variables *fathereducation, and mothereducation* are positive and significant at 5% level of significance. Furthermore, the coefficients of the regional dummy(s) are significant at 1% or 5% or 10% which means that there is a substantial regional variation in health care spending for the children within the household.

(c) The table:V is prepared based on regression results for pulled sample **(Household level Standard Error**). In this case, our aim is to see the effect of collective decision of the parents. In particularly, we like to see what happens when parents take decision for medical investment collectively for all children in the household; whether there is gender biasness when parents take decision for medical investment collectively for all children in the household. In this case, we also find almost same results as the regression results in Table:IV. In both cases, the regression results reveal that there is substantial gender biasness in health care spending for the children within the household.

4.3 Charts and Tables :

Table: I

Summary statistics of some variables:

Variable	Obs	Mean	Min	Max
Healthcare_cost	2491	384.5548	3	70000
Gender	2491	0.4628663	0	1
Age	2491	4.695303	0	10
Highest_passed	2491	0.4347652	0	19
Attending_school	2491	0.5917302	0	2
What_class	2491	0.9642714	0	19
Chronic_dis	2491	1.956644	1	2
Immu_bcg	2491	0.5584103	0	2
Immu_dpt_1	2491	0.5620233	0	2
Immu_polio_1	2491	0.5688479	0	2
Immu_measles	2491	0.6174227	0	2
Immu_hepatites	2491	0.6471297	0	2
Rural	2491	0.6932959	0	1
Hhsize	2491	5.124047	3	15
Landasset	2491	53.61582	1	1179
Non_landasset	2491	362998.5	0	1.72E+07
Father's educeducation	2491	3.758731	0	13
Mother's education	2491	3.744279	0	13

Table_II

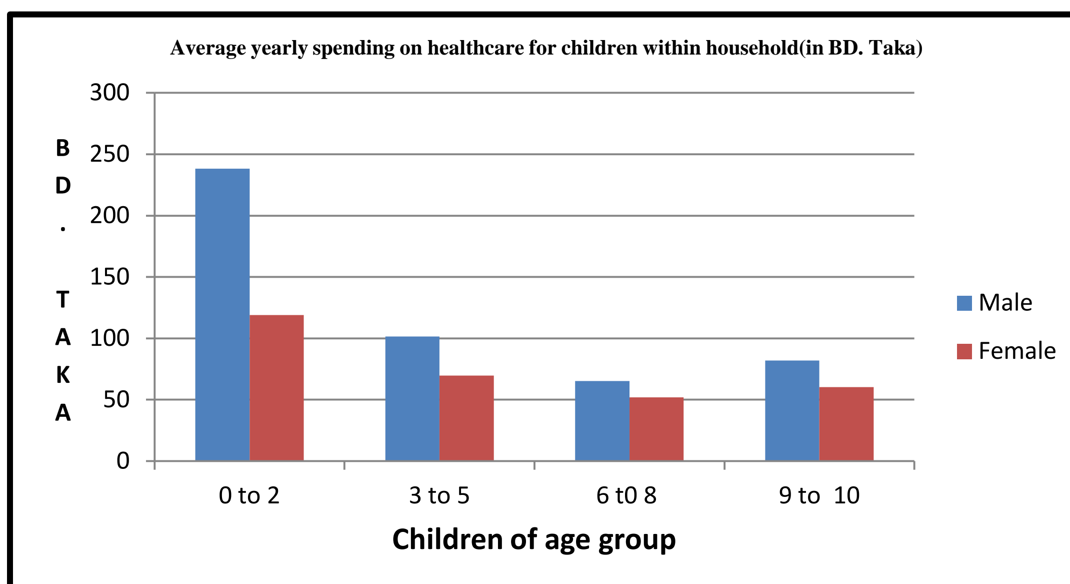
Correlation between dependent and independent variables

	ln_hea~t	gender	age	highes~d	chroni~s	rural	hhsize	landas~t	non_la~t	father~n	mothereduc~n
ln_healthcare_cost	1										
gender	-0.0689	1									
age	-0.1271	0.0106	1								
highest_passed	-0.0098	-0.0013	0.4331	1							
chronic_dis	-0.1424	0.0395	-0.052	-0.0451	1						
rural	-0.0781	-0.0024	0.015	-0.0397	0.0593	1					
hhsize	-0.04	-0.0015	0.062	0.0201	-0.0007	0.1346	1				
landasset	0.0357	-0.0138	0.0388	0.0332	0.014	0.1195	0.1665	1			
non_landasset	0.0944	-0.0231	0.0036	0.0507	0.0033	-0.2369	0.066	0.1041	1		
fathereducation	0.1488	0.0123	-0.029	0.0645	-0.0064	-0.2202	-0.1206	0.2132	0.2747	1	
mothereducation	0.1486	0.013	-0.103	0.0298	-0.0078	-0.2233	-0.1991	0.1668	0.2746	0.6831	1

Table_III				
Age group	Average yearly spending on healthcare for male and female children within household(in BD. Taka)			
	Male	Female	difference	t-statistics
0-2	238.0983	118.9199	119.1784**	1.7164
3-5	101.4083	69.69743	85.93774**	1.7282
6-8	65.32046	51.93122	13.38925*	1.2888
9-10	81.9307	60.30818	21.62252	0.9167

*** **indicates statistical significant at 1% level of significance**
** **indicates statistical significant at 5% level of significance**
* **indicates statistical significant at 10% level of significance**

Chart:01



Table_IV: Regression results for pulled sample (individual level Standard Error)				
Dependent variable:	ln_healthcare_cost = log (healthcare_cost)			
Repressors:	Coefficients			
	(1)	(2) (Base specification)	(3)	(4)
Gender	-0.161***(0.048)	-0.153***(0.047)	-0.151**(0.047)	0.267(0.202)
Age	-0.075***(0.017)	-0.069***(0.017)	-0.160***(0.035)	-0.092**(0.030)
Age2=age*age			0.009**(0.003)	
Highest_passed	0.021(0.022)	0.036(0.023)	0.023(0.021)	0.036(0.023)
Attending_school	-0.027(0.054)	-0.020(0.053)	0.021(0.054)	-0.020(0.053)
What_class	0.009(0.014)	0.003(0.014)	-0.002(0.0146)	0.003(0.014)
Chronic_dis	0.904***(0.125)	0.865***(0.124)	-0.869***(0.124)	0.868***(0.124)
Immu_bcg	0.330(0.450)	0.461(0.419)	-0.605(0.420)	0.480(0.420)
Immu_dpt_1	-0.335(0.423)	-0.413(0.396)	0.313(0.396)	-0.417(0.395)
Immu_polio_1	-0.011(0.238)	-0.065(0.234)	0.171(0.232)	-0.077(0.236)
Immu_measles	-0.090(0.132)	-0.082(0.132)	-0.081(0.134)	-0.087(0.132)
Immu_hepatitis	-0.103(0.099)	-0.070(0.102)	0.065(0.102)	-0.069(0.102)
Rural	-0.067(0.055)	-0.066(0.055)	-0.070(0.055)	-0.069(0.171)
Hhold_size	-0.013(0.015)	-0.054***(0.015)	-0.056***(0.015)	-0.064(0.046)
Land-asset	0.0001(0.0002)	0.0002(0.0001)	0.0002(0.0001)	0.0005(0.0006)
Non land-asset	6.890*(3.520)	4.820(3.500)	4.710(3.480)	-1.340(1.010)
Father's Education	0.024**(0.007)	0.024***(0.007)	0.025**(0.0075)	0.032(0.023)
Mother's Education	0.016*(0.008)	0.017**(0.008)	0.017**(0.008)	0.023(.025)
Regional Dummy:				
Borisal		0.144(0.131)	0.134(0.131)	0.161(0.132)
Chittagong		0.274**(0.100)	0.272**(0.101)	0.284**(0.101)
Dhaka		-0.182*(0.101)	-0.194*(0.101)	-0.170*(0.101)
Khulna		-0.432***(0.115)	-0.443***(0.115)	-0.420***(0.115)
Rajshahi		-0.247**(0.111)	-0.266**(0.112)	-0.240***(0.112)
Rangpur		-0.488***(0.107)	-0.496***(0.107)	-0.471***(0.107
Interaction term:				
Age_gender				0.015(0.016)
Rural_gender				0.004(0.110)
Hhsize_gender				0.006(0.029)
Land-asset_gender				-0.0001(0.0003)
Non land-asset_gender				1.390(6.820)
Father's education_gender				-0.005(0.014)
Mother's education_gender				-0.004(0.016)
Constant	5.425***(0.152)	5.707***(0.186)	7.580***(0.316)	5.748***(0.206)
Summary Statistics				
F-test: F(14, 10065) = 127.13, Prob > F = 0.0000				
Adj.R^2	0.0741	0.1173	0.1201	0.1197
SER	1.45	1.39	1.39	1.39
n	2491	2491	2491	2491

Table_V: Regression results for pulled sample (Household level Standard Error)				
Dependent variable:	ln_healthcare_cost = log (healthcare_cost)			
Repressors:	Coefficients			
	(1)	(2) (Base specification)	(3)	(4)
Gender	-0.161***(0.050)	-0.153***(0.049)	-0.151***(0.049)	0.267(0.202)
Age	-0.075***(0.017)	-0.069***(0.017)	-0.160***(0.035)	-0.092**(0.030)
Age2=age*age			0.009**(0.003)	
Highest_passed	0.021(0.023)	0.036(0.023)	0.023(0.021)	0.036(0.023)
Attending_school	-0.027(0.055)	-0.020(0.054)	0.021(0.056)	-0.020(0.053)
What_class	0.009(0.015)	0.003(0.015)	-0.002(0.014)	0.003(0.014)
Chronic_dis	.904***(0.130)	0.865***(0.131)	-0.869***(0.131)	0.868***(0.124)
Immu_bcg	0.330(0.450)	0.461(0.419)	-0.605(0.421)	0.480(0.420)
Immu_dpt_1	-0.335(0.423)	-0.413(0.396)	0.313(0.396)	-0.417(0.395)
Immu_polio_1	-0.011(0.238)	-0.065(0.234)	0.171(0.233)	-0.077(0.236)
Immu_measles	-0.090(0.134)	-0.082(0.135)	-0.081(0.136)	-0.087(0.132)
Immu_hepatitis	-0.103(0.104)	-0.070(0.107)	0.065(0.108)	-0.069(0.102)
Rural	-0.067(0.061)	-0.066(0.060)	-0.070(0.060)	-0.069(0.171)
Hhold_size	-0.013(0.021)	-0.054**(0.020)	-0.056**(0.020)	-0.064(0.046)
Land-asset	0.0001(0.0002)	0.0002(0.0002)	0.0002(0.00020)	0.0005(0.0006)
Non land-asset	6.890*(3.830)	4.820(3.900)	4.710(3.890)	-1.340(1.010)
Father's Education	.024**(0.008)	0.024**(0.008)	0.025**(0.0084)	0.032(0.023)
Mother's Education	0.016*(0.009)	0.0176*(0.009)	0.017*(0.009)	0.023(.025)
Regional Dummy:				
Borisal		0.144(0.152)	0.134(0.151)	0.161(0.132)
Chittagong		0.274**(0.122)	0.272**(0.122)	0.284**(0.101)
Dhaka		-0.182(0.121)	-0.194(0.122)	-0.170*(0.101)
Khulna		-0.432**(0.136)	-0.443**(0.136)	-0.420***(0.115)
Rajshahi		-0.247*(0.128)	-0.266*(0.128)	-0.240***(0.112)
Rangpur		-0.488***(0.124)	-0.496***(0.124)	-0.471***(0.107)
Interaction term:				
Age_gender				0.015(0.016)
Rural_gender				0.004(0.110)
Hhsize_gender				0.006(0.029)
Land-asset_gender				-0.0001(0.0003)
Non land-asset_gender				1.390(6.820)
Father's education_gender				-0.005(0.014)
Mother's education_gender				-0.004(0.016)
Constant	5.425***(0.171)	5.707***(0.203)	7.580***(0.343)	5.748***(0.206)
Summary Statistics				
F-test: F(14, 10065) = 127.13, Prob > F = 0.0000				
Adj.R^2	0.0741	0.1173	0.1201	0.1197
SER	1.45	1.39	1.39	1.39
n	2491	2491	2491	2491

5.0 Cause analysis of gender gap:

Women in Bangladesh find themselves in subordinate position comparing to men. Because women have very limited access to resources in the country and they are socially, culturally, and economically dependent on men throughout their whole lives (Fariyal F Fikree, Omrana Pasha, 2004). The major causes of women's powerlessness and dependency on men are illiteracy, lack of awareness, poor knowledge and skills. Besides this, they are lacking of self-esteem and confidence. Moreover, like many other developing countries, patriarchal system of social structure exists in Bangladesh where women hold the lower hierarchical position compared to men and have a little control over the household decision making process. Furthermore, women are assigned to carry out the household chores and 3C's (caring, cooking and cleaning) which are their traditional responsibility in the family (Shahnaj Parveen, 2008, Jannatul ,Rahman, 2011). However, women are disadvantaged with regard to health and health care because of individual and societal beliefs and attitudes towards appropriate gender specific roles, needs and the choices of individuals within households on the basis of the factors explained below.

Although the government of Bangladesh, international development partners and NGOs have been working individually and also collectively in reducing gender gap (as discussed in section one of this paper), yet higher level of gender disparity still exists in the country. Most of the empirical evidences show that religious and socio-cultural beliefs and norms, individual and social attitudes towards women, and curse of poverty enhance the gender gap in the society (Fariyal F Fikree, Omrana Pasha, 2004; Shahnaj Parveen, 2008). We, therefore, need to look into the family setting and traditional belief of her people to find the root causes (pull and push factors) of pervasive gender gap in the country.

5.1 Socio-cultural factors that cause gender disparity:

(i) Hierarchical family settings :

Historically, hierarchical family settings still remain in the country, in which men hold the controlling position (in terms of resource allocation and domestic decision making process) in the household and women as a whole hold relatively lower hierarchy which largely discriminate women from birth to adulthood (even in whole life).

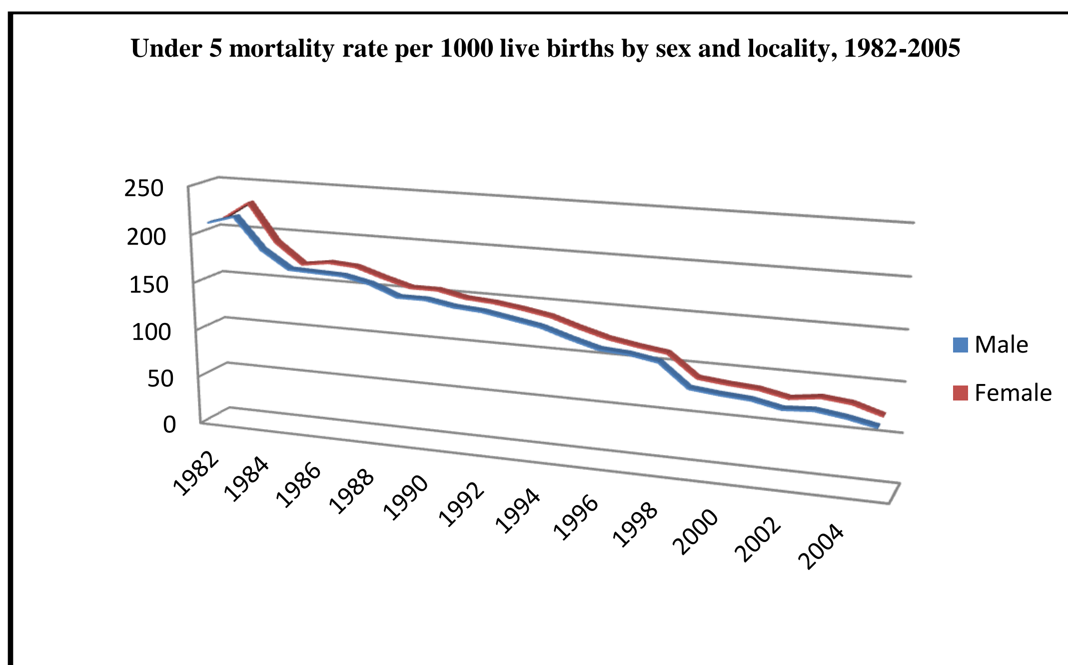
(ii) Learning at the childhood:

Conditioning (differentiation) of girls and boys starts immediately after a child is born at home; at the same time, different roles and attitudes of the family are observed based on gender (sex) of the new born baby which demonstrates the social norms and values. These social norms reveal, whether girls and boys get equal access to early childhood education. For example, socialization goals and child-rearing practices of the parents in the society differ substantially for boys and girls. In the early age, a girl is taught how to achieve pain bearing capability, hardships, and modesty which favors the boy of that family. More likely, a girl of tender age is taught to earn domestic skills such as cooking, sewing, caring and cleaning. Emphasis is given to prepare her to take the responsibility of child bearing and rearing in future. On the other hand, a boy is taught how to achieve skills for income generating activities and he is sent to school on the priority basis. Family tries to prepare him as the future leader of the family, more widely as the future leader of the society (UNESCO Bangkok, 2007, A.M. Sultana, 2010).

(iii) Negligence (Girls are neglected) since birth:

Female children are often neglected in the household in Bangladesh. It happens even in the well developed higher class people. A common practice based on religion in the Muslim community that 'Azan (a call for prayer at mosque)' is given immediately after a male child

is born. It is considered as the formal recognition of new born baby and a significant announcement of his arrival in the society (A.M. Sultana , 2010, Zaman, 1999). On the contrary, a female child is not ritually recognized (‘Azan is not offered) at her birth. Incidence of giving birth of a male child brings joy and optimism in the family; while a daughter receives relatively poor reception at her birth. This negligence leads to gender based health disparities among the young age population. This negligence results into insufficient nutrition, less preventive care, and irregularity in seeking health care during illness for female children. Consequently, we find in the chirt-01 that the rate Under 5 mortality rate per 1000 live births by sex in Bangladesh, 1982-2005 is always higher for female than that of male children.



Source : Bangladesh Bureau of Statistics, SVRS (1982-2005)

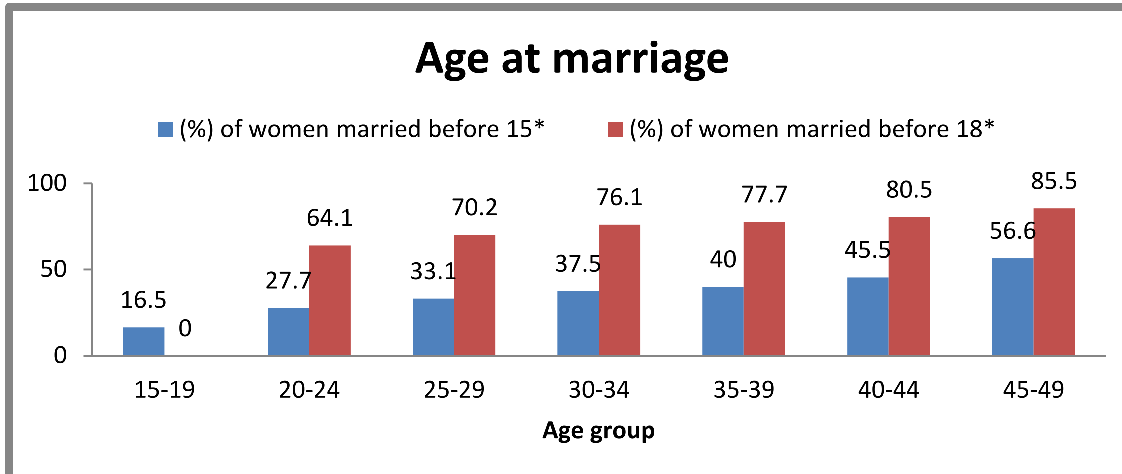
(iv) Women’s access to education and gender gap:

Lack of education is one of the root causes of gender gap which prevent women from equal participation in socio economic activities along with men and it enhances the degree of discrimination against women. According to the human development report

(HDR) 2002, UNDP, the literacy rate among male and female are 52.3% and 35% respectively. Though the school enrollment rate of female children at primary and secondary level is much more higher than boys in recent years. Yet, the status of women does not change accordingly. It happens because parents are much more concern about the safety for their daughters than sons (Haider, 2012). There are a wide range of factors such as poverty, low status in the family and community, backwardness in education, traditional social practices and lacking of social safety net which enhance the dropout (from school) rate among the adolescent girls. As a result, they (adolescent girls) fail to continue study towards higher education, rather in most cases, family arranges marriage for these adolescent girls. In Bangladesh, one thirds of the population are estimated living under poverty (HIES-2010). Thus, poverty, negligence and discouraged by family, lack of security and opportunities are the basic constraints towards the female education particularly higher secondary and above. According to the report of UNICEF, the school attending rate of adolescent girls is 53 % at secondary level and for tertiary level, the figure is more shocking. It is six girls for every ten boys which is well below the MDG target of full equality (UNICEF, 2010).

(v) Women and poverty :

Women are the direct victim of the curse of poverty. It is seen that among the poor, women seldom can have basic needs like the health care services, education. One of a consequence of poverty is child marriage which is embedded so deeply in the social and cultural setting that it could be a leading cause of women discrimination and deprivation of access to all opportunities and benefits in family and societal life. Though there is a existing law in order to protect the child marriage, yet the proportion of child marriage is quite high in Bangladesh. The chart shows the prevalence of child marriage.



Source: Bangladesh Bureau of Statistics, Gender Statistics, 2010.

Among the poor, the young women are thought to be the financial burden for the family as they don't provide any financial support for the family like sons , rather the family needs to spend huge amount to arrange marriage for the daughters and it cost relatively higher due to dowry (an amount of money is given by the bride's parents to the bride-groom). Thus the parents do hurry in marrying their daughter (A.M. Sultana, 2010). Consequently, adolescent girls can not continue their study while parents decide to merry them off and immediately they drop out from school. Thus, the girls are deprived of acquiring necessary skills and qualification required for the entry into the labor market (UNICEF, 2010).

(vi) Religious influence on women lives:

Islam is the major religion in Bangladesh (app. 90%) and the Hindus holds the second position (app. 8.5%) on the basis of the number of followers. Thus, religion belief and rules puts significant impact on the lives of her people. It is well known that Islam itself does not devaluate the status of women, the local practice and wrong explanation of Islamic rules creates discrimination against women. For example, *PURDAH* (used by Muslim women) which is considered as a constraint for women towards participation in social and economic activities,

particularly in public place. A local belief, based on Islam, is that heaven lies under the feet of husband which affects the lives of women, especially the lives of rural women (Haider, 2012). In the Hindus community, it is mandatory that sons are responsible to perform the last rites at their parents' funeral and it is strictly maintained in the society which influences the parents to have a male child.

(vii) Inheritance and property rights of women (legal aspect):

The civil laws and Muslim personal laws of Bangladesh ensure the Inheritance and property rights of women, though there is a controversy whether the status and rights of women are well protected. In spite of having the right to ownership and having the source of income with property under the provisions of these laws, women can seldom practice these rights. According to Muslim marriage law, women are entitled to have *mahr* (money, property given to the bride) which is specified in the *kabin nama* (marriage contract/ marriage certificate). But due to many reasons, (especially ignorance of women, dominance of men) women rarely can own *mahr* or the terms and conditions maintain in the cabin nama (Haider, 2012, Kabeer, 1985). According to Muslim personal laws and inheritance laws, the legal rights of a woman is specified as follows : (i) Under this law, a daughter inherits only half of a son's share; if there are no male children, a daughter inherits a fixed share and the rest of the estate is inherited by other agnatic relatives of the deceased. In case, if there are no female children, a son inherits total share of the estate of the deceased. (ii) Regarding the issue of spouses, a wife receives one eighth of the deceased husband's property. On the other hand, the husband gets one fourth of his deceased wife's property. Thus, it is claimed that Muslim Personal Laws enhance gender disparity in the society, though there is a debate on this issue among the law makers (Sultana Kamal, September, 2001).

(viii) Labor force participation :

Women in Bangladesh are mainly engaged in household chores such as child rearing, cooking, cleaning and caring of others. A little number of women are engaged in paid work. The proportion of women's participation in formal labor force shown in the Table-v. The labor force survey 2005-06 reveal that 12.1 Million women participated in labor force which is too small comparing with the male (37.3) at national level. The situation is almost same when we see the disaggregated figure on the basis of rural and urban. Whereas half of the total population constitutes by women. Moreover, while women in rural area earn something from poultry or livestock is spent for subsistence purpose (Sheikh Kabir, Uddin Haider, 2012). As a result women's access to resources in Bangladesh is very limited which results into less women's access to decision making process in the household.

Table: v

Labor force aged 15 years and over by sex and locality, 1995-2006

	National		Rural		Urban	
	Felame	Male	Felame	Male	Felame	Male
1995-96 LFS	5.6	30.6	3.8	23.9	1.6	6.7
1999-00 LFS	8.6	32.2	6.4	25.1	2.2	7.1
2002-03 LFS	10.3	35	7.7	27.3	2.7	8.6
2005-06 LFS	12.1	37.3	9.3	28.4	2.8	8.9

Source : Labor force survey , 1995-96 to 2005-06, BBS

(ix) Health situation of women :

The common picture of women's health situation in Bangladesh, is high maternal mortality, high fertility rate, malnutrition and ill health. According to the sample vital registration system, BBS, 2010, the maternal mortality rate is 2.16 per 1000 live births and the fertility rate is 2.12 (average fertility of per women during reproductive age 15-49) which is still the highest in the world. In patriarchal social setting where women are often dominated by men, the

status of women is always lower than men. Thus, the lower social status, poverty, and illiteracy cause women's deprivation of necessary healthcare and malnutrition (Haider, 2012). Moreover, as caring of other family members is a women's traditional responsibilities, they (women) are to wait for meal until all the family members finish their meals. Though women needs to have more nutritious diet due to menstruation and pregnancy, particularly for reproductive health, they seldom get it. Consequently, they suffer from anemia, malnutrition, and so many physical complicacy (Srivastava, Goswami, 2011). Women are also susceptible to diarrhea and communicable diseases because of poor sanitation (unhealthy/ non-improved) system.

6.0 Conclusion and recommendations:

The principal aim of this paper is to estimate gender gap in medical investment for children within the household and to identify the fundamental determinants of gender discrimination against women exist in the society. The study reveals that there is a clear gap between male and female children in health care spending within the household. It is estimated that the health care expenses made by the household (within the sample) for female children is approximately 15% lower than that of male children holding all other variables constant.

Furthermore, the study pays attention in determining the root causes of pervasive gender discrimination against women in the community. It has been revealed in many empirical studies that in spite of remarkable progress in some socio-economic indicators for instance substantial reduction of poverty rate, increase in enrollment rate (both male and female) in primary and secondary level schools, increase in women's participation in labor forces etc. over last two decades, still higher degree of gender gap persists in Bangladesh almost all sectors like health, education, participation in labor force, and access to and control over resources etc (Martin , F. Shah, 2006 ; A.M. Sultana, 2010). It is found that socio-cultural norms, religious beliefs, patriarchal family setting and dominance of male counterparts of women contribute to the regular forms of

discrimination against women. The study highlights some basic causes of gender disparity against women includes patriarchal family settings, ignorance of female children at birth, lacking of opportunities for education, poverty among women, less investment for women's health care in the household and so forth. As it has been proven that at household level, the investment in health care for female children is significantly lower than that of male children, the study suggests to invest more for women's healthcare as a whole (at both household and government level) and it also emphasizes for special measures on the social, economic and environment (improve sanitation, access to drinking water, logistic supports etc) determinants of health. It is perceived that a comprehensive health care policy including institutional and program levels might help to improve the health situation of women which would result in reduction of gender gap prevails in health sector.

However, women are often discriminated at home, at work places, and overall in the community. This study, therefore, also reveals the root causes of pervasive gender gap in the society which should be reflected in the policy formulation in reducing gender gap. The promotion of gender and empowerment of women is a burning issue for achieving MDGs and sustainable economic development. The government of Bangladesh expressed strong commitment to improve gender situation by adopting policy reforms and development programs which comply with the Convention on elimination of all forms of discrimination against women (CEDAW) and Fourth World Conference on Women: Equality, Development and Peace was held in Beijing in 1995. In addition to it, many national and international NGOs also have been working towards the reduction of gender gap by improving the status of women. Though some progress has been made on this issue, the government still has been facing tremendous challenges in achieving expected equality between men and women. Some policy implications (both short term and long term), therefore, are recommended on the basis of this study in order to achieve substantive gender equality.

I. It is essential to ease the health care budget of the household so that all the family members can get better health care services. At the same time, everybody should have some specific health insurance policy;

II. To promote advocacy and comprehensive gender analysis on health financing and health insurance proposal in order to address women's health and family planning needs effectively;

III. Government should ensure equal and easy access to gender responsive health and education services more widely;

IV. Law and order enforcing agencies along with both marriage registrars and birth registrars should be more efficient and sincere in order to end violence against women and girls at home and in the communities;

V. Early marriage and dowry, which are two root causes of gender discrimination, are deeply embedded in the improvised and traditional cultural settings in Bangladesh. No single solution is available to prevent and protect such kind of social diseases. The following study, therefore, suggests that women need to have easy access to education, particularly to the higher study and comprehensive social awareness programs need to be undertaken by the government in collaboration with NGOs of national and international level;

VI. Mass media like electronic media, print media even social media like facebook, YouTube, twitter etc. should come forward in order to build mass awareness against dowry, early marriage, son preference, and violence against women. They should also take pragmatic steps in raising voice for women regarding women's legal rights, better education, nutrition, reproductive health, participation in labor market and above all for their access to better opportunity.

VII. Women should be given priority for human resources development programs (Training, technical or vocational learning etc) in order to enhance women's skills and capability so that they can easily enter into the formal labor force of the country;

VIII. Gender issues, especially social and cultural education regarding early marriage, sex biasness, dowry system etc should be incorporated in school curriculum in order to build gender awareness among the young generation;

IX. Local government institutions, NGOs and community leaders jointly can organize counseling parents on importance of maternal health, women's education, bad effect of early marriage and dowry system which could be an effective measure to improve the situation of women in general;

X. Documentaries, short film or commercial film based on positive image of women can play a vital role in changing the mind set of common people.

References :

Shahnaj Parveen (2007), *Gender Awareness of Rural Women in Bangladesh*, Journal of International Women's Studies Vol. 9 #1 November 2007

Gender Equality in Sector Wide Approaches : A Reference Guide (June 2002), Development Assistance Committee, OECD ,

World Bank, (2012), *Toward Gender Equality in East Asia and the Pacific: A Companion to the World Development Report*—Conference Edition.

Convention on the Elimination of All Forms of *Discrimination* against women (2008); Layout 1; http://www.unodc.org/documents/human-trafficking/Toolkit-files/08-58296_tool_9-3.pdf

United Nations Children's Fund (UNICEF), December (2011), *Gender Influences on Child Survival, Health and Nutrition: A Narrative Review*

Jannatul Ferdaush, K. M. Mustafizur Rahman (2011), *Gender Inequality in Bangladesh , Unnayan Onneshan-The Innovators*.

Farida Faisal, 2011, *Public Policy and Gender Mainstreaming Strategy: Redressing Gender Inequality*

CPD-UNFPA Paper 19 (October 2002) , Gender-Related Development Index ,For 64 Districts Of Bangladesh,

Moser, Caroline N. (1993) *Gender Planning and Development*, Routledge, London

World Bank (2012), World Development Report-2012; Gender equality and Development, World Bank,

OECD , 2002, Gender Equality in Sector Wide Approaches; A Reference Guide

World Bank, 2012, *Toward Gender Equality: East Asia and the Pacific, Regional report*

UNICEF, 2010, *Women and girls in Bangladesh*

CEDAW report, Bangladesh (2009), Ministry of Women and Children Affairs (*www.mowca.gov.bd*) Government of the People's Republic of Bangladesh,

BBS-2006: Multiple indicator Cluster Survey-06, Bangladesh Bureau of Statistics and UNICEF, Ministry of Planning.

BBS-2005: Child and Mother Nutration Survey-05, Bangladesh Bureau of Statistics and UNICEF, Ministry of Planning.

World Bank, 2012, *Integrating Gender into the World Bank's Work: A Strategy for Action*

Fariyal F Fikree, Omrana Pasha, 2004, *Role of gender in health disparity: the South Asian context*

Sheikh Kabir Uddin Haider, 2012*, Dimension and intensity of gender inequality in Bangladesh: an overview,*

Kabeer Naila (1985). "*Do Women Gain from High Fertility.'' In Women, Work, and Ideology in the Thrid World* (ed. Haleh Afshar) New York: Tavistock Publication.

Sultana Kamal ,September,2001, Advocate – *Bangladesh, Law for Muslim Women in Bangladesh*, Ozean Journal of Social Sciences 3(1), 2010

Archana Srivastava, Dr. Ajay Goswami, 2011, *Gender Discrimination in Education and Health Care in Pre-social Children in Ballia District* (U.P.)

Abay Asfaw, Stephen Klasen, Francesca, Lamanna, 2007, *"INTRAHOUSEHOLD HEALTH CARE FINANCING STRATEGY AND THE GENDER GAP IN INDIA''.*

Rozana Himaz (2008) , *Intrahousehold Allocation of Education Expenditure and Returns to Education: The Case of Sri Lanka*, Manor Road Building, Oxford OX1 3UQ

Martin , F. Shah(2006), *Bangladesh Gender Profile*, KfW Bankengruppe, Group communications Palmengartenstr. 5-9, 60325

A.M. Sultana, 2010, *Socio-Cultural Dimensions of Women's Discriminations in Rural Communities*